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Challenges in Integration and Integrated Care

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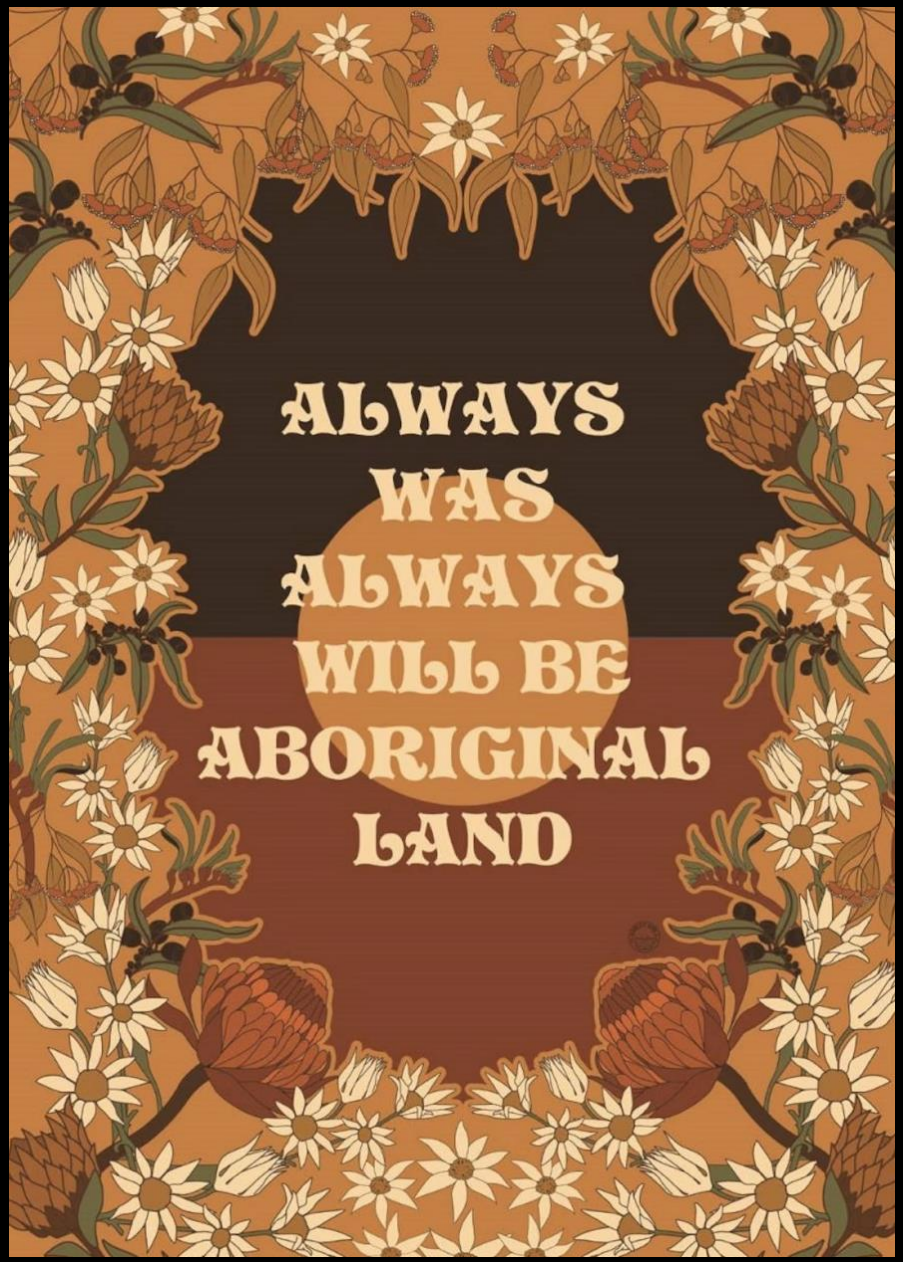

The work I am presenting was conducted on the lands of the Wurundjeri people of the Kulin nation.

I wish to acknowledge them as the Traditional Owners, and to pay my respects to their Elders, past and present.

This land was never ceded.

image credit to @harleyandj

Disclosures, disclaimers & perspectives

- Addiction psychiatrist & researcher

- Supported by a NHMRC Emerging Leader fellowship (GNT2008173) in methamphetamine use and trauma/PTSD
- CI and site PI on a MRFF-sponsored multisite study of MDMA for PTSD/ Alcohol Use Disorder (MPATHY)
- CI on an Eastern Health Foundation grant on the PANDA pilot study- Psilocybin assisted treatment for Alcohol and Depression
- Member of the RANZCP Psychedelic Assisted Therapy Steering Committee

background
integrated care
psychedelics & PAT
context
Australian implementation
research
evidence base
safety
gaps
unanswered questions
& challenges

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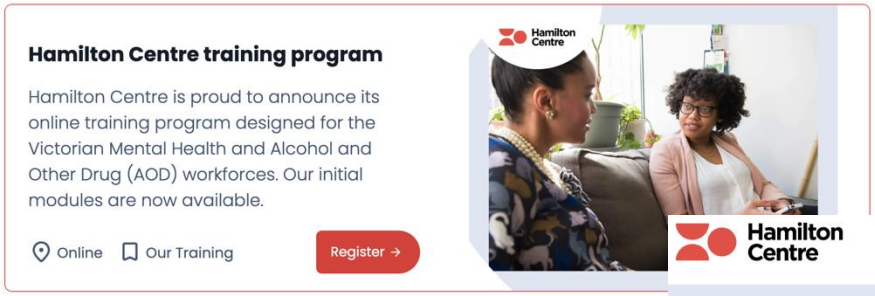
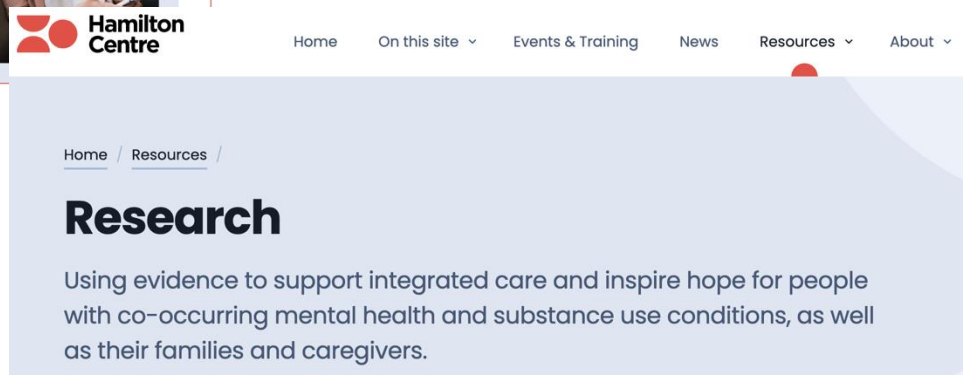
background

Integrated care

- Over **2 in 3** service users in AOD settings have a previous MH diagnosis; nearly **1 in 2** people seeking care in MH services have a co-occurring AOD problem





Integrated care

- Presence of both problems
  - Complicates and impedes recovery from both
- Pressing need for holistic approaches to treatment that acknowledge and actively treat both problems
- For many people, substance use is a solution an underlying problem
- Attractiveness of integrated treatment approaches; and **transdiagnostic** treatments that address underlying challenges (e.g., trauma/ PTSD)

Integrated care & psychedelics

- Transdiagnostic approaches
  - Addressing core constructs or mechanisms of change

