Comorbidity in General Practice

The provision of care for people with coexisting mental health problems and substance use by general practitioners

Revised Report July 2002

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September 2001
Revised Report July 2002

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Executive Summary

General practitioners encounter people with coexisting mental health problems and substance use very frequently. The spectrum of comorbidity disability seen by these primary health care providers is much broader than that seen in the specialty services which generally treat only the most severely affected and disabled patients. People with comorbidity present in general practice in non-specific ways and their problems are often not clearly defined, but this is the nature of primary care.

There is a lack of specific research into the provision of care for patients with comorbidity in the general practice and other primary health care settings.

While there are some lessons to be learnt from specialty settings, the application of this knowledge in the primary care setting requires a leap of faith as there is currently little evidence to support this transferability.

There are also some lessons from research based in primary care that has focussed on mental health problems and substance use occurring in isolation. However, there has not been any specific research activity regarding the management of these problems when they coexist in the primary care setting.

It would be fair to say that the skills level of general practitioners in Australia is highly variable in both the mental health and addiction areas. Consumers and their carers expressed mixed feelings about the treatment they had experienced, not only at the hands of GPs but also from specialised services. It is important to note that some had developed very effective long term relationships with their GPs.

There are several reasons for this variability in skills, ranging from inadequate undergraduate training through to structural factors that reward short consultations and penalise those who strive for good practice. There is a considerable amount of activity through the Divisions of General Practice aimed at up-skilling GPs in both the mental health and the addictions areas. And there is a small number of Divisions (17 at present) that are focussing specifically on assisting their member GPs to provide better management for people with comorbidity. A few of these programs are well established, with some developing resources and models of care that will be generalisable to other Divisions. This is a significant first step.

Given the dearth of evidence regarding the role of the GP and appropriate approaches to the detection, assessment and management of people with comorbidity, this project undertook a series of qualitative research activities. These activities attempted to better define the role of the GP, and to develop some consensus regarding approaches to comorbidity that GPs could reasonably adopt, given the structural constraints of practice. The project eventually derived a set of “principles of reasonable best practice” that might guide future research and educational endeavours. These were derived from consultations with GPs, with consumers and carers, with mental health and substance...
use advocacy groups, and with specialists from the mental health and addiction fields. While the absolute numbers of those consulted has not been large (overall probably 100+ people) the project attempted to obtain the views of this broad spread of stakeholders through direct consultation, focus groups and two surveys.

All groups consulted (professional and lay) were concerned that expectations regarding the role of the GP were not unrealistic. The pressure on GPs to respond to every different interest group and to end up with an unmanageable set of responsibilities was acknowledged. This has been succinctly summarised in another context [that of coordinated care for people with complex physical care needs]:

“The problem with GPs is that they are in an ideal position to do everything” *

General practitioners have become wary of sets of clinical practice guidelines that are impossible to implement, even if they are evidence based. In many instances the evidence has been derived in settings quite dissimilar from those to which the guidelines eventually refer and where they are to be implemented. The project authors feel that the principles that have been developed reflect good practice that is within the capacity of any reasonable GP. Comorbidity is so prevalent that to ignore it is to ignore a large area of need that is part of the GP’s business.

The reasonable approaches developed are based on the patient centred clinical method. The illness experiences of people need to be considered. A change of heart needs to occur within general practice and the community at large so that substance use and mental health problems are recognised as issues that need to be discussed and that are amenable to specific interventions. Any clinician working in the community setting soon realises that patients and their families bear most of the responsibility for carrying out a management plan. This will not just happen, unless the plan is initially negotiated, explained and accepted. People with comorbidity need to be challenged to think about their predicament but clinicians “ramming it down their throats” will not bring about the desired change in behaviour. The GP needs to be aware of the complex interactions between the substance use and the mental health problem. The GP needs to accept that the course of the condition is often relapsing and that this does not necessarily reflect inadequate therapy. In many instances a harm minimisation approach is all that can be achieved. If this is achieved then this at least is some achievement.

Interestingly the issue of shared care did not emerge strongly from the research process as a significant option for most GPs faced with someone with comorbidity. There is an anomaly here. People with comorbidity obviously have complex care needs. However at

* Attributed to Dr Malcolm Battersby. Director Coordinated Care Training Unit. Flinders University.
the time of this research (early to mid 2001) GPs experience with shared care arrangements for people with both mental health problems and substance use problems was limited. Therefore these types of arrangements did not emerge as reasonable options. Current programs (with a few exceptions) have focussed on mental health shared care or substance use shared care but not to any great degree on both in an integrated form.

The full set of practice principles is contained in the relevant section of the report.

Finally, from a policy viewpoint there are three main messages.

Firstly, there needs to be support for primary care/general practice based research into clinical approaches to comorbidity. We have the epidemiological data that tells us this is a major problem. Future research activity needs to focus on interventions and seeing whether they work. These types of studies are not easy to conduct in the community setting. However, unless work is done in these settings GPs will remain in the dark about what types of interventions are practically possible in the swamp of clinical reality and which improve outcomes.

Secondly shared care programs that have in the past focussed on either mental health or substance use, need to be enriched by addressing comorbidity in an integrated manner. This requires collaborative work across several disciplines, professions and services; it will require a conceptual shift within both specialty sectors that until now have tended to operate in both philosophical and procedural isolation from one another.

Thirdly there needs to continue to be support for up-skilling in the mental health and addictions areas for GPs. There is still a significant proportion of Divisions that have no activities in either of these areas at all. Divisions that have been active in one or either area can then move on to activities aimed at the needs of people with comorbidity. There is a significant number of Divisions that are involved now in such activities.

Their experiences need to be shared and resources that are developed need to be made available for other Divisions and agencies involved in education and training for primary health care providers. There needs to be some facility for sharing of information on comorbidity. Similarly there needs to be someone responsible for prodding those Divisions that have not taken up activities in these areas. Comorbidity issues need to be addressed by all Divisions.

In summary then, there is much to be done. This project has clarified the issues that need to be addressed and has identified several clinically relevant questions that must become the subject of research. One of the striking observations made in the process of this project was the degree of concordance between the different stakeholders regarding what these issues where general practice sits. The challenge now is to continue to build on the work that has already been done so that the level of care for people with comorbidity delivered in the primary care setting is of a uniformly acceptable standard.
Chapter 1 Introduction

The comorbidity problem

The coexistence in an individual of two (or more) disorders is commonly referred to as comorbidity. The coexistence of mental disorders and substance use problems is a particular challenge for clinicians as the two conditions combine to produce substantially poorer health and greater impairment of function than would normally be attributed to either on its own (Hickie et al., In press; Holland, 1999).

For example, a man might be experiencing relatively minor depression. He starts to regularly consume alcohol to deal with the effect that this depression is having on his life. The depressive nature of the alcohol serves to exacerbate his depression, leading him to drink more. The result is a significant reduction in his general health and wellbeing.

There is a continuum of severity for people with comorbidity that includes major mental disorders, substance abuse, dependence and high levels of resultant harm at its extreme end. However, even relatively minor use of a substance by a person experiencing mental health difficulties may lead to worsening of this condition and may have significant health implications. Indeed the coexistence of substance use and mental health problems has been linked to increases in impulsive, aggressive and disinhibited behaviours, as well as increases in anxiety, depression and self harm (Evans & Wiley, 2000). Comorbidity may lead to social problems, difficulties with activities of daily living, worsening of physical health and significant legal and financial difficulties (McDermott & Pyett, 1993). In extreme situations a person may end up behaving in self-destructive and antisocial ways. They may become homeless, be disengaged from their family and community, and may begin exhibiting high-risk behaviours including offending, intravenous drug use, needle sharing, suicide attempts, unsafe sex, and binge consumption (Murray et al., Year unknown; McDermott & Pyett, 1993). Overall, the presence of comorbidity increases the incidence of relapse and the need for acute intervention for both the substance use and the mental health problem (RachBeisel et al., 1999). There is decreased likelihood of sustained recovery from either of the conditions and an increased risk of early mortality (Evans & Wiley, 2000; Mueser et al., 1992, NSW Health, 2000).

"[Comorbid substance use and mental disorder is] more likely to be chronic and disabling, and to result in greater service utilisation. They are therefore more likely to cause misery and suffering among those afflicted by them, and considerable social cost in terms of marriage breakdown, social isolation, poor educational attainment, unemployment and chronic financial difficulties"
The Australian Burden of Disease and Injury Study revealed that apart from road traffic accidents (and asthma in females) the most common causes of disease in people aged 15 to 24 are - alcohol dependence, suicide, bipolar affective disorder, heroin dependence, schizophrenia, depression, social phobia, borderline personality disorder, generalised anxiety disorder and eating disorders (Mathers et al., 2000). The presence of so many mental health and substance use issues in this list supports the idea that both of these problems are common and that both contribute significantly to a reduction in the general health and well-being of the community.

It is also common for substance use and mental health problems to occur together (comorbidity) in members of the community. Population studies in America suggest that of the 22.5% of people that suffer a mental disorder at some point in their life, 29% have coexisting substance use, and of the 13.5% that suffer alcohol dependence or abuse, 37% have a coexisting mental disorder (Reiger et al., 1990). In Australia, the National Survey of Health and Wellbeing revealed that a majority of the 25% of adults that have a mental disorder in any one year also suffer some form of substance use (Hall et al., 1999).

The extent of the comorbidity problem in Australia is highlighted by the inclusion of this issue in both the National Drug Strategic Framework (1998/99-2002/03) and the 2nd National Mental Health Plan (1998-2003). These important policy documents place comorbidity as a high priority and state the need to provide better care and improved management. The commitment of the Australian Government to the comorbidity problem is demonstrated further by its creation of a National Comorbidity Project. This project was established with the aim of identifying and developing appropriate prevention, treatment and service delivery approaches for coexisting substance use and mental health problems. The NSW Health Department has produced a set of 'Service Delivery Guidelines' in an attempt to provide some direction for health services involved in the management of people experiencing coexisting mental health and substance use problems (2000).

