Complex cases and comorbidities

Patients with a substance use disorder (SUD) often have multiple physical or mental health comorbidities that need to be managed alongside their substance use.

Trauma and chronic pain are more prevalent in patients who misuse substances, as are unemployment, low socioeconomic status, and homelessness.[1]

These factors add layers of complexity to a patient's presenting problem and are potential barriers to care. Patients who experience competing pressures arising from their social circumstances may not be ready, willing, or able to change their AOD use[2].

Treating patients with multiple comorbidities

Treating patients with multiple comorbidities is complex and is best met by using a whole-person care approach to identify patient motivations and barriers to care.[3]

As a GP, you will not be able to resolve these bigger issues for your patients, however by providing whole of person care, you reduce some of the barriers they face accessing quality health care.

The resources on this page are designed to support you as you take a longer-term approach to caring for patients with complex comorbidities.

A suggested approach to support longer-term care for patients with complex comorbidities

A suggested approach to support longer-term care for patients with complex comorbidities		
Suggested approach	**Description**	**Resources**
Take the long view	It takes time for problems to develop, and it takes time to manage and treat them. Celebrate the small wins with your patient. Establish effective work life boundaries and self-care practices. Caring for your patients is essential but taking on their problems is not. Vicarious trauma is a recognised problem within the AOD field. Seek help if you are identifying with a patient's story and taking it home with you. Find like-minded GPs who can care for your AOD patients while you're away. This improves continuity of care and takes the guilt out of having time away. Debrief and problem solve with your supervisors, mentors, Balint groups, professional psychologist/coach.	Join an RACGP AOD case-based discussion group every Thursday night and connect with other GPs and AOD experts to discuss and debrief cases. Click here for more information and to register for AOD Connect: Project ECHO.

[1] Australian Institute of Health and Welfare (2021) Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2018. AIHW, Australian Government.

[2] Alcohol and Drug Foundation 2021. Identifying risk factors. Viewed 19 January 2022.

[3] Department of Health, Australian Government 2016. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Viewed 19 January 2022.

Harm minimisation	Assist the patient to make their alcohol and drug use as safe as possible by discussing ways they can reduce the harms associated with their substance use. For example: • safer injecting practices • planning drug use during the day • avoiding driving • don't buy on credit cards • ensure complying with court orders • know their legal rights.	Harm minimisation resources
Use agenda mapping	Take a 'health coach' approach. Your aim is to help the patient decide on their own motivations for change and their own strategies to manage their condition. For example: • make a list of your priorities and the patient's priorities • revisit this list at each consultation, from most urgent to least urgent • review using the whole-person care model (biomedical, mind-body, social connection, physical activity, and nutrition) • patients shift between stages of change, so direct your advice relevant to how they present each time.	Motivational Interviewing resources
Enlist a team approach to help facilitate whole-person care	Take a team approach, for example: • build a care plan using your agenda map • enlist a social worker support to help with housing, finances and legal issues • share the load by referring to AOD/psychiatry services who may have case workers who can coordinate appointments and provide support • enlist other allied health professionals where appropriate.	Whole of Practice Package resources
Social prescribing	Social prescribing or 'community referral', is a way of formalising a referral to non-clinical services where patients get support based on their interests and make community-based connections. This supports areas of health that cannot be addressed in the traditional health care system and acts as a long term 'protective factor' against relapse or comorbidity. Consider referrals to local activity groups such as park run, craft groups, volunteer charity groups, sports coaches, parenting courses, cultural or faith groups, teachers and education, beauty treatments, and peer groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Your practice nurse/care plan nursing staff are typically reliable sources of information. Some organisations have support workers who can attend appointments and assist patients with day-to-day problem solving.	Social prescribing Report RACGP

How to take a long-term approach

In this two-part video, Dr Paul Grinzi explores strategies that GPs can adopt to incorporate treatment of alcohol and other drug use into their practice. Part I explores how to prioritise your consults using a chronic disease management approach, and Part 2 looks at ways to use the MBS and tips for time management.