- Neurotransmitter systems that underpin both substance use and mental health challenges

background psychedelics & PAT

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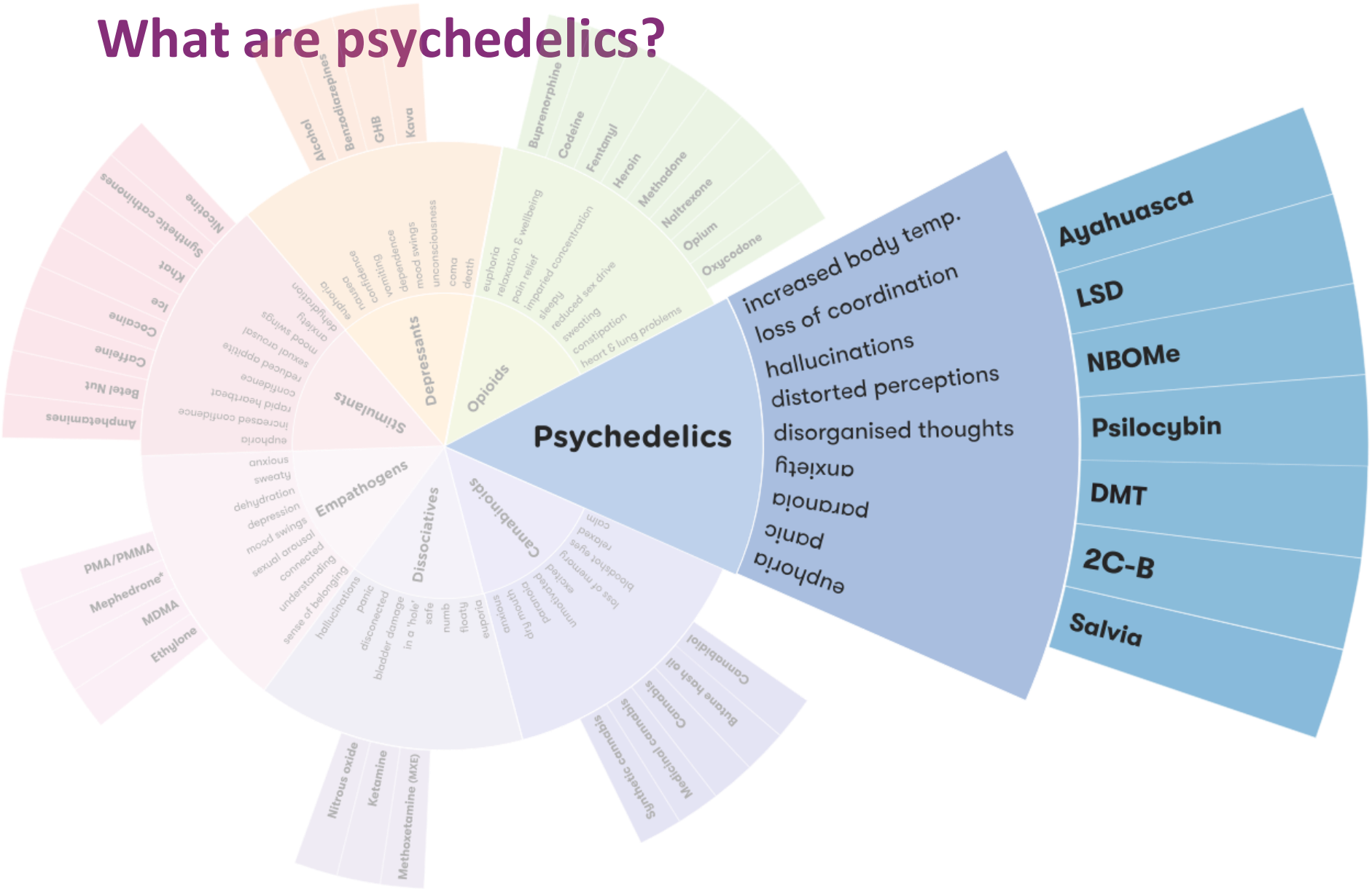
What are psychedelics?



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What are psychedelics?

Table 1 Notable Landmarks of Mid-Twentieth Century Psychedelic Research Plus Events of Cultural Significance

Year	Landmark	References
1943	LSD's psychoactive effects discovered by Albert Hofmann (16th and 19th April)	Hofmann, 1980
1947	Werner Stoll publishes first paper on psychological effects of LSD in humans	Stoll, 1947
1950	First English language publication on LSD	Busch and Johnson, 1950
c. 1953	ACNP Founding president Joel Elkes (President in 1961) publishes on LSD after openly self-experimenting with it	Bradley *et al*, 1953; Roberts, 2008
1954	Aldous Huxley's 'The Doors of Perception' published: documents mescaline self-experiment	Huxley, 1954
1956	Term 'psychedelic' coined by Humphrey Osmond in communication with Aldous Huxley	Huxley, 1980
1957	Term 'magic mushrooms' coined by LIFE magazine	Wasson, 1957
1958	Identification of psilocybin in magic mushrooms by Albert Hofmann	Hofmann *et al*, 1958
1959	Closed conference held in Princeton on 'the use of LSD in psychotherapy', Jonathan Cole attends, an early ACNP president	Abramson, 1959
1960	First major European conference on psychedelics; Sidney Cohen publishes positive meta-analysis on LSD safety	Passie, 1996; Cohen, 1960
1961	Jonathan Cole (ACNP president 1965-66) expresses 'very mixed feelings on psychedelic research' as critical commentaries emerge	Mangini, 1998
1962	The Marsh Chapel or 'Good Friday' experiment conducted at Harvard under Timothy Leary's supervision but without institutional approval	Pahnke, 1966; Mangini, 1998
1963	Leary dismissed from Harvard; Aldous Huxley and JFK die (both on 22nd November)	Stevens, 1987
1964	Cole takes 'sober look' at psychedelics in JAMA; discussions on LSD take center stage at 1964 APA meeting; Ken Kesey travels across US taking LSD with 'Merry Pranksters'	Mangini, 1998; Cole and Katz, 1964; Stevens, 1987; Wolfe, 1968
1965	Sandoz stop manufacture of LSD and psilocybin	Stevens, 1987
1966	Prohibition of psychedelics and curtailment of research begins in US; Senator Robert Kennedy formally questions this move	Stevens, 1987; Lee and Shlain, 1992
1967	Timothy Leary declares 'turn on, tune in and drop out' at festival in Golden Gate Park	Stevens, 1987
1970	President Nixon signs Controlled Substances Act, LSD and psilocybin made Schedule I	Stevens, 1987; Lee and Shlain, 1992

Abbreviations: ACNP, American College of Neuropsychopharmacology; JAMA, *Journal of the American Medical Association*; NIMH, National Institute of Mental Health.

What are psychedelics?

Table 1

The classic psychedelics and their natural sources

Chemical name	Common name(s)	Natural sources
5-methoxy-*N,N*-dimethyltryptamine (5-MeO-DMT)	Toad	Yopo tree (*Anadenanthera peregrina*) seeds Colorado River toad (*Bufo alvarius*) and Sonoran Desert toad (*Incilius alvarius*) skin exudate
N,N-dimethyltryptamine (DMT)	Spirit molecule	Chacruna shrub (*Psychotria viridis*; a component of the ayahuasca brew) and other plant species
Lysergic acid diethylamide (LSD)	Acid	Derived synthetically from ergot fungus (*Claviceps purpurea*)
Mescaline (3,4,5-trimethoxyphenethylamine)	Peyote	Cacti species (*Lophophora williamsii, Echinopsis pachanoi, Echinopsis peruviana*)
Psilocybin, psilocin	Magic mushrooms, shrooms	*Psilocybe* mushroom species

Source: Reference 7

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What are psychedelics?

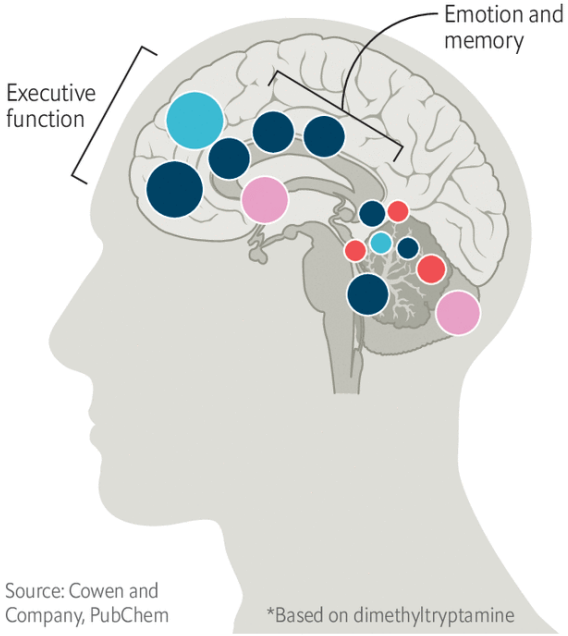
Class	Primary receptor activation	Onset and duration of action
Indoleamines (aka tryptamines)		
Psilocybin (phosphoryloxy-N,N-dimethyltryptamine) Psilocin (active metabolite of psilocybin, 4-hydroxy-DMT)	5-HT1, 5-HT2, 5-HT6 and 5-HT7 partial agonists	Onset 10–40 min po, peak 90–100 min, duration 4–6 h (most effects abate 6–8 h) Half-life: 2–3 h
N,N-dimethyltryptamine (DMT) 5-methoxy-DMT (5-MeO-DMT) Ayahuasca (aya) (DMT from *Psychotria viridis* plants and *Banisteriopsis caapi,* containing the potent MAO inhibitors beta-carboline alkaloids)	5-HT1, 5-HT2, 5-HT6, and 5-HT7 partial agonists	DMT IM onset within 2–5 min and can last 30–60 min DMT smoked or inhaled free-base <30 min DMT IV peak 5 min, abate by 30 min Aya: effects within 60 min, peak 90 min, can last 6 h
Phenylalkylamines (synthetic "amphetamines")		
2,5-dimethoxy-4-iodoamphetamine (DOI) 2,5-dimethoxy-4-bromoamphetamine (DOB)	5-HT2A, 5-HT2B, 5-HT2C agonists	onset 1-2 h, duration 16–24 h
Mescaline		Peak within 2 h po, duration up to 8 h
Semi-synthetic Ergolines		
Lysergic acid diethylamide (LSD)	5-HT1, 5-HT2, 5-HT6 and 5-HT7 partial agonists D1 and D2 dopamine receptors and adrenergic receptors	po onset 30–45 min, peak 1–2.5 h, duration 9–12 h IV onset 3–5 min, peak 1 h, duration 9–10 h

Tuning in

Psychedelic interactions with brain receptors

Circle size=effect and number of receptors

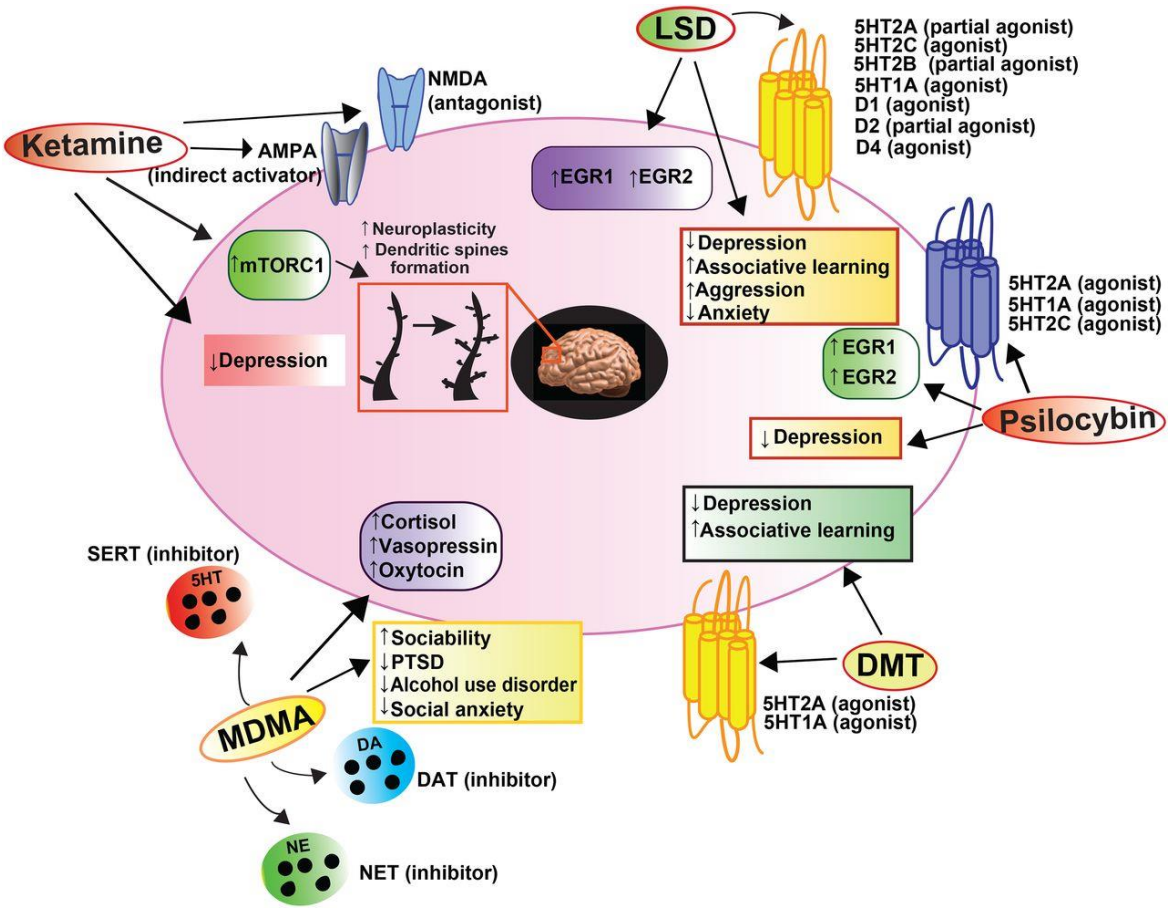
Psychedelics			
5-MeO-DMT*	5-HT2A	5-HT1A	
Ketamine	NMDA		
LSD	5-HT2A	5-HT2B	5-HT1A
Mescaline	5-HT2A		
Psilocybin	5-HT2A		



Source: Cowen and Company, PubChem

*Based on dimethyltryptamine

The Economist



Gregorio et al. https://www.jneurosci.org/content/41/5/891

MDMA

- MDMA
  - Not a ‘classic’ psychedelic
  - Actions at 5-HT transporter (SERT)
  - Also blocks DAT (dopamine), and promotes release of oxytocin
  - ‘Entactogen’, ‘empathogen’

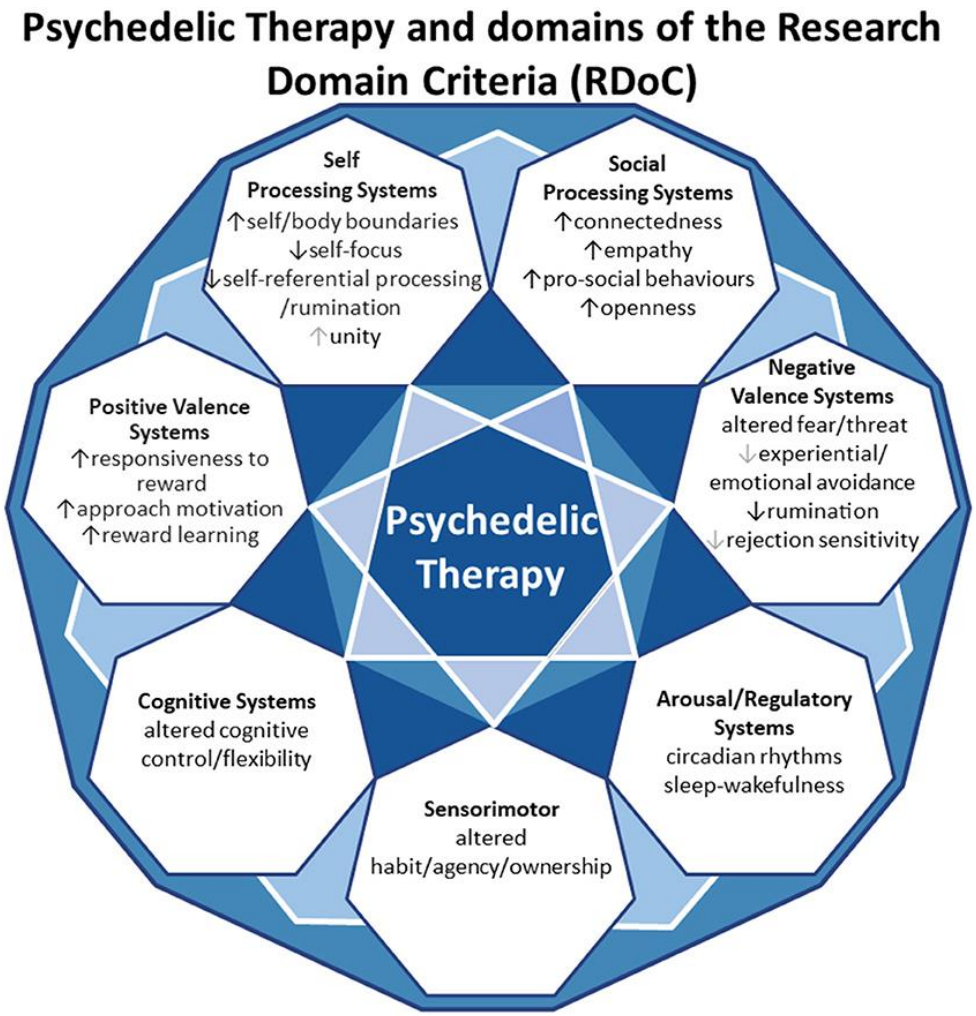
What is psychedelic assisted psychotherapy?

- Crux of the model is that this is psychotherapy with the *addition* of a medicine that may enhance therapeutic process
- Used in 2-3 session dosing rather than continual/ maintenance model (e.g. antidepressant medication)

Factors that influence a psychedelic experience.

Lawrence & Carhart-Harris 2019

How might psychedelics work?



Kelly, J. R., et al (2021). *Frontiers in Psychiatry*, *12*, 800072.

MDMA-AT for PTSD: How might it work?

Catalysing therapy

- Fear extinction learning, memory consolidation; enhancing learning
  - BDNF- mediated?
- Openness
- Self-experience
  - Self compassion
- Promoting therapeutic alliance

Potential memory mechanisms

A.A. Feduccia, M.C. Mithoefer

Progress in Neuropsychopharmacology & Biological Psychiatry 84 (2018) 221–228

Table 1
MDMA enhances molecules involved in memory, learning, and fear extinction.

MDMA-mediated molecules	Memory, learning, and fear extinction mechanisms	References
Serotonin	• Induce affective states to alter fear memories with safety information • Increases DA release • Increases oxytocin release • Modulates MDMA-enhanced fear expression	(Hogberg et al., 2011; Koch and Galloway, 1997; Thompson et al., 2007)
Dopamine	• Increases attention • Induces prediction error • Destabilization of memory traces • Positive behavioral reinforcement	(Asan, 1997; Esber et al., 2012; Merlo et al., 2015; Schultz et al., 1997)
(Nor)epinephrine	• Increases emotional arousal • Enhances learning and memory • Enhances extinction learning • Modulator of cortisol effects	(Berlau and McGaugh, 2006; Liang et al., 1986; McGaugh, 2000; Mueller et al., 2008; Roozendaal and McGaugh, 1996; Roozendaal et al., 2006a; Roozendaal et al., 2006b)
Acetylcholine	• Promotes synaptic plasticity • Increases glutamate release (nAChR)	(Acquas et al., 2001; Fisher and Dani, 2000; Garcia-Rates et al., 2010; Gray et al., 1996; Nair and Gudelsky, 2006; Radcliffe and Dani, 1998)
Glutamate	• Promotes synaptic plasticity	(Abad et al., 2014)
BDNF	• Enhances learning and memory • Modulates synaptic plasticity	(Abad et al., 2014; Bramham and Messaoudi, 2005; Edut et al., 2014; Edut et al., 2011; Young et al., 2015)
Oxytocin	• Mediates socially reinforced learning • Suppresses amygdala activity	(Eckstein et al., 2015; Ferrier et al., 1980; Guastella et al., 2008; Heinrichs et al., 2004; Hurlemann et al., 2010; Rimmele et al., 2009; Savaskan et al., 2008)
Cortisol	• Increases emotional arousal • Modulates learning and memory	(de Quervain et al., 2011; Hamacher-Dang et al., 2013; Izquierdo et al., 2006; Meir Drexler and Wolf, 2017; Soravia et al., 2006)

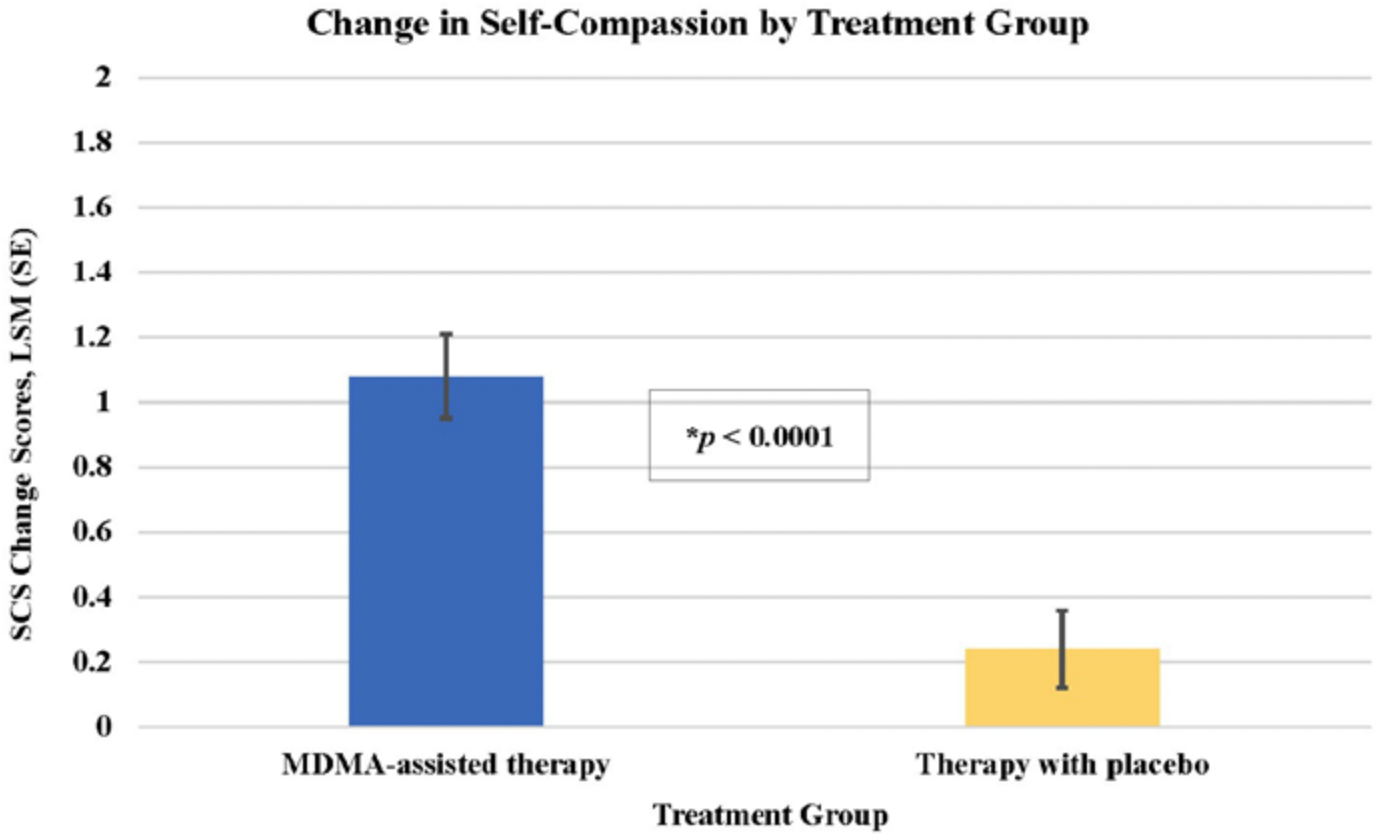


Fig 2. Self-compassion change scores in MDMA-assisted therapy. Least square means (SE) change in Self-compassion Scale (SCS) from baseline to follow-up by treatment group: MDMA-assisted therapy = 1.08 (0.13) vs. Therapy with placebo = 0.24 (0.12), $p < .0001$.

https://doi.org/10.1371/journal.pone.0295926.g002

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context Australian implementation

A sequence of events in Australia…

- Oct 2022 initial TGA decision
- Feb 2023 change in TGA decision, with 1 July timeline for implementation

'Serious concerns' over TGA's decision making on landmark psilocybin, MDMA ruling

Background Briefing / By Annika Blau and Geoff Thompson

Posted Sat 18 Mar 2023 at 6:20am, updated Mon 20 Mar 2023 at 10:56am

In Brief

ANZJP

The down-scheduling of MDMA and psilocybin(e): Too fast and too soon

Steve Kisely[1,2]

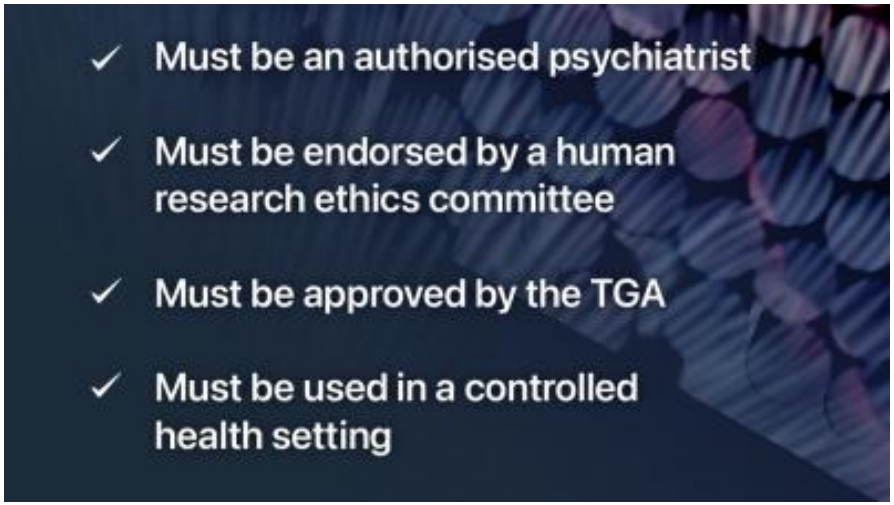
Australian & New Zealand Journal of Psychiatry
2023, Vol. 57(7) 933–934
DOI: 10.1177/00048674231174171

Where are we now?

- Authorised prescriber pathway since 1 July 2023 for psychiatrists
  - psilocybin (TRD)
  - MDMA (PTSD)

- RANZCP Clinical Memoranda and guide

- TGA Guide



RANZCP Psychedelic-Assisted Therapy Steering Group

The steering group is responsible for:

- considering the appropriate level of information and support to provide to members
- providing guidance and recommendations for RANZCP media commentary
- providing relevant information about the prescribing pathway to members and the general public.

Psychedelic Assisted Therapy Steering Group Terms of Reference [PDF; 121 KB]

The Steering Group is developing additional resources to be released in the coming weeks including principles for best practice and a training framework for psychiatrists.

The PAT Steering Group is also involved in ongoing advocacy around the monitoring and reporting of efficacy and safety outcomes from PAT. The College advocates that data, including on adverse events, must be collected systematically and longitudinally.

Where are we now?

- Several private clinics across Australia
  Metropolitan settings
  (Melbourne, Sydney; Perth)
  Model varies – mostly 1-2 dosing sessions in a package of assessments & 4-6 sessions of therapy

- Several clinical trials across Australia
  Indications include generalized anxiety disorder, PTSD, treatment-resistant depression, autism spectrum disorder, eating disorder
  e.g., 4 ANZCTR registered RCTs of MDMA
  e.g., 8 ANZCTR registered RCTs of psilocybin

Where are we now?

Research

ANZJP

Attitudes toward psychedelics and psychedelic-assisted therapy among potential mental health service users and the general population in Australia

Australian & New Zealand Journal of Psychiatry
2024, Vol. 58(10) 904–913
DOI: 10.1177/00048674241261779

Zohaib Nadeem[1], Stephen Parker[1,2,3], Hugh McGovern[4,5] and Lena KL Oestreich[5,6,7]

International Journal of Mental Health Nursing

WILEY

International Journal of Mental Health Nursing

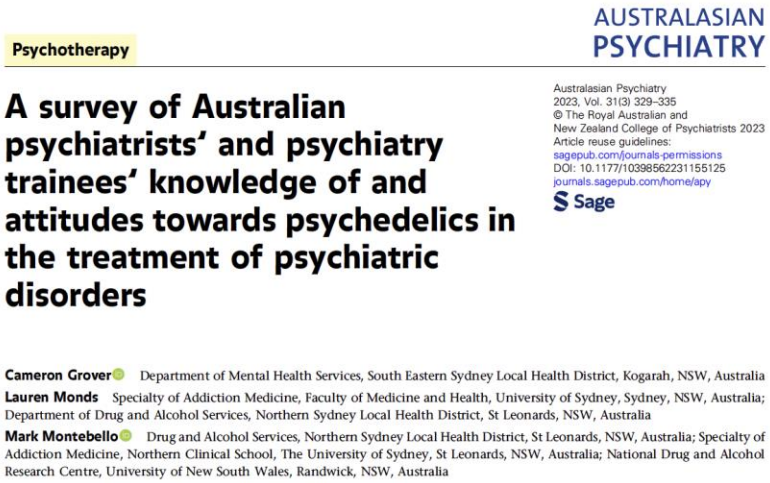
ORIGINAL ARTICLE OPEN ACCESS

The Acceptability of Psychedelic-Assisted Therapy Amongst Mental Health Consumers: Utilising the Theory of Planned Behaviour

Eva Louie[1,2] | Ellen Towers[1] | Alyssa R. Morse[3] | Joshua Watt[1,2] | Zachary Bryant[4] | Paul Haber[1,2] | Kirsten Morley[1,2]

- Consumer preferences, perceptions and attitudes

Where are we now?



Psychotherapy

AUSTRALASIAN PSYCHIATRY

A survey of Australian psychiatrists' and psychiatry trainees' knowledge of and attitudes towards psychedelics in the treatment of psychiatric disorders

Australasian Psychiatry
2023, Vol. 31(3) 329–335

DOI: 10.1177/10398562231155125
journals.sagepub.com/home/apy
Sage

Cameron Grover Department of Mental Health Services, South Eastern Sydney Local Health District, Kogarah, NSW, Australia
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- Clinician perceptions and attitudes

ORIGINAL PAPER

Drug and Alcohol REVIEW APSAD WILEY

Australian psychologists' attitudes towards psychedelic-assisted therapy and training following a world-first drug down-scheduling

Jordan J. Negrine[1] | Cheneal Puljević[2] | Jason Ferris[3] | Paul Liknaitzky[4,5] | Christopher Perlman[6] | Timothy Piatkowski[1,7]

Where are we now?

"We don't want to run before we walk": the attitudes of Australian stakeholders towards using psychedelics for mental health conditions

Breanne E Kunstler[a,b,c], Liam Smith[a,b], Christopher J Langmead[b], Denise M Goodwin[a,b], Breanna Wright[a,b] and Melisssa A Hatty[a,b]

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[b] Neuromedicines Discovery Centre, Monash Institute of Pharmaceutical Sciences, Monash University, Melbourne, Victoria, Australia
[c] Corresponding author: brea.kunstler@monash.edu

- Policymaker and stakeholder views

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research challenges

Challenges

- Blinding
  - 90% of participants in recent trials guessed their treatment allocation
- Expectancy effects
- Generalisability- less than 10% of screened participants make it on to these trials

"So I'm guessing we're in the placebo group."

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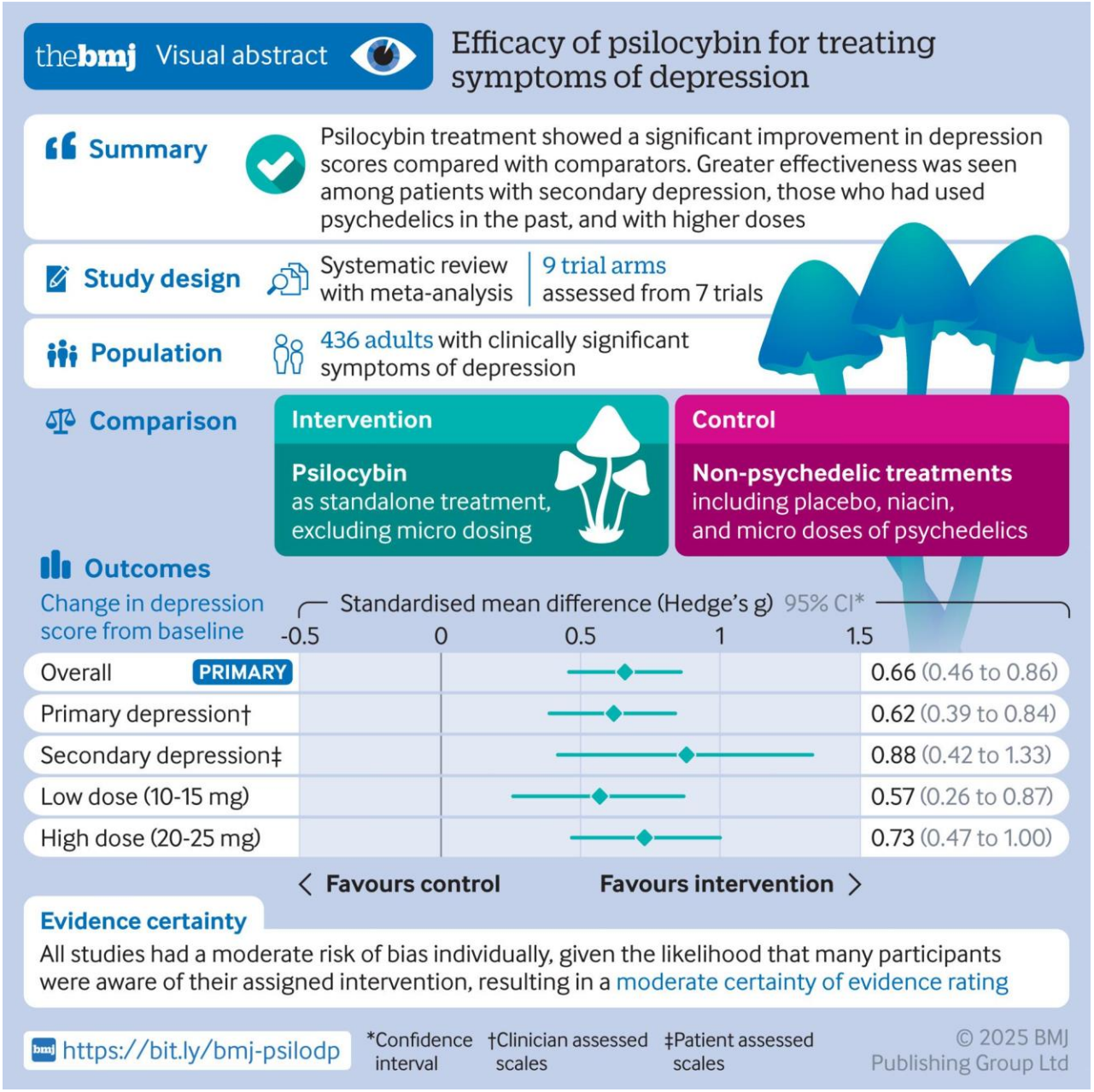
research effectiveness

Mental Health

- Psilocybin for treatment resistant depression
  - Several meta-analyses
    - 7-10 completed RCTs (approx. <500 patients)
    - All with major caveats, moderate risk of bias – meaning low certainty of evidence
    - Evidence to date in favour of psilocybin; limited medium to longer term data

- Metaxa and Clarke. BMJ 2024. https://doi.org/10.1136/bmj.r111
- Menon et al. Acta Psychiatrica Scandanavica 2025. https://doi.org/10.1111/acps.13778



Athina-Marina Metaxa, and Mike Clarke BMJ 2024;385:bmj-2023-078084

Mental Health

- MDMA for PTSD
  - Several systematic reviews & meta-analyses
    Yong et al 2025 ANZJP review of meta-analyses

Results: Fourteen systematic reviews comprising 20 primary studies involving up to 353 participants were included. All reviews included studies of one-to-three sessions of 50–125 mg MDMA-assisted psychotherapy (some with supplemental dosage) compared to either 25–40 mg of MDMA or inactive placebo with psychotherapy. Four were deemed high quality. Meta-analyses reported substantial benefits of MDMA-assisted psychotherapy in improving post-traumatic stress disorder symptoms (standardised mean difference, 0.8–1.3), response rate (relative risk, 1.3–3.5) and remission rate (relative risk, 2.3–2.9) compared to psychotherapy alone. However, for reviews that assessed the certainty of evidence, the evidence was rated as low to very low certainty due to high risk of bias, indirectness and imprecision. There was moderate-quality evidence that MDMA-assisted psychotherapy was associated with an increased odd of transient adverse events. However, reviews noted reliance on spontaneous rather than systematic adverse event reporting, discrepancies between adverse events reported in published studies and clinical trial registries, and a lack of long-term safety data.

Conclusion: Four high-quality systematic reviews suggest low to very low certainty evidence for efficacy outcomes and moderate to very low quality evidence for safety outcomes.

https://doi.org/10.1177/00048674251315642

MDMA – PTSD

Table 1. Summary of major outcomes reported in systematic reviews.

Outcomes	Summary of findings
Study characteristics	• Reported on both the safety and efficacy of MDMA-AP: *n* = 10 • Reported on safety only: *n* = 2 (Breeksema et al., 2022; Colcott et al., 2024) • Reported on efficacy only: *n* = 2 (Hoskins et al., 2021; Luoma et al., 2020) **Intervention group**: 50–125 mg MDMA-AP (1–3 sessions) **Comparator group**: active placebo (25–40 mg of MDMA) or inactive placebo along with psychotherapy **Risk of bias assessment tools**: Cochrane Risk of Bias tool, modified quality and risk of bias checklist (NHMRC, 1999), Critical Appraisal Skills Programme (CASP), CONSORT Harms 2022, or qualitative assessment **Certainty of evidence assessment**: GRADE approach, ICER Evidence Rating Matrix, AHRQ Methods Guide for Comparative Effectiveness Reviews
Methodology quality (assessed by authors using AMSTAR-2)	high = 4, moderate = 1, low = 3, critically low = 6
Efficacy of MDMA-AP	**PTSD symptoms**: SMD in CAPS score of −0.8 to −1.3 (Bahji et al., 2020, 2023; Green et al., 2023; Hoskins et al., 2021; Kisely et al., 2023; Mackey et al., 2022; Mustafa et al., 2024; Tedesco et al., 2021) **Response rates**: RR of 1.3 to 3.5 (compared to comparator group) (Bahji et al., 2020, 2023; Kisely et al., 2023; Mustafa et al., 2024; Tedesco et al., 2021) **Remission rates**: RR of 2.3 to 2.9 (compared to comparator group) (Bahji et al., 2020, 2023; Mustafa et al., 2024; Tedesco et al., 2021) **Loss of diagnosis**: RR of 1.70 (compared to comparator group) (Mustafa et al., 2024) **Depressive symptoms**: MD in Beck's Depression Inventory of −10.8 to −11.1 (Green et al., 2023; Illingworth et al., 2021) **Daily functioning**: MD in Sheehan Disability Scale of −1.5 (Mustafa et al., 2024); SMD of −0.4 to −0.8 (Green et al., 2023; Mustafa et al., 2024) **Long-term outcomes** (change in PTSD symptoms after 2–74 months follow-up): SMD of −0.8 to −1.1 (Bahji et al., 2020; Tedesco et al., 2021)
Safety of MDMA-AP	**Any adverse events (immediate)**: OR of 1.7 to 3.5 (compared to comparator group) (Colcott et al., 2024)[a] **Any adverse effects (up to 7 days)**: OR of 1.6 (compared to comparator group) (Colcott et al., 2024)[a] **Adverse events of special interest**: No significant difference found **Rate of discontinuation**: No significant difference (Colcott et al., 2024) or lower risk of discontinuation in the intervention group: RR of 0.32 (Mustafa et al., 2024) **Long-term adverse events**: 2–4% of adverse events reported after 12 months (Colcott et al., 2024)

AHRQ, Agency for Healthcare Research and Quality; ICER, Institute for Clinical and Economic Review; MD, mean difference; MDMA-AP, MDMA-assisted psychotherapy; OR, odds ratio; SMD, standardised mean difference; RR, relative risk.
The statistical summaries reported for efficacy and safety outcomes are presented at a high level and should be interpreted within the context of each individual review and its certainty of evidence.
[a]Refer to individual review for incidence rate or RR of each adverse event.

Substance Use Disorder

- Much less evidence
- People with SUD often excluded from MH trials

Current Addiction Reports (2025) 12:15
https://doi.org/10.1007/s40429-025-00629-8

Check for updates

Psychedelics in the Treatment of Substance Use Disorders and Addictive Behaviors: A Scoping Review

Jérémie Richard[1,2] · Albert Garcia-Romeu[1,2]

Accepted: 13 October 2024

- Uncontrolled studies, self-reports from self-experience and non-medicalized settings (which may not be transferable)

- Trials for specific SUD indications include
  - psilocybin for alcohol use disorder
  - ketamine for alcohol use disorder
  - psilocybin pilot for methamphetamine use disorder

Bogenschutz (2022) Psilocybin for AUD

JAMA Psychiatry

RCT: Psilocybin-Assisted Treatment of Alcohol Use Disorder

POPULATION

53 Men, 42 Women

Adults with alcohol dependence

Mean age, 45.8 y

SETTINGS / LOCATIONS

2 Academic centers in New York and New Mexico

INTERVENTION

95 Individuals randomized

49 Psilocybin
Administered orally in 2 all-day sessions (dose range, 25-40 mg/70 kg)

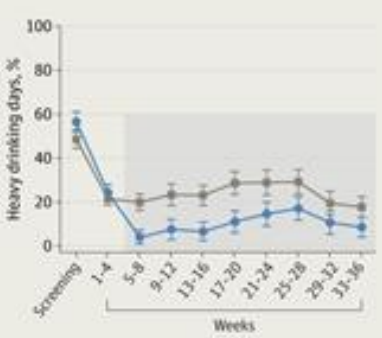
46 Diphenhydramine control
Administered orally in 2 all-day sessions (dose range, 50-100 mg)

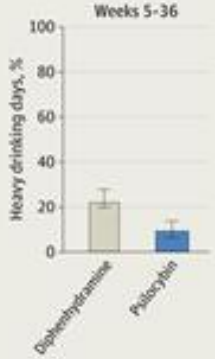
PRIMARY OUTCOME

Percent heavy drinking days (scale, 0-100), assessed using the timeline followback interview, contrasted between groups over the 32-wk period following the first administration of study medication.

FINDINGS

Percent heavy drinking days during the 32-wk double-blind period was lower in the psilocybin group compared with the diphenhydramine group





Percent heavy drinking days
Psilocybin=9.7%
Diphenhyramine=23.6%

Mean difference, 13.9 (95% CI, 3.0-24.7; *P* = .01)

Bogenschutz MP, Ross S, Bhatt S, et al. Percentage of heavy drinking days following psilocybin-assisted psychotherapy vs placebo in the treatment of adult patients with alcohol use disorder: a randomized clinical trial. *JAMA Psychiatry*. Published online August 24, 2022. doi:10.1001/jamapsychiatry.2022.2096

Integrated care

- No completed studies so far
- Promising indications include
  - alcohol use disorder + PTSD
  - alcohol use disorder + depression
  - methamphetamine + depression

- Major gap in research

Turning Point
TREATMENT · RESEARCH · EDUCATION

MPATHY study

mpathy

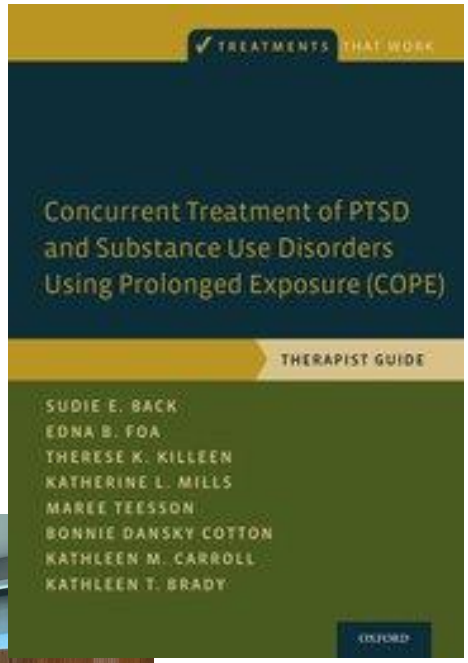
Lead investigator:
Kirsten Morley
University of Sydney

PI (Sydney): Paul Haber
PI (Melbourne): Shalini Arunogiri

Investigators:
Kath Mills, Maree Teesson, Dan Lubman, Andrew Baillie, Alyssa Morse, Yong Yi Lee, Sudie Back

MPATHY

- Evidence based integrated trauma-focused psychotherapy based on prolonged exposure (COPE) and relapse prevention
- Addition of MDMA (x 2 dosing sessions)
- Total of 14 sessions of psychotherapy, incl. 2 MDMA dosing & integration sessions
- Primary outcome PTSD severity; Secondary outcome AUD severity



Turning Point
TREATMENT · RESEARCH · EDUCATION

research safety & adverse effects

Is it safe?

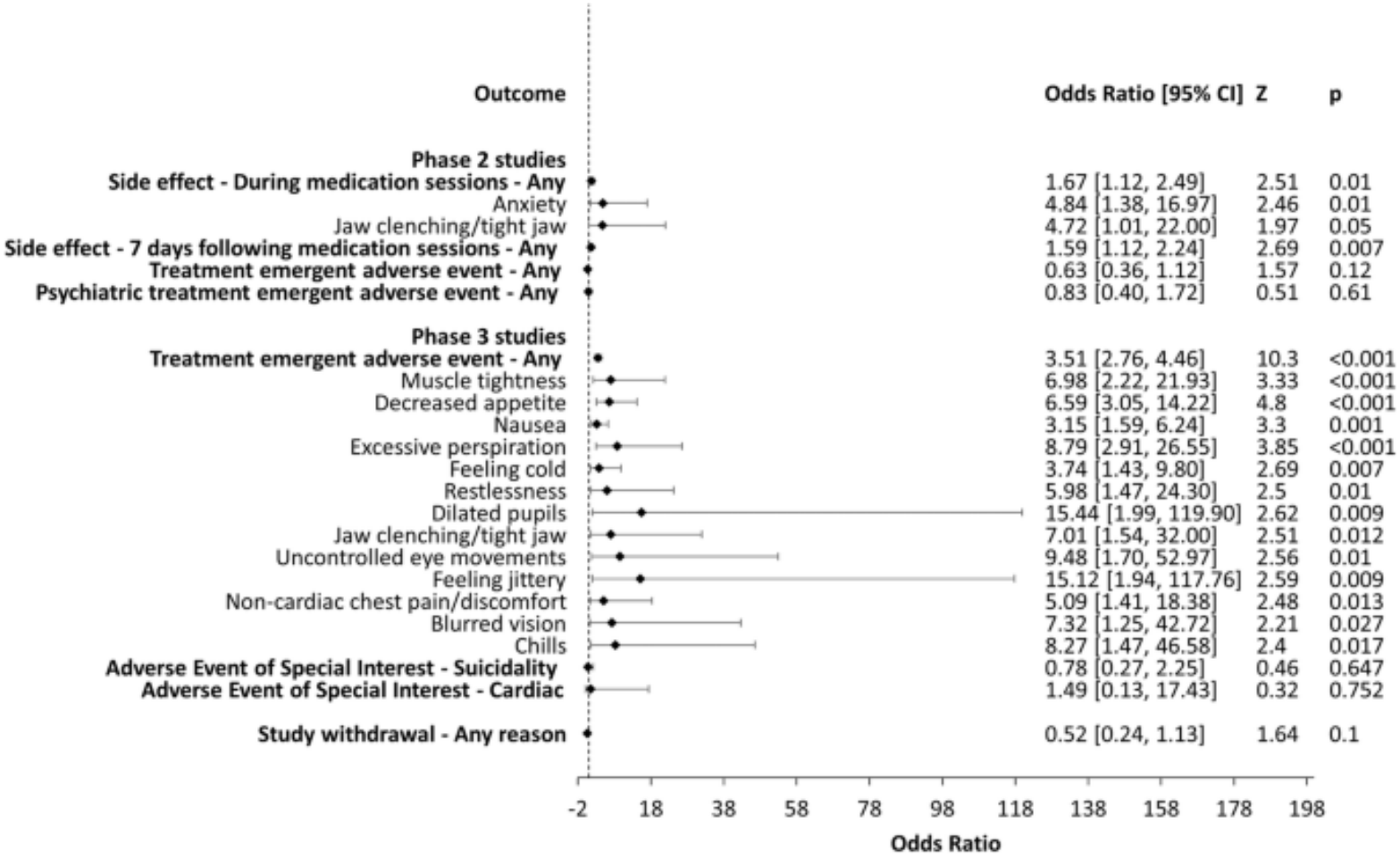
- Current studies have been conducted in very selective clinical trial populations, and largely in psilocybin and MDMA (much less data on other psychedelics)
- Registry and TGA data during this roll out will be **critical** to informing a safety signal in a general (non-clinical trial) population

ARTICLE OPEN

Check for updates

Side-effects of mdma-assisted psychotherapy: a systematic review and meta-analysis

Julia Colcott[1,2], Alexandre A. Guerin[2], Olivia Carter[1], Sally Meikle[1] and Gillinder Bedi[2]✉



Turning Point
TREATMENT · RESEARCH · EDUCATION

research gaps

Gaps in research evidence

- Major gaps and limitations in existing evidence
  - Very little to no evidence in Australian context to date
    (but several trials currently in planning or underway)

Gaps in research evidence

- Major challenge in providing informed consent whilst gaps in evidence remain
- Safety; long term follow-up data
- Challenges in implementation
- Current model may not be widely implementable or accessible

Implementation & Integration

Integration as a task of making sense, making meaning, and applying insights

Implementation as a process of evidence gathering, perspective taking, and application

Thank you for listening

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Thanks to our Melbourne mpathy team
Dan Lubman, Daniel Pham, Sarah Catchlove, Liron van Heerden, Taya Grainger, Emily Bove, Anna Bough, Trudi Mckenzie, Temika Mu, Michelle Sharkey, Vicky Phan, Christina Ngo-Nguyen, Adam Milne

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mpathy