Despite the observation that the coexistence of substance use and mental health problems is almost the rule rather than the exception (Andrews et al., 1999; Blume & Marlatt, 2000), and the observation that these conditions often combine to produce severe clinical presentations, service providers at all levels struggle to provide adequate care for patients with comorbidity (Ziedonis & Brady, 1997). This inadequacy of service provision is due mainly to a general lack of clear consensus regarding the assessment and diagnosis of comorbidity clients coupled with the presence of significant confusion regarding approaches to management and treatment. In-fact, there is still no uniformly accepted, comprehensive and coherent theoretical framework for the care of patients with coexisting substance use and mental health problems (Goldsmith, 2000; ADCA, 2000). As a result, service providers generally feel overwhelmed and lacking in
confidence when faced with clients experiencing comorbidity difficulties, believing that they do not have adequate experience or resources to provide beneficial treatment (McDermott & Pyett, 1993).

Effective service delivery at any level is dependent on the capacity of providers to assess and respond to the various health problems that people present and comorbidity is no exception. Use of the term 'comorbidity' has provided a clinical label for this common coexistence and has forced service providers to re-think their approach to clients experiencing difficulties of this type. The traditional approach of providing treatment for substance use or mental health problems through separate specialist services is generally considered inadequate for people with comorbidity (Sellman, 1989; Singer et al., 1998). Clinicians are no longer able to focus on just one half of the issue and they are beginning to explore the interaction of substance use and mental health and seek better methods to treat comorbidity (eg. the New Hampshire Clinic - Drake et al., 1993). Given the commonness of this condition, its potential seriousness, and the difficulty that providers currently experience in evaluating and treating clients, even small improvements in the level of care provided will have a significant positive impact on the health and wellbeing of comorbidity clients (NASMHPD & NASADAD, 1998).

**Comorbidity in general practice**

Given the sheer numbers involved, there will never be sufficient specialist resources to provide adequate care for all people with coexisting substance use and mental health problems (Kavanagh, 2000). In-fact many people experiencing comorbidity difficulties are never seen by a specialist, with general practitioners (GPs) being the first and only point of contact for a majority of sufferers (Kamerow et al., 1986; Landry et al., 1991). Treating comorbidity in the general practice setting is challenging as the GP is faced with the need to manage two conditions and their interaction simultaneously (Kavanagh, 2000). Yet treatment of patients with comorbidity in the general practice setting is desirable and it holds a number of advantages. General practitioners are amongst the most accessible health care professionals with 85% of Australians visiting their GP at least once a year (Deeble, 1991). This means that these clinicians are in an excellent position to intervene early and to coordinate the provision of continuous care to patients experiencing comorbidity difficulties. Further, the use of brief and direct interventions at this level would allow GPs to care for the majority of patients with comorbidity with-out the need for referral to specialist service providers. This simplifies access for clients and reduces the load on specialists allowing these services to focus on people with higher levels of disability.

The role of GPs in caring for patients with comorbidity includes:

- Early detection and accurate diagnosis of comorbidity
- Provision of information on condition and treatment approaches
• Brief interventions for people with lower levels of disability
• Referral and co-ordination of care for people more severely affected by comorbidity
• Medical treatment for physical health complications
• Provision of a high level of support to the patient and their family
• Long term monitoring and follow-up

(Mooney, 2001; NSW Health, 2000)

GPs encounter difficulties that are similar to those experienced by most health care service providers involved in the care of people with coexisting substance use and mental health problems. Patients with comorbidity are considered by GPs to be problematic to work with, difficult to evaluate, and even harder to provide treatment for. These views are exacerbated by low levels of education and training in comorbidity issues and little access to clinical support or supervision for GPs by the specialities.

The presence of comorbidity is not always explored by GPs and many do not inquire about the presence of mental health issues or the use of substances at all (Crum & Ford, 1994). There is a lack of consistency regarding how comorbidity is defined and how it should be treated. There is little evidence that GPs use the brief interventions for mental health problems or for substance use problems that are available to them. Few (if any) of these interventions have been evaluated for their effectiveness in the context of comorbidity and they may not in-fact represent ‘best practice’ (Mooney, 2001). Poor interactions between GPs and specialist services result in haphazard referral of patients with comorbidity preventing the provision of comprehensive and holistic care (Astolfi & Willey, 2000).

The quality and effectiveness of service provision for patients with comorbidity currently depends upon the interest and expertise of the individual practitioner (NSW Health, 2000). If GPs are to be successful in caring for patients with comorbidity then there is a need for an increase in knowledge regarding issues related to comorbidity by all clinicians. Specifically, general practice improvements in identification, assessment, diagnosis and management of clients with comorbidity in the general practice setting will ensure that all patients attending their GP with coexisting mental health and substance use problems will receive an adequate level of attention and care.

The PARC Comorbidity Project

There is a definite role for GPs in providing care for people with coexisting substance use and mental health problems. However, the current level of care being provided by GPs is inconsistent and a number of areas for improvement have been identified. The PARC comorbidity project has explored issues regarding the approaches that GPs use
when faced with patients experiencing comorbidity difficulties. The ultimate aim of this project is to improve the level of care provided to people with coexisting mental health and substance use problems by establishing positive changes in the management of comorbidity in the general practice setting. The first step is to establish what the management ought to be.

The PARC Comorbidity Project aims to:

- **Conduct a review** of the Divisions of General Practice with activities in the area of comorbidity.

- **Identify key issues** in the identification and management of people with coexisting mental health and substance use problems in the general practice setting.

- **Conduct a literature review** and extensive consultation with GPs, consumers and other health-care professionals to determine pragmatic ‘best practice’ approaches to the detection, assessment and treatment of comorbidity in the general practice setting.

- **Establish a set of basic principles** that will guide GPs in providing care for patients experiencing comorbidity difficulties.

- **Identify key areas of change** that will enhance the level of care provided to people with coexisting mental health and substance use problems in general practice (including policy development, practice, research, education & training, service support etc).

**References**


McDermott, F., & Pyett, P. (1993). *Not Welcome Anywhere: People who have both a Serious Psychiatric Disorder and Problematic Drug or Alcohol Use Volume 1*. Victorian Community Managed Mental Health Services, Fitzroy.


Chapter 2 Methodology

The PARC Comorbidity Project attempts to determine how GPs currently manage patients with comorbidity and explores problems that occur in this management process. The project also attempted to identify approaches that may lead to an improvement in the quality of care provided. This has been achieved through several inter-related processes (Figure 2.1) described briefly as follows. Specific methodology of each activity is detailed in the relevant sections of this report.

Review of the activities of Divisions

A survey and review of the Australian Divisions of General Practice explored the activities of these Divisions in relation to comorbidity. This review led to the identification of Divisional programs that have begun to pay specific attention to improving the level of care provided to patients experiencing coexisting mental health and substance use problems.

Literature review

A review of the current literature explored national and international literature regarding the primary care management of patients with coexisting substance use and mental health problems. The aim of this review was to establish useful approaches for the detection, assessment and treatment of comorbidity in the general practice setting.

Primary care professional, consumer and carer consultation

Meetings with primary care professionals, and carers and consumer advocacy groups were conducted to explore the primary health care needs of people experiencing comorbidity difficulties. Drawing on the experiences of these ‘experts’ led to the identification of where general practice sits within this cluster of other related services.

GP Comorbidity Survey

This survey was case based and involved a large number of GPs with considerable experience in mental health and drug and alcohol areas. Questions in the survey explored approaches taken to the detection, assessment, treatment and referral of patients with comorbidity and identified a number of key improvements required.

Multi-disciplinary focus groups

The literature review, primary care consultation and GP survey were used to identify a number of key issues regarding the general practice care of patients with comorbidity. Two multi-disciplinary focus groups were held to discuss the issues raised by these
processes. The meetings involved a range of professionals and consumer representatives with an interest and considerable expertise in comorbidity. Discussion around a set of questions led to a reasonable degree of consensus regarding the best approaches GPs may take to comorbidity and improvements that are required.

**Development of Principles of Care**

Outcomes from the literature review, primary care consultation, GP survey and the focus groups were used to develop an initial set of principles with the aim of providing some guide for GPs involved in the care of patients with coexisting substance use and mental health problems.

**Validation of Principles of Care**

A second survey of GPs was conducted to seek some consensus and feedback regarding the use of these principles. This process allowed the development of a final set of principles for the assessment, diagnosis and management of patients with coexisting mental health and substance use problems in general practice.
Primary care professional, consumer & carer meetings

GP comorbidity survey
(Consultation phase 1)

Multi disciplinary focus groups

Draft set of principles

Validation of principles through second survey of GPs

"Principles for the assessment, diagnosis and management of patients with coexisting mental health and substance use problems in general practice"
Chapter 3 Literature Review

Introduction

The term *comorbidity* in this project refers to the coexistence of a mental health problem and substance use.

This coexistence of substance use and mental health problems is common. The fact that people with mental problems may use psychotropic substances (prescribed or non-prescribed) should come as no surprise. Similarly it is not surprising that people with frequent substance use (and these substances have psychotropic effects) develop mental health problems. What is surprising is that for so long clinicians and health service planners have chosen to see these two areas as being distinct!

As mentioned in the introduction of this report, substance use adds significantly to the morbidity associated with mental health problems (Hickie et al., In press; Holland, 1999). Currently there is little clear consensus regarding the best approaches to providing care for patients with coexisting mental health problems and substance use in the general practice setting. The current quality and effectiveness of service provision relies mainly on the interest and expertise of individual clinicians. There is a need for GPs to increase their level of knowledge and skills regarding comorbidity so that they may be better equipped to provide care to people with this difficult set of problems.

Methods

This review attempts to bring together the relevant literature to provide some idea of how GPs might best manage comorbidity. Searches were conducted using Medline, Psychlit, Austhealth and the Internet. The review includes Australian and international literature from the general practice, psychiatry and addiction fields, as well as Commonwealth reports and reports from Divisions of General Practice. This review explores issues in the detection, assessment, and treatment of comorbidity in the general practice setting. A number of basic approaches for the general practice management of mental health and substance use problems are established. These approaches are supplemented by the additional review of approaches from more specialised settings that have been modified to suit GPs.

Defining ‘comorbidity’

Within the literature there is a lack of a clear definition of the clinical terms associated with coexisting substance use and mental health problems. Terms used to refer to people suffering these types of problems, including 'dually diagnosed', 'dually disabled', 'mentally ill chemical abusers' (MICA), and 'dual disordered substance abusers' (DDSA). These terms are used almost interchangeably to cover a range of mental health diagnoses and varying degrees of substance abuse (Lindsay & McDermott, 2000).
For the purposes of this review the term ‘comorbidity’ will be used to refer to the coexistence of a mental health problem with some form of substance use. This project has a somewhat broader focus than other reviews and studies that have considered only the coexistence of severe mental disorders and DSM diagnosable substance use disorders. In the general practice setting people with ‘serious mental disorders’ and ‘chronic substance use disorders’ are the minority. There is a much larger group of people presenting in primary care with less severe but nevertheless significant comorbidity that may be addressed through the types of brief interventions that are available for primary care health professionals.

**Detection of comorbidity**

Detection refers to the ability of a clinician to recognise the presence of a certain disorder, illness or health problem. Substance use and mental health problems are common and their coexistence may have a significant impact on a patient’s health and well being (Andrews et al., 1999; Holland, 1999). Detection of this comorbidity is important as it allows the clinician to begin to explore and understand the full extent of a persons’ condition and implement appropriate and effective treatment (Siegfried, 1998). Despite this, the presence of comorbidity is not always explored by GPs and it frequently remains undetected in the general practice setting (Kavanagh, 2000; Anath et al., 1989; Mooney, 2001). In fact, GPs have been found to often overlook significant mental health problems and fail to recognise substance use underlying a patient’s physical, emotional and psychosocial symptoms (Amodei et al., 1994; Whyshak & Modest, 1996). Detection that does occur tends to be for patients with more severe presenting problems. This is of particular concern given that the majority of general practice patients do not have severe mental disorders or an obvious substance addiction but may still experience significant difficulties due to comorbidity (NASMHPD & NASADAD, 1998).

A person experiencing comorbidity difficulties will generally initially attend their GP with a rather ambiguous clinical presentation (King et al., 2000). The presence of two overlapping conditions places competing demands on the clinicians attention and reduces their ability to address either the substance use or the mental health issue adequately (Borowsky et al., 2000). The detection of substance use in people suffering mental health problems may be complicated by fluctuating psychiatric and psychological symptoms (Wittchen et al., 1999), while the detection of mental health problems in a person that is using substances may be complicated by intoxication or withdrawal (King et al, 2000). In addition there is the significant background noise of the (sometimes minor sometimes major) physical problems the patient brings to the GP. Faced with this confusing interaction, the GP will often focus on one side of the presentation and not recognise the presence of dual underlying problems. GPs need to be aware that the presence of either substance use or a mental health problem places a person at ‘high risk’ and they are likely to be suffering comorbidity. In fact, the recognition of either substance use or a mental health problem should lead the GP to automatically inquire...
about the possible presence of comorbidity (Hickie et al., In press). However, this does not often occur as many GPs are simply not aware of comorbidity and its related issues and they do not seek to detect its presence (Moatti et al., 1998). In order to improve the recognition and detection of comorbidity there is a need for GPs to become more familiar with the signs, symptoms, and implications of substance use, mental health problems and their interaction (Evans & Willey, 2000; Goldsmith, 2000).

GPs are often unable to detect comorbidity because time demands during an initial assessment force them to focus on the patient’s main presenting problem. This can be problematic given that many patients experiencing comorbidity difficulties will present strictly physically and may be reluctant to talk to the clinician about the actual problems underlying their attendance (Ford & Kamerow, 1990; Ford et al., 1988). For example, one study found that only 50% of individuals that were depressed said that they would raise this with their GP and only 10% of individuals with an addiction problem would talk about this unless specifically asked (Kates et al., 1997). Reasons for non-disclosure by patients include concerns regarding confidentiality of the information given and fear of reprisal for their use of substances, particularly illicit drugs. Further, patients experiencing substance use and mental health problems fear they may acquire a label that will lead to stigma from their friends, family, employer and even the clinician. The cognitive and emotional aspects of both the mental health problem and the substance use compounds these fears leading the patient to deny and distort many characteristics of their comorbidity (Mueser et al., 1992). To overcome this it is essential that the GP seeks to establish a good relationship with the patient. Developing rapport allows the client to be more comfortable discussing issues such as drug use (Wilson et al., 1990) and increases the likelihood of detecting comorbidity when it is present. Interview techniques that aid detection include maintaining empathy and eye contact, clarifying physical complaints and asking open-ended questions. It may also be useful for clinicians to explore the problems that the patient is experiencing in their everyday life. Evidence of substance use and/or mental health problems may arise when the patient is encouraged to talk openly about difficulties associated with daily living, physical health, social and familial relationships, finances, work and life satisfaction (Wittchen et al, 1999).

Regardless of the presenting problem, the primary responsibility of detecting and addressing comorbidity belongs to the doctor as recognition depends mainly on the clinicians willingness to initiate discussion of substance use and mental health issues (Ford et al., 1988). There is some suggestion that GPs are often unwilling to initiate such discussion as they do not feel they possess adequate time, knowledge or skills to intervene appropriately and detection is therefore not worthwhile (Burdekin, 1993; Roche et al., 1995; Samet et al., 1996). This reluctance to identify comorbidity is exacerbated by the lack of any clear guidelines for management of patients identified as having comorbidity (Evans & Willey, 2000). Raising the ability and confidence of GPs to intervene and provide appropriate treatment for people with comorbidity is essential in
order to increase the willingness of these clinicians to detect this condition in their patients.

Simple screening procedures are time efficient and potentially useful as they may aid detection of certain conditions by indicating patients that require further specific assessment. There is certainly some support for the use of brief, self-administered screening tools to aid the detection of either substance use or mental health problems or both. Examples for alcohol use assessment include CAGE (Crum & Ford, 1994), and the AUDIT questionnaire (Saunders et al., 1993). For both mental disorders and alcohol use examples are the PRIME MD - 1000 (Johnson et al., 1995), and SPHERE (Hickie et al., In press). However, considerable concern exists regarding the use of these tools to detect comorbidity in general practice settings. Concerns are about sensitivity for substance use related problems [in the case of the CAGE assessment] and specificity with respect to mental disorders [in the case of SPHERE and other screening instruments proposed for general practice (Holmwood et al., 2001)]. Unfortunately little benefit has been demonstrated for the use of screening tools use in terms of patient outcome (Ford & Kamerow, 1990; Carey & Correia, 1998). A skilled, inquisitive, concerned GP who considers both mental health and substance use issues worthy of attention will be far more successful at detecting less severe comorbidity than these technical screening tools (Crum & Ford, 1994; Ziedonis & Brady, 1997). GPs that are most likely to gain from the use of these tools are those who do not routinely ask psychiatric, psychological or substance use questions (Ford & Kamerow, 1990). It may be more important to encourage GPs to routinely inquire about use of substances and to explore basic mental health issues during every initial assessment, regardless of the presenting problem (King et al., 2000)

Summary of literature - Detection of comorbidity

- Detection of comorbidity allows the use of appropriate and effective treatment.
- Comorbidity is not always explored by GPs and frequently remains un-detected.
- GPs need to routinely inquire about substance use and mental health issues.
- Recognition of either substance use or a mental health problem should lead the GP to inquire about the presence of comorbidity.
- Detection of comorbidity is aided by development of rapport, demonstration of empathy and asking open questions about difficulties the patient is experiencing.
- There is a need to raise the ability and confidence of GPs to provide appropriate treatment for comorbidity.
- Use of technical screening tools is problematic and does not necessarily increase detection of comorbidity or improve patient outcome in general practice settings.
Assessment & Diagnosis of comorbidity

During the assessment process a clinician will usually seek to explore and clarify the assortment of clinical features of a patient’s presentation in an attempt to determine a diagnosis that will guide treatment. Having recognised the presence of comorbidity, the clinician must attempt to assess and diagnose the range of different substance use and mental health problems that the person may be experiencing in order to decide on a suitable management approach (Evans & Wille, 2000). The presence of two conditions at the same time can make the assessment and diagnosis of comorbidity challenging for the clinician. It is important for the GP not to focus just on one primary aspect but to conduct a thorough assessment to ensure that subsequent treatment addresses all of the problems that the patient is experiencing (Ziedonis & Brady, 1997; Hickie et al., In press; Crum & Ford, 1994). The assessment and diagnosis process is complicated further by the interaction of these two conditions. The relationship between symptoms of mental health and substance use problems is complex, but developing some degree of understanding of this interaction may improve the outcome of comorbidity treatment (Ziedonis & Brady, 1997). Variations in the type and degree of comorbidity means that patients experiencing this condition require a treatment approach that is centred on their specific individual needs (Kavanagh, 2000). Beyond establishing the presence of two conditions that interact, the assessment of comorbidity should focus on the individuals level of functioning rather than necessarily seeking to establish separate diagnoses (McDermott & Pyett, 1993). This assessment should include the effect that the coexisting substance use and mental health problems have on employment, intimate and family relationships, income, accommodation, social networks, physical health problems and self-esteem (Goldsmith, 2000). Focussing assessment on the actual difficulties that a patient is experiencing will ensure that the treatment process is aimed at minimizing/reducing the impact of comorbidity on the persons life.

Assessment of mental health in patients with comorbidity

GPs have regular opportunities to identify and diagnose people experiencing mental health problems (Kendrick, 1999). Assessment of mental health requires an understanding the pattern and natural course of these problems and generally includes history of current difficulties, background psychiatric history and family psychiatric history (Ziedonis & Brady, 1997). A brief mental state exam may guide assessment of the current problem and will provide an evaluation of a patient’s appearance, activity, mood and affect, speech and language, thought content, perceptual disturbances and insight and judgement (Evans & Willey, 2000). This assessment should also include establishing if the person is at risk of self-harm, particularly if the person is engaging in risky substance use behaviours. The best way for GPs to assess suicidality is to ask directly, but the clinician needs to be prepared to follow up the questions with a discussion about alternative solutions to ensure the clients safety (Davies, 2000).
The use of substances by patients with comorbidity influences the ways in which the mental health problem presents itself. GPs need to be able to differentiate between substance-induced symptoms and the symptoms of an actual underlying mental health problem. GPs may gain a reasonable idea of the actual mental status of a particular patient by taking advantage of their long-term relationship with that patient, accessing old notes, and conducting the assessment over several consultations. The accuracy of this assessment will be further enhanced by monitoring symptoms over a period of abstinence as symptoms that are related primarily to drug use will usually fade over time (Landry et al., 1991).

Formal psychiatric classifications have become extremely complex and lack validity in general practice settings (Hickie, 1999). In-fact, a substantial proportion of the mental health problems experienced by general practice patients do not meet the criteria for psychiatric classification (Wohlfarth et al., 1993). Placing an emphasis on applying strict diagnostic labels to patients with comorbidity during the assessment of mental health should be avoided as it can give rise to unhelpful and demoralising generalisations regarding treatment and prognosis (Goldsmith, 2000). It may even affect a clients’ access to specialist services (Primm et al., 2000). It is better for the assessment process to focus on the effect that the mental health problem is having on the person’s life and to develop a flexible working diagnosis. Together they will lead to a negotiated approach that will reduce morbidity and improve quality of life.

**Assessment of substance use in patients with comorbidity**

The assessment of drug and alcohol use in patients with comorbidity is useful for forming a diagnostic impression related to both this substance use and the mental health problem (Landry et al., 1991). However, the assessment of drug and alcohol use in patients with a mental disorder is problematic on several levels.

Initially clinicians need to understand that the assessment of substance use in people with comorbidity needs to take into account the way the mental disorder effects the substance use and vice versa. These people experience greater morbidity at lower levels of use (Lehman et al., 1999; Mueser et al., 1997). Cognitive and emotional characteristics of the mental health problem create many potential sources of unreliability and/or invalidity in the reporting of substance use by patients with comorbidity, and a high degree of under-reporting occurs (Carey, 1997; Shaner et al., 1993; Test et al., 1989). Patient self-report remains the best method to determine the level of use, provided that GPs use a subtle, rather than a direct approach (Samet et al., 1996). In-fact, there are a number of steps that clinicians may take to enhance the accuracy of drug and alcohol assessment in patients that are also experiencing a mental health problem (see Figure 3.1).
Figure 3.1. Assessment of substance use in patients with comorbidity

To improve the accuracy of substance use assessment, GPs should:

- Make the assessment when the person is psychologically stable and is not intoxicated or suffering withdrawal.
- Use self-report in conjunction with other sources of information (family, blood test, urine sample etc).
- Provide assurances of confidentiality.
- Evaluate whether the person has reasons for distorting their report and address these.
- Conduct substance use assessment after assessing other areas of life functioning and history in order to take advantage of established rapport.
- Conduct the assessment in a non-judgemental way and make the person comfortable by being familiar with substance use vocabulary and patterns.
- Use simple, direct questions and clear time frames.
- Use open-ended questions and normalise substance use to make it more likely that a patient will admit to heavier quantities and greater frequencies.
- Use repeated assessments over time when possible.

(adapted from Carey, 1997)

Most people that use substances have a reason for this use - generally it is to make them feel good. There are also a number of specific reasons why people experiencing mental health difficulties are prone to using substances. Substance use may provide a sense of normality and temporary wellbeing for people with mental health problems, it can provide relief from the symptoms of this problem and the side effects of psychiatric medication (El-Guelbaly, 1990). Further, substance use allows the person to belong to a sub culture, they are able to experience social interaction as they belong to a peer group where they may assume an identity as drunk or drugged rather than ‘mad’ (Holland, 1999). It is important for GPs to respect the function that substance use may serve and the reasons underlying a patient’s desire to use (Carey, 1996). For this reason,
assessment of substance use in patients with comorbidity should extend beyond questions regarding quantity and frequency to include inquiry regarding the patients’ perceptions of why they use, the effects this use has and problems that is causes. It is important for clinicians to keep in mind that people with mental health problems (particularly severe mental illness) may be unaware or confused regarding the consequences of their use (RachBeisel et al., 1999). GPs may conduct this assessment by asking the patient to identify what happens before and after they use a particular substance (Carey, 1996). Benefits and consequences can then be explored by asking open questions regarding what the patient believes they gain from their use and any concerns that they have regarding problems they have experienced. Having a patient identify the positives and negatives of substance use is part of determining their ‘readiness to change’ (Samet et al., 1996; Richmond et al., 1998). A person that believes that they are obtaining mostly positive effects from their use or who cannot see the negatives will most likely not be ready to do anything about reducing or stopping their use.

Assessing the interaction of substance use and mental health

The presence of psychiatric symptoms contributes to a person’s tendency to use substances, while the use of substances adds to the tendency to have psychiatric symptoms (McDermott & Pyett, 1993; Friedman et al., 1987). When faced with comorbidity clinicians need to go beyond identifying and assessing the individual conditions and explore how these problems are related and interact. Understanding the relationship between substance use and mental health problems not only assists in the assessment and diagnosis process, it affects the treatment approach and may improve the patient outcome. For example, if alcohol dependence is found to be causing a person’s depression, then treating the alcohol dependence is akin to treating the depression and it may alleviate or even eliminate the depressive symptoms with out the need for direct treatment of the depression (Shuckit et al., 1997). Despite this, the interactions between substance use and mental health problems are generally are not well understood and are often left unexplored by clinicians. Exploration of the basic interactions that underlie the coexistence of substance use and mental health problems should be part of the comorbidity assessment process. Sufficient inquiry regarding how these two conditions have developed in relation to each other should be conducted to allow the clinician to develop a suitable management approach that will address both problems (NSW Health, 2000).
Figure 3.2. Basic relationships that underlie the coexistence of substance use and mental health problems

The use of substances causes or exacerbates an underlying mental health problem.

An example is where a person that is using amphetamines in increasing amounts begins to experience psychosis as a result of this use.

Substance use is a result of an attempt to reduce the symptoms of a mental health problem.

An example is where a person experiencing lethargy, poor motivation and loss of pleasure due to depression uses cocaine to go out and have a good time.

Both the substance use and the mental health problem develop somewhat independently of each other due to common causes or risk factors.

An example is where personality traits and a generalised low ability to cope with situational and life stressors produces a susceptibility to both depression and the use of alcohol.

Regardless of whether the substance use and mental health issues are primary, secondary or independent of each other, they become intrinsically connected overtime and result in a worsening clinical picture.

Summary of literature - Assessment & Diagnosis

- Development of a suitable approach to managing comorbidity requires thorough and accurate assessment of both substance use and mental health problems.

- Assessment of comorbidity should focus on actual difficulties that the patient is experiencing and avoid the use of strict diagnostic categories.

- Assessment should utilise the GPs long-term relationship with the patient to counter the effect of substance use on clinical features.

- GPs need to take steps to enhance the accuracy of substance use assessment in patients with comorbidity as they are prone to distortion.

- Patients with comorbidity have reasons for using substances and it is important to assess their perceptions towards benefits and consequences of use.

- It is essential to assess the basic interactions that occur between substance use and mental health problems in comorbidity to ensure that subsequent treatment is appropriate and effective.
Chapter 4 Management of comorbidity

General practitioners are amongst the most accessible health care professionals. They see 85% of Australians at least once a year (Deeble, 1991). The provision of brief and effective interventions in the general practice setting allows GPs to manage the majority of patients with comorbidity without the need to refer to more expensive and harder to access specialists (Kamerow et al., 1986; Landry et al., 1991; Kavanagh, 2000). Successful management of comorbidity will lead to a reduction in the use of substances, minimisation of the effect of mental health features, and significant enhancement of a patient’s quality of life.

Comorbidity tends to respond poorly to traditional substance use approaches and patients do not receive maximum benefit from psychiatric treatment programs (Singer et al., 1998). Only a comprehensive approach to management that addresses both the substance use and the mental health problem will lead to significant improvements in the overall functioning of patients with comorbidity (Friedmann et al., 1999). Despite considerable literature regarding comorbidity, there is limited information regarding the nature of specific effective approaches for the treatment of patients with comorbidity in the general practice setting (Kavanagh, 2000; Evans & Willey, 2000). There is, however, some support for the use of an integrated, simultaneous approach that combines elements of pharmacological, psychological and social interventions. This approach to management needs to target the substance use, the mental health problem and the complex interaction between them (Ziedonis & Brady, 1997).

Approaches to patients that are not necessarily ready to change

Determining readiness to change

Before starting any treatment for comorbidity it is important for the clinician to determine the patient’s ‘readiness’ to change. Assessment of readiness will allow the clinician to decide on an approach that is appropriate for the patient’s stage of change. There is little point in attempting to begin a particular treatment if the person is not ready for it. When assessing readiness in patients with comorbidity the clinician should not assume that the state of readiness is the same for both the mental health problem and the substance use. In-fact, it is quite possible that the persons level of insight is greater for one issue and they may be accepting of the need to change for one problem while not being aware of the need to change for another. GPs may determine the ‘stage of change’ during routine assessment process by asking a number of simple, direct questions (as outlined in Figure 3.3).
**Education**

A patient with comorbidity who is in a stage of ‘Pre-contemplation’ generally lacks insight regarding the negatives associated with either their substance use, their mental health problem or both. In this situation, the role of the GP is to provide information that will allow this person to develop some insight into the cause of their difficulties. The aim of this education approach is to all the individual to begin to see the need to be involved in treatment. When educating people about comorbidity the clinician should detail the nature and prognosis of this condition including the likely physical and psychological consequences of continued behaviour. The negatives of comorbidity should be followed by information regarding how effective treatment may help alleviate the difficulties the patient is experiencing (WHO, 2000).

**Psycho-education**

Information must be provided in the correct manner as provision of advice in an off-hand manner, to a person who is not ready, may push them into a defensive position. Use of a psycho-educational approach helps the clinician to provide information in an emotionally cool, non threatening, and cognitively focussed manner (McDermott & Pyett, 1993b). This approach begins with exploring difficulties that the patient is experiencing so that the information provided is relevant to their specific situation. Use of a psycho-educational approach to provide information to patients with comorbidity facilitates their active engagement in treatment by creating the framework for an effective therapeutic relationship (Hickie, 2000).

**Harm-minimisation**

Clinicians that adopt a ‘harm-minimisation approach’ accept that patients will use substances, so they attempt to reduce the effects that use has on that person’s general health and well-being. This approach is particularly relevant for patients with comorbidity who have multiple problems and few positive aspects in their lives with little or no incentive to attain abstinence (McDermott & Pyett, 1993). When faced with a person that wishes to continue to use alcohol or drugs, the role of the GP may be to provide education regarding safe substance use. This may include teaching the person ways to control their consumption and avoid binges that may lead to overdose, providing information on safe injecting behaviours and needle exchange, and providing support to reduce the financial, legal, and social problems associated with use (Carr, 1997).
Figure 3.3. Determining readiness to change

**Ask questions**

“Do you think your substance use is a problem?”

“Do you think your mental health symptoms are a problem?”

“Does your substance use affect your [depression, anxiety etc.]? Is this a problem for you?”

**Match to a ‘Stage of readiness’**

- **Pre-contemplation**
  The person basically denies that there is a problem and they do not believe that there is anything that needs to be changed.

- **Contemplation**
  The person is ambivalent about changing but has considered that change may possibly be needed.

- **Determination**
  The person has made a decision to change, but has not yet begun to act upon this.

- **Action**
  The person is receiving treatment and is beginning to change their behaviour.

- **Recovery**
  The person is continuing to change and is maintaining improvements in their behaviour.

- **Relapse**
  The person has suffered a setback in returning to their old behaviour and usually returns to a stage of contemplation and ambivalence.

(*) Samet et al., 1996; (c) Prochaska & DiClemente, 1986)
Motivational interviewing

Motivational interviewing is a brief form of counselling that attempts to enhance a person’s motivation to change their behaviour and may be used to shift a patient from a stage of ‘Contemplation’ to a stage of ‘Determination’ or even ‘Action’. People that are contemplating change often have a lot of ambivalence regarding their need to change. Motivational interviewing attempts to resolve some of this ambivalence by having the patient weigh up some of the positives and negatives of changing their behaviour (Samet et al., 1996). The motivational interviewing technique involves the use of basic counselling skills to reflectively emphasise the side of the patient’s ambivalence that is directed towards change (Woodward, 2001). The following five principles form the basis of this approach - Express empathy by developing understanding, Develop discrepancy, Avoid argument, Roll with resistance, and Support self efficacy (Astolfi & Evans, 2000).

Initially the clinician will explore with the patient their perception of the problem, reasons that they have for doing something about it, and the risks of not changing (Samet et al., 1996; Woodward, 2001). The clinician will then conduct a directed, empathetic discussion with the patient, to review the data they have reported and make recommendations regarding behaviour change, treatment options, symptom management and quality of life improvements. Motivational interviewing emphasises a patient’s personal responsibility to change behaviour, enhances their adherence to treatment regimes and increases the likelihood of a positive management outcome (Richmond et al., 1998; Rollnick et al., 1992).

Motivational interviewing is a technique that may be used by GPs as it can be conducted over several short sessions. Motivational interviewing requires little specific training and builds on the basic counselling skills that GPs should already have. This technique has been used by GPs to successfully help clients begin to reduce their use of substances (eg alcohol, Astolfi & Evans, 2000). Motivational interviewing is particularly useful for patients with comorbidity because it is non-confrontational and may enhance the self-esteem and self-efficacy that has been undermined in these people.

Goal setting

It is essential for GPs to assess readiness to change and to use educational and motivational techniques as people are more likely to take advantage of treatment when they understand that they have a problem and feel that they need to change (Rollnick et al., 1992). The best way for clinicians to link problem behaviour with treatment is to have the patient set goals. These goals will depend on the persons’ stage of change and may be aimed at substance use, the mental health problem or both. GPs should assist patients with comorbidity to develop specific, achievable goals that will guide selection of a suitable treatment approach.
Pharmacological interventions

The use of psychiatric medication is well established as an effective approach for the management of mental health problems. Although few specific pharmacological interventions have been evaluated for their effectiveness in the context of comorbidity, psychiatric medication has been used successfully to treat psychosis, depression and anxiety experienced by patients with comorbidity (Ziedonis & Brady, 1997; Kavanagh, 2000). For example, Anti-depressant treatment of depression has been shown to produce improvements in mood coupled with reductions in substance use (Nunes & Quitkin, 1997). Based on this, the use of appropriate psychiatric medication should be part of a GPs multifaceted approach to coexisting substance use and mental health problems. Selection of an appropriate medication should be based on efficacy, cost and possible side effects. This selection may be aided by use of up-to-date general practice prescribing guidelines and provision should be accompanied by appropriate means for the patient to record benefits and side effects (Hickie, 2000).

There are a number of important considerations to be made when prescribing medications to people that are involved in the use of substances.

It is important for GPs to warn the patient of possible interactions that may occur between prescribed and non-prescribed substances. However, the risk of possible drug interactions must be weighed against the risks of not attempting to control serious mental health symptoms with medication (Carey, 1996).

It is important for clinicians to realise that any medication can be misused by taking it in a non-prescribed manner. When prescribing medications for patients with comorbidity, GPs should avoid substances that can cause physical dependence, especially benzodiazepines, barbiturates and stimulants. There are, however, a number of exceptions to this rule. For example a GP may wish to provide sedatives to a person who is experiencing acute anxiety before more suitable medication prescribed specifically for the anxiety begins to take its effect.

It is important for clinicians to be aware that people that regularly use non-prescribed substances may have idiosyncratic beliefs regarding medications and their effect (Woodward, 2001). For example, a regular drug user will attend carefully to immediate effects and may devalue medications that work slowly. Most anti-depressants take 2 - 4 weeks before they begin to have an effect. It is important to inform patients with comorbidity of delays in the effects of psychiatric medicine to ensure that they continue to take them to receive full benefit.

The other issue in prescribing medication is adherence. In order to receive full benefit from medication patients need to take it as agreed, with adherence a strong predictor of successful treatment (Swartz et al., 1998). Patient’s reasons for non-adherence include severe side effects, inappropriate doses, inadequate interpersonal support, and poor therapeutic alliances (Lin et al., 1995). Adherence is a particular issue for patients with
comorbidity as substance use has been linked with non-adherence, higher relapse rates and problematic outcomes (Swartz et al., 1998; Fenton et al., 1997). GPs may take a number of basic steps to increase a patient’s adherence to psychiatric medicine. GPs should begin with discussing the diagnosis and the need for medication with the patient. Adherence may be enhanced by selection of an appropriately effective medication, simplifying the medication regime, anticipating side effects, involving family members where appropriate, arranging follow-up appointments and inviting the patient to call if they are experiencing problems (Evans & Willey, 2000; Woodward, 2001).

**Psychological interventions**

Management of comorbidity begins with exploring the difficulties that a patient is experiencing while offering explanation, support and reassurance. Comorbidity effects people in a number of different ways and requires a variety of treatment approaches (Kavanagh, 2000). There are a number of psychological therapies that GPs may find useful when attempting to reduce the impact of substance use and mental health problems experienced by patients with comorbidity. These general counselling, behavioural and cognitive approaches vary in length and suitability but generally aim to teach the client better ways to think and act. These approaches promote autonomy, enhance self-esteem and ultimately lessen the anxiety and distress experienced by patients with comorbidity. Psychological interventions allow the patient to take control over their comorbidity as they learn new skills that they may then continue to use for the rest of their life.

**Supportive counselling**

People with substance use and mental health problems struggle at times to cope with the daily events of everyday life. Supportive counselling does not specifically aim to reduce substance use or mental health features but instead attempts to assist patients with comorbidity by helping them to understand their condition and develop ways to cope with difficulties that arise (Davies, 2000). On the most basic level, GPs may assist a comorbidity patient to reduce the effect of stressors in their life by teaching them controlled breathing and relaxation exercises. More applied ‘supportive psychotherapy’ targets specific interpersonal or psychosocial problems and attempts to optimise a patient’s level of functioning by strengthening their existing coping mechanisms (Davies, 2000). For example, a GP may use supportive counselling to help a patient to cope with everyday problems including as budgeting, general self-care, and social interactions. Supportive counselling is a practical psychological approach and should form part of a holistic approach to management of comorbidity in the general practice setting.

**Behavioural approaches**

A number of behavioural approaches may be used by GPs who are attempting to treat coexisting substance use and mental health problems. Behavioural therapies aim to
identify and change aspects of a person’s behaviour which are implicated in the cause and maintenance of comorbidity (WHO, 2000). Various behavioural approaches exist. Basic approaches involve positive and negative reinforcement of desirable and undesirable behaviour. More complex approaches involve teaching new skills that will allow a person to cope with challenging high-risk situations. For example, social skills training may change the way a comorbidity patient interacts with the people around them improving their work, social and family situation.

Patients with comorbidity that may benefit from a behavioural approach may be determined using a symptom checklist (Figure 3.4). Attention to disordered sleep patterns, physical exercise, and the planning of pleasurable activities may be used to assist patients with depressive and anxiety symptoms. Similarly teaching skills to slow consumption, drink refusal skills, and skills to avoid high-risk situations may assist patients to reduce their consumption of alcohol (NIAA, 1999; Gill & Polkinghorne, 2000).

**Figure 3.4. Identifying patients that may benefit from a behavioural approach**

**Behavioural symptom checklist:**

- Loss of motivation
- Decreased productivity
- Apathy and indifference
- Difficulty problem solving
- Social withdrawal
- Difficulty setting goals
- Impaired ability to make decisions

WHO, 2000 pg 211

**Cognitive approaches**

Certain individuals find it difficult to control negative thoughts and feelings that lead them to drinking and drug taking (Davies, 2000). This may be worse in patients with comorbidity where the individual is already struggling to deal with the influence of their...
mental health problem on their thought processes. The basis of cognitive approaches is to teach a person ways to deal with the thoughts and feelings that are involved in comorbidity difficulties. At the basic level the clinician will attempt to help the patient to change the way they think about their substance use, their mental health problem and the difficulties they are experiencing (Hickie, 2000). More formal ‘cognitive therapy’ involves helping people to develop a better understanding of psycho-social stressors in their life and teaching them effective cognitive skills to cope with these. For patients with comorbidity, cognitive therapy may be used to minimise the effect of mental health problems and reduce the ‘need’ to use substances. Patients with comorbidity that may benefit from a cognitive approach may also be determined using a symptom checklist (Figure 3.5). The role of the GP may then be to help patients recognise negative and unproductive thought process that sustain comorbidity and teach them to replace these with more helpful thoughts (Davies, 2000; WHO, 2000).

**Structured problem solving**

Perhaps the most common cognitive approach to comorbidity utilised in the general practice setting is structured problem solving. Structured problem solving is a very accessible form of psychological intervention for GPs as it can be learnt quickly, requires little on-going supervision and can be broken down into a manageable time frame (3-6 sessions, 15-30 minutes). Structured problem solving may be used by GPs to help a patients with comorbidity develop practical approaches to perceived problems and to learn new cognitive skills that aid the development of a general approach to coping with ongoing life stressors. Sessions involve having the patient initially identify specific problems and then moving them from a position of general hopelessness by asking them to create a list of reasonable options to these problems. Asking the patient to then evaluate each of their options forces them to engage in a rational style of thinking that is often not seen in people who are experiencing mental health problems.

**Cognitive behavioural therapy**

Cognitive behavioural therapy (CBT) combines behavioural and cognitive elements into a single therapy approach. CBT is based on the premise that behaviour is the result of disturbed mood that is caused by distorted, negative thinking (Davies, 2000). The therapy process involves examining maladaptive thought patterns and encouraging behaviours that avoid self-defeating interactions. CBT and has been demonstrated as an effective approach to comorbidity as it has been used to treat mild to severe mental health problems and successfully modify coexisting substance use (Brown et al., 1997).
Figure 3.5. Identifying patients that may benefit from a cognitive approach

Cognitive symptom checklist:

<table>
<thead>
<tr>
<th>Excessive self-criticism</th>
<th>Angry thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings</td>
<td>Feelings of hopelessness</td>
</tr>
<tr>
<td>worthlessness</td>
<td>of Feelings of hopelessness</td>
</tr>
<tr>
<td>Feelings of helplessness</td>
<td>Excessive or unrealistic fear</td>
</tr>
<tr>
<td>Brooding about the past</td>
<td>Decreased pleasure or enjoyment</td>
</tr>
<tr>
<td>Excessive guilt</td>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Decreased self-confidence</td>
<td>Feeling pessimistic</td>
</tr>
<tr>
<td>Feelings of depression or sadness</td>
<td></td>
</tr>
</tbody>
</table>

WHO, 2000 pg. 211
There has been some doubt raised regarding the use of CBT in the general practice setting. More intensive therapy of this type involves at least 8 sessions of 25 minutes and requires a clinician with a reasonably high level of expertise (Davies, 2000). However it is possible that briefer forms of CBT used by GPs may be effective in the general practice setting. For example, a randomised control trial of brief CBT for cannabis use demonstrated that as little as one session increased the number of days the person remained abstinent and reduced associated health and psychological problems (Swift et al., 2000). This brief form of CBT may be suitable for treating comorbidity in the GP setting whilst more intensive approaches are reserved for patients with established mental disorders and chronic substance addiction.

**Family therapy**

Both substance use and mental health problems may develop in a family context with the family situation often maintaining or exacerbating these conditions (Glynn & Haenlein, 1988; Sheils & Rolfe, 2000). Involving the family in treatment of substance use has been found to raise the rate of engagement and retention, lower relapse rates and increase the likelihood of sustained recovery (Textor, 1987). Family members may play a therapeutic role by monitoring substance use, providing support, helping developing strategies for reducing use, promoting abstinence and guarding against relapse. Further, families have been shown to play a critical role in recovering from comorbidity (Mueser & Fox, 1988). Involving the family in treatment of comorbidity increases the number of supportive relationships the patient has and leads to an improved quality of life (Laudet et al., 2000; Dixon et al., 1995). Involvement of the family may begin as early as the initial evaluation of the patient and GPs may encourage family members to serve a role throughout management. Families may play a therapeutic role in the treatment of comorbidity by encouraging the patient’s treatment efforts, mobilising social support, monitoring progress and assisting adherence with medication.

**Specific approaches to substance use**

Interventions that are successful in reducing the use of substances in patients with comorbidity tend to produce positive benefits in the symptomatology of the mental health problem and reduce the general difficulties experienced by the individual (Mueser et al., 1997). Substance use problems vary in their degree of severity. The majority of patients with comorbidity have relatively low levels of substance use and may be treated using briefer interventions in the general practice setting (Drake et al., 1989). Brief interventions for substance use involve sessions of 5-15 minutes in length where the clinician uses educational and motivational techniques to help the patient to set some goals for substance use reduction. Over the course of several sessions the clinician will develop a treatment plan to assist the patient to achieve the reduction goals that they have set. Brief interventions may be applied by most GPs. These interventions are certainly more effective than no intervention at all, and may even be as effective as more
intensive approaches if they are used correctly. However, brief substance use treatments are generally only suitable for patients with relatively stable psychiatric conditions and should form only one part of a multifaceted approach to comorbidity (Evans & Willey, 2000).

**Alcohol treatment**

Alcohol is the most widely used and abused substance with up to 50% of general practice patients (in some age groups) experiencing difficulties associated with its use (Carr, 1997). The most harm is experienced not by dependent or regular heavy drinkers but by those who sporadically drink in dangerous ways (Gill & Polkinghorne, 2000). As health physicians, GPs are well placed to provide information and advice on dangerous drinking levels and to teach patients ways to control their consumption of alcohol. The majority of general practice patients are interested in setting goals to moderate or reduce their drinking rather than attempting to obtain abstinence. Brief interventions by GPs have been shown to significantly change the drinking behaviour of up to a third of people who are not heavily dependent (Saunders et al., 1993). Strategies that the GP may instigate include teaching behavioural skills to slow consumption, drink refusal skills, setting and achieving limits, learning skills to avoid high risk situations and increasing the persons ability to cope with everyday problems that may lead to drinking (NIAAA; Gill & Polkinghorne, 2000).

**Other drugs**

While alcohol is by far the most commonly used drug in the co-morbidity context, there is an increasingly significant problem with opiates, stimulants and hallucinogens [Ref: Australian Institute of Health and Welfare. 1999 National Drug Strategy Household Survey 1998]. There is good evidence for maintenance-based treatments for opiate dependence. There is increasing evidence that supports the use of brief interventions for cannabis use particularly with those people with lesser degrees of dependence.. [ref: Copeland J; Swift W; Roffman R; Stephens RA Randomised controlled trial of brief cognitive-behavioral interventions for cannabis use disorder. J Subst Abuse Treat 2001 Sep;21(2):55-64; discussion 65-6] However there is less evidence on the effectiveness of treatments for stimulants and other classes of illicit drugs, particularly in the primary care setting. [Ref National Centre for Education and Training on Addiction Models of Intervention and Care for Psychostimulant Users Monograph Series no 32. Kamieniecki G Vincent N, Allsop S, Lintzeris N 1998]

It is important to note that at present general practitioners in Australia have limited expertise in such management. There is also documented general practitioner ambivalence about the role of being principle provider of services.

Abstinence Based Interventions

A. Detoxification

Detoxification (detox) involves the management of unpleasant and possibly even dangerous withdrawal reactions to the acute cessation of a substance that has been used frequently enough for addiction to occur (Sacks & Keks, 1998). GPs will generally refer a person to a drug and alcohol specialist for detox when they are experiencing serious psychological and physiological effects of substance use and immediate cessation of use is required. Conducting non-complicated detox in the patient’s own home is possible and is less expensive and less traumatic than in-patient hospital stays (Wiersema, 1996). GPs may serve a role in the detox process by providing support during this home withdrawal attempt and a number of protocols to assist exist (eg. Saunders et al., 1996). This style of detox should be performed only if the patient is physically healthy, has only ever experienced mild to moderate withdrawal symptoms in the past and there is only a low risk of serious withdrawal effects such as seizures (Sacks & Keks, 1998). It is important for the GP to assess whether the person has sufficient support from friends or family and to determine if they will have access to any substances during withdrawal. For patients with comorbidity it is especially, it is particularly important to make sure that there is no history of suicidal ideation or previous suicide attempts.

Immediate cessation of substance use does not automatically improve the personal or social functioning of a person that is experiencing comorbidity difficulties. In-fact, a person that has recently undergone detox may experience a variety of new difficulties as they no longer have their usual strategy for coping.

B. Psychological and Social support

Provision of psychological and social support before and after the actual detox may assist the person to maintain their abstinence (Pani et al., 1997). For example, the patient may benefit from joining a self-help group such as Alcoholics or Narcotics Anonymous. However, attending support groups can be difficult for a person that has a mental health problem as well as an addiction (Powell et al., 1996). GPs may play a role in encouraging patients to join self-help and other support groups by ‘breaking the ice’ and making the initial contact with members of a given group. Support groups increase the level of social
support, improve substance use treatment outcome, reduce the likelihood of relapse and even have a positive influence of the mental health problem (Laudet et al., 2000; Gill, 2000).

C. Anti-craving drugs

Anti-craving drugs such as Naltrexone and Acamprosate are effective in aiding and maintaining the cessation of alcohol use in the dependent patient as they reduce the patient’s physical urges to use. However, they need to be used in the context of a comprehensive treatment program. GPs are currently reluctant to prescribe these medications for a variety of reasons (reference).

Despite the use of anti-craving medications and the provision of psychological and social support relapse remains a constant threat after detox. Perhaps the best approach may be for the GP to anticipate the occurrence of relapse and to strongly encourage the patient to maintain regular contact even if they begin using again.

Maintenance based interventions

In many instances abstinence is not an option, particularly for those people with opiate dependence. There is a long history of methadone being used to assist these people with good evidence that health outcomes are improved [ref Ward J, Mattick RP, Hall W 1998 Methadone maintenance treatment and other opioid replacement therapies]. General practitioner prescribing of methadone on a large scale has been a recent phenomenon in Australia. Demand for this service continues to outstrip the limited supply. While feasible on a larger scale, the majority of general practitioners at least in Western Sydney, are reluctant to be involved with prescribing methadone or with being major providers of specific treatments for people with illicit drug use problems. [ref Abouyanni G, Stevens LJ, Harris MF, Wickes WA Ramakrishna SS et al (2000) GP Attitudes to managing drug and alcohol dependent patients: a reluctant role. Drug and Alcohol Review 19 165-170]

Another maintenance based intervention for opiate dependence is buprenorphine but there is limited experience with this in the Australian General Practice setting. Experience in France [ref Moatti JP, Souville M, Escaffre N, Pnadoa Y (1998) French general practitioners’ attitudes towards maintenance drug use treatment with buprenorphine Addiction 93 (10) 1567-1575] seems to indicate that this can be successfully managed through general practice but only in the context of a comprehensive system of support for the GP and the client.
Referral & Secondary service interaction

Patients with comorbidity experience a range of health and social problems such that their needs often cannot be fully met by just one service provider. GPs may seek to refer a patient with comorbidity in situations where they believe that the person will benefit from the assistance of a specialist, usually a mental health or drug and alcohol service provider. GPs should definitely refer a patient with comorbidity when there are signs of persistent substance abuse or physical dependence, suicidal ideation, mania, depression with psychotic features, schizophrenia or other serious psychiatric disorders (Ziedonis & Brady, 1997).

Through skilful referral by their GP, patients with comorbidity may receive continuous integrated care that results in comprehensive management of both their substance use and their mental health problem. This skilful referral begins with the selection of a suitable specialist or support service. GPs often experience significant confusion regarding the services that particular providers offer and whether they are suitable for patients with comorbidity. Similarly many services have strict entry criteria and only accept certain people, and often patients with coexisting substance use and mental health problems are excluded. In order to avoid inadvertently sending a patient on a referral run-around it is important for GPs to take steps to ensure that a particular service is appropriate for the client and that the client is appropriate for a particular service. To do this, GPs need to have access to information regarding the providers available in a given area, the services that each offers and their suitability for patients with comorbidity.

In most situations it is reasonable for the patient to be followed by both the secondary service provider and a GP, with each serving a significant role in management. In order to achieve the maximum benefit, the care provided by multiple clinicians must be coordinated. Case conferences and joint assessments that involve GPs, mental health specialists and drug and alcohol workers are effective elements of coordinated care (Mooney, 2001). The Enhanced Primary Care item numbers available for general practitioners provide financial reimbursement to encourage the use of these collaborative activities and make coordinating care for patients with comorbidity easier. However, a number of serious difficulties affect the interactions between GPs and specialty service providers involved in the care of patients with comorbidity. These difficulties include a lack of consistency in approaches to comorbidity, confusion regarding primary patient responsibility, poor systems of referral, too few appropriate specialist services, and inadequate communication between clinicians involved in the care of a given patient (Mooney, 2001; Philip, 1999). There have been a number of significant attempts to address these problems and a list of potential improvements are outlined (Figure 3.6). It is only through improving interactions between primary care providers (GPs), specialised services, non-government organisations, and mainstream health care agencies that the provision of suitable continuous care to people with comorbidity can be ensured (NSW Health, 2000; Mooney, 2001).
Improved service interaction for patients with comorbidity requires:

An enhanced common understanding of 'comorbidity', treatment approaches and service responsibilities including standardised assessment procedures.

Introduction of procedures to promote collaboration between services including mutual agreement regarding who takes primary role, standardised referrals and established clinical pathways for patients with comorbidity.

Formal service agreements and combined strategies for health promotion and prevention

Use of joint assessments, co-management, clinical meetings and case reviews to enhance continuity of care and promote a coordinated and integrated approach to the management of comorbidity.

(Fooney, 2001; Philip, 1999; NSW Health, 2000)

Follow-up & Monitoring

Recovery from comorbidity requires more than just reducing substance use and adhering to psychiatric medication; it is a long term process that involves development of new life skills and coping strategies (Laudet et al., 2000). An individual experiencing issues with coexisting mental health and substance use problems will have needs that vary according to the phases of their life and the course of their illness. At any one time a patient with comorbidity may require medication or detoxification, and at another time they may require counselling, support, outreach or follow-up. Throughout this process GPs support patients with comorbidity and reinforce their recovery by helping them to cope with stigma, low-self esteem, emotional lability, the constant threat of relapse, side effects from prescribed medication, physical complications and withdrawal effects. In short, the support provided by GPs is long term and variable in intensity as dictated by the patient's needs. In fact, even if the patient is no longer actively engaged in treatment, follow-up and monitoring are part of the GP's approach to the management of comorbidity.

As a family doctor the GP is well situated to play a role in following a patient across time to monitor their progress with treatment and to provide any ongoing care that is required. It is through this long term follow-up that the GP will be able to identify any variations in a
patient’s mental state or substance use. Regular allows the GP to increase the frequency of contact, increase or change medication or facilitate entry into another service if required (Evans & Willey, 2000). Indeed, follow-up should be frequent so that re-engagement can be early enough to prevent an unnecessary relapse that requires emergency hospital admission.

Follow-up is an important part of management of comorbidity as it ensures that patients continue to take their medication and use the skills that they have learnt during treatment. Relapse prevention begins early in the management process and should include providing the patient with skills to avoid lapses and to prevent lapses becoming relapses (WHO, 2000). Relapses, if they do occur, should always be considered as opportunities to learn rather than as an indication of failure.

**Summary of literature - Management & Treatment**

- Management of comorbidity requires an integrated approach that includes treatment that addresses the substance use, the mental health problem and their interaction to improve the patient’s quality of life.

- It is essential to ensure that the treatment approach is matched to the patients readiness to change.

- Educational and harm minimisation approaches may be useful for patients who are not yet ready to change.

- Motivational interviewing may be used to highlight the positives of changing and move a person towards beginning treatment.

- Psychiatric medication is effective for treating mental health problems and substance addiction, selection of an appropriate medication and ensuring adherence are important.

- Effective psychological interventions include supportive counselling and also and behavioural and cognitive therapies.

- Briefer structured problem solving and CBT have both been shown to be effective in reducing the impact of mental health problems and addictive behaviour.

- Briefer interventions directed at substance use, particularly alcohol use, are effective in reducing consumption and associated consequences on mental health.

- GPs may assist in home detox, particularly by providing pharmacological, psychological and social support.

- Skilful referral and coordinated specialist care allows comorbidity patients to benefit from the care of multiple service providers.
Follow-up with monitoring are an essential part of long term management to ensure that a patient continues to receive appropriate care, to reinforce treatment and to prevent relapse.

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CHAPTER 5 Activities of Divisions

A Review of Current Comorbidity Activities within the Australian Divisions of General Practice

Introduction

The Divisions of General Practice represent regional groups of GPs and play a major role in promoting the continuing education and up-skilling of general practitioners. The Divisions regularly conduct analyses to determine the needs of the GPs and the patients for whom they are caring. This needs analysis process has led many of the Divisions to establish programs to improve the level of care provided to people experiencing difficulties with mental health and alcohol and other drugs. For example, the PARC Mental Health Shared Care Report revealed that at least 46% of Australian Divisions are involved in activities to enhance integration between GPs and specialised mental health services. The current project provides a review of Australian Divisions of General Practice that have begun to pay extra attention to providing care for patients with coexisting mental health and substance use problems.

Methods

Divisional survey

A brief search of the ‘Australian Divisions of General Practice Directory’ and the ‘National Information Service Activities of Divisions Database’ revealed 80 Divisions with major mental health or drug and alcohol programs. Divisions with these programs were sent a survey question that asked them to provide details of involvement in any ‘comorbidity activities’ (Comorbidity was defined as the coexistence of substance use and mental health problems). This survey was conducted as part of the Mental Health Shared Care Project being undertaken by PARC in the first half of 2001. A total of 70 divisions provided responses to this survey with 13 providing details of current comorbidity activities and a further 4 indicating that they were considering comorbidity activities in the future. The positive replies were mostly accompanied by descriptions of collaborations between GPs and specialist services and there was also a definite indication that some of the Divisions were considering comorbidity training options while others were awaiting the outcome of funding applications.


Primary Mental Health Care Australian Resource Centre July 2002
**NIS Database Search**

A comprehensive search of the National Information Service Activities of Divisions Database was conducted to support and extend the information determined through the divisional survey process. This search included all sections of the database and revealed 8 Divisions with listings that included some specific mention of either 'comorbidity' or 'dual-diagnosis'. These entries included statements recognising the importance of addressing the issue of comorbidity and descriptions of strategies and programs that have been implemented to address the needs of GPs caring for this client type.

**Follow-up**

The results of the divisional survey and the database search were combined to provide a total of 17 Divisions involved in a variety of comorbidity activities. Each of these Divisions was contacted in an attempt to gain further information regarding the extent of these activities. All of this information was compiled into a brief report containing the details of these Divisional comorbidity activities. The information contained in this brief report was faxed to a contact at the Division so that the accuracy of the details could be checked and confirmed.

**Current comorbidity activities within Australian Divisions of General Practice**

**Far North Queensland Division of General Practice**

Contact: Peta Wilkinson (Mental Health Project Coordinator)

This Division has performed a substantial amount of work in the area of GP shared care that has led to the development of a mental health coordinated care program. This mental health program includes a model for managing dual diagnosis patients that outlines the best way to involve drug and alcohol services.

**NSW Central West Division of General Practice**

Contact: Lyn Chapman (Clinical Program Manager and Mental Health Project Officer)

This Division has demonstrated significant interest in improving the level of care provided to patients with coexisting substance use and mental health problems by including comorbidity in its development of a Primary Mental Health Care strategy. Stage 1 of the strategy aims to provide GPs with resources to improve their ability to provide adequate care for patients with comorbidity. Discussions with area health services have been initiated in an attempt to improve interactions between GPs, Drug and Alcohol specialists and mental health specialists.
**Hunter Rural Division of General Practice**

Contact: Fran Timmins (Mental Health Program Officer)

Comorbidity was included in the rationale for the development and implementation of a division wide mental health program. The aim of this program is to develop a model that will optimise coordinated care between community based mental health workers and GPs. Local mental health teams include drug and alcohol workers that are able to provide support for GPs involved in the care of patients with comorbidity. These teams have introduced a screening tool to aid the identification of people with drug and alcohol related problems.

**Wagga Wagga & District Divisions of General Practice**

Contact: Julie Porritt (Program Director)

This Division has focussed on raising the skill level of GPs in shared care project activities, drug and alcohol issues (including methadone prescribing), and mental health promotion and prevention. The aim of this work was to reduce the effect of comorbidity and to improve the general health of the population by promoting better treatment through 'seamless health care delivery'. This Division is currently working in partnership with the Greater Murray Area Health Service to develop ways to provide early intervention for patients with comorbidity [dual diagnosis]. Research is being conducted to identify risk factors and early predictors for comorbidity (particularly in adolescents) and to develop effective interventions for people with coexisting substance use and mental health problems.

**Bendigo & District Division of General Practice**

Contact: None provided

This Division has developed a joint working party within their Managed Care Project that is able to respond to the needs of patients with dual drug, alcohol and mental health problems. The Division is currently trying to increase the sharing of information and resources between the Division and organisations that are involved in caring for people with comorbidity. The Division has developed a Drug & Alcohol Resource Manual that was funded by the district health service and they have recently been awarded further funding for its update.

**Sunshine Coast Division of General Practice**

Contact: Shayle Woods (Mental Health Coordinator/Director)

This Division is seeking to collate clinical management guidelines in the area of mental health that include information on alcohol and other drugs so that they may be distributed to GPs. The Mental Health Coordinator for the Division is involved with a working party that is investigating various clinical interventions for the treatment of...
patients with comorbidity, including the involvement of various health care providers. This Division is continuing to provide education and for GPs regarding shared care arrangements and has begun to encourage drug and alcohol workers to invite GPs to participate in care planning and case conferencing.

**South Eastern Sydney Division of General Practice**

Contact: None provided

This Division is planning to provide educational programs for GPs in the areas of mental health and/or alcohol and other drugs. Strategies to enhance the care of patients with comorbidity include encouraging more effective use of the new MBS EPC items. These items will aid the development of partnerships between GPs, drug and alcohol services and mental health services through care planning and case conferencing (RACGP, 2000).

**Manly Warringah Division of General Practice**

Contact: Daryl Schaefer (Mental Health Program Coordinator)

This Division conducted a program where a nurse was used to accompany patients with comorbidity to appointments with counsellors and psychologists. Evaluation revealed that the model was too expensive and that the GPs were not particularly accepting of the program. The program ran for twelve months before being discontinued.

**NSW Central Coast Division of General Practice**

Contact: Samira Farmakis (Programs Development Manager)

This Division has numerous projects currently in progress, working closely with the Central Coast Area Health Services, in the areas of mental health and alcohol and other drugs.

Projects relevant to comorbidity include:

- A **general practitioner needs assessment** to identify service delivery opportunities in the areas of mental health and alcohol and other drugs.

- A joint ongoing mental health project involving the Division, Central Coast Health Mental Health Services, GPs, consumers and other various stakeholders.

- A **Community Mental Health Worker** needs assessment in managing clients with alcohol and other drugs related problems (conducted by the Central Coast Health Alcohol & Other Drugs Service).
• An ongoing 'GP project' managed by the Central Coast Health Alcohol and Other Drugs Service. This project initially assessed the needs of GPs involved in treating patients with alcohol and other drug problems. This project has resulted in the development of a very successful model for the integration of GPs into drug and alcohol services. GPs were provided with an information package that included some basic guidelines for the management of patients with coexisting mental health and drug and alcohol problems*.

This Division has also established a Dual Diagnosis Steering Committee and has recently been awarded funding through the NSW Alliance of Divisions to pilot a new model of care for patients with comorbidity. This project will be conducted over two years having commenced in July 2001.

**South East NSW Division of General Practice**
Contact: Tina Philip (Mental Health Project Officer)

Following a needs analysis assessing the involvement of GPs in mental health shared care this Division conducted an investigation into current practice and possible future developments in the area of comorbidity. A report considering the management of patients with comorbidity made recommendations that included the following:

- **Systems issues** namely definitions, evidence based treatment protocols, service responsibility, and health promotion
- **Training and education** for GPs and also secondary service providers
- **Clinical issues** namely the development of a comprehensive and integrated model of care
- **Policies & procedures**, namely formal agreements and protocols for referral between GPs and secondary services

**Northern Rivers Division of General Practice**
Contact: Tim Armstrong (Mental Health Project Officer)

This Division has been involved with local area health services in establishing a 'Dual Disorders Project'. This project has involved mental health services, drug and alcohol services, non-government organisations, and GPs. The Dual Disorders Project officer (Molly Galea - Northern Rivers Area Health Service) is working to improve links,

increase expert knowledge and to establish practical systems for the care of people with comorbidity. GPs are considered an integral part of service delivery and a workshop with doctors from the Division was conducted to establish their needs. The GPs involved in this meeting raised concerns regarding the inflexibility of other services and the inadequacy of reimbursements for the longer consultations that patients with comorbidity require.

Illawara Division of General Practice

Shoalhaven Division of General Practice

Contact: Andrew Dalley (CEO Illawara division)

Illawara Division conducted a GP needs analysis that identified mental health as the number 1 priority with drugs and alcohol in the top 10. Both Divisions jointly applied for (and received) funding to develop, pilot and evaluate a dual diagnosis education program for GPs. This educational program will be developed to meet the specific needs of GPs and their patients.

The following six modules are proposed:

- Identification of patients with comorbidity
- Stages of change
- Motivational interviewing
- When and how to refer
- Case management of patients with dual diagnosis
- Health needs of patients with dual diagnosis

Dual Diagnosis Project - Central Bayside Division of General Practice

Monash Division of General Practice
Dandenong & District Division of General Practice
Sherbrook & Pakenham Division of General Practice
Mornington Peninsula Division of General Practice

Contact: Lisa Allwell (Dual Diagnosis Project Officer)

This Dual Diagnosis Project involved partnership between five metropolitan Divisions of general practice and the Dual Diagnosis Resource Centre (Victoria). The aim of the
The project was to identify and support the development of an effective role for GPs in the early detection and treatment of patients with comorbidity.

Project initiatives include:

- Development of a model to support GP involvement in the care and effective treatment of patients with comorbidity.

- Development of a range of educational activities aimed at providing GPs with skills development to deal effectively with patients with comorbidity. Activities included peer support, access to secondary consultations, CME workshops and development and distribution of a referral pathway for drug and alcohol services.

- Linking and liaising with service agencies involved in the care of patients with comorbidity to promote an active role for GPs in this sphere.

**Summary/Overview**

While a few Divisions have established programs in place, many are in the developmental phase of their programs. There is great opportunity for these Divisions to share resources and to develop common approaches to evaluation. In particular the identification of appropriate interventions for GPs, criteria for referral, practical referral pathways and the development of sound care coordination processes could be shared across Divisions. Common approaches to education and training for GPs (as envisaged in the NSW pilot projects) would also be of practical benefit.

This having been said, the great majority of Divisions do not have programs that address the issue of comorbidity. In-fact, over one third of Divisions do not have any activities addressing mental health at all, despite this being a National Health Priority area.
CHAPTER 6  GP Comorbidity Survey: Consultation

Phase 1

Introduction

This project's review of current literature has revealed a number of distinct gaps in the knowledge regarding the best approaches to general practice management of coexisting mental health and substance use problems. Clear and practical guidelines for the care of patients with comorbidity in the general practice setting do not exist and GPs are forced to rely predominantly on their own clinical experience and judgement.

In the absence of any clear evidence regarding best management approaches this project initiated a process to develop a set of reasonable principles that will guide GPs involved in the care of patients with