How to take a long-term approach		
Video	**Description**	**Resources**
Take a Long Term Approach Part I **View video**	• Substance use disorder (SUD) is considered a chronic disease, often associated with comorbid mental or physical health conditions. • Triage their health concerns and address urgent or life-threatening issues (suicidality or acute infection). Review and reassess. • Foster a non-judgemental approach and acknowledge the patient's circumstances. • Social and psychological issues are often a patient's main priority. These take the longest to repair. • Invest time in treatment planning, potentially a whole consult. • Allow the patient to find their own solutions.	• Download video transcript Part I and Part II • Search the MBS • Chronic disease GP Management Plans and Team Care Arrangements
Take a Long Term Approach Part II **View video**	• Regular consults help you treat the whole person, their AOD use and comorbidities • Consultation item numbers for managing longer term use/dependence: telehealth, chronic disease care planning, mental health treatment plans, case conferences and team care. • Get a team involved to support you. • Invest in time management shortcuts, such as auto-fills and templates. • You can make a real difference to a patient's quality of life. Witnessing these rewards outweigh the difficulties and challenges along the way.	

Frequently asked questions

How do I approach treatment of patients with mental health comorbidities?

Screen patients regularly for their mental health and substance use. Treating a substance use disorder (SUD) and mental health condition concurrently and in parallel is best practice[4]. For example when an SUD becomes more severe, so can the anxiety, and vice versa. The Comorbidity Guidelines are helpful at providing practical approaches to management of a substance use and mental health comorbidities.

To support management and treatment of common presentations such as anxiety, depression, and insomnia, access the Comorbidities resources.

How do I approach treatment of patients with common physical health comorbidities?

Having a chronic disease can be overwhelming for patients. A supportive family member or case worker should be enlisted to help. This is especially important in cases of cognitive impairment due to substance use and traumatic brain injury that can impact on a person's ability to follow through with management plans. If you need help with specific physical comorbidities, HealthPathways, via your local PHN, includes guidance for management and referral. To support management and treatment of common physical comorbidities, access the comorbidities resources.

How do I approach treatment of patients presenting with chronic persistent pain?

Start from a place of empathy and focus on supporting quality of life improvements as identified by your patient. Explore their pain and its functional impacts, discuss the role of opioids and the newer evidence-based interventions that do not involve medication for management of chronic non-cancer pain[5].

Monitor the patient's pain and tailor a plan with the patient that is collaborative. This may involve a slow and well supported weaning schedule. For resistant patients, consider their dependence and assess for possible co-existing opioid use disorder using the DSM-5 criteria for diagnosing an SUD. Consider and discuss whether opioid replacement/substitution therapy may offer better treatment.

In recent years, many helpful resources have been developed to support GPs to discuss chronic persistent non-cancer pain with patients. To access videos, articles, toolkits, and patient resources such as animated videos and handouts, access the Chronic non-cancer pain resources.

How do I approach treatment of patients who have experienced trauma?

Trauma informed care is recommended for all those who work in a general practice setting as this approach can improve outcomes for both patients and clinicians over the longer term[6]. Trauma informed care can provide a safer environment for patients and all those who work in your practice, by preventing the triggering of trauma symptoms in those who have a trauma history.

In your care planning, be openly optimistic with your patients and take a strengths approach. A positive attitude can assist recovery, prevent relapse, and support treatment planning. Whole-person care (biomedical, mind-body, social connection, physical activity, and nutrition) will help identify motivations and barriers to care, assisting you to make appropriate referrals to engage a multidisciplinary team. Access the Trauma informed care resources for further trauma-specific information in relation to alcohol and other drugs.

[4] Royal Australasian College of Physicians 2020. Evolve Top-5 recommendations on low-value practices. Viewed 19 January 2022.

[5] Australian Family Physician, RACGP 2016. The inherited chronic pain patient. Viewed 19 January 2022.

[6] NSW Ministry of Health. What is trauma-informed care? Viewed 19 January 2022.

How do I help patients at higher risk of harms from their substance use?

Particular cohorts of the population, such as those listed below, are at higher risk of substance related harms[7]. These groups have needs that will impact who you enlist for support/referral and the type of social prescribing you undertake.[8] For more information on support of higher risk patients, access the following resources:

- Aboriginal and Torres Strait Islander peoples
- LGBTQIA+
- Custodial health
- Young people
- Pregnancy, homelessness, rural health

Further Training

RACGP AOD Program training modules related to this topic are available on *gplearning* and include:

- Alcohol and Other Drug - Essential Skills
- Alcohol and Other Drugs: Facilitating behaviour change
- Alcohol and Other Drugs: At-risk groups – Trauma

Developed by the RACGP AOD GP Education Program, May 2022.

[7] Alcohol and Drug Foundation 2021. Identifying risk factors. Viewed 19 January 2022.
[8] Australian Institute of Health and Welfare (2021) Priority Populations, AIHW, Australian Government. Viewed 19 January 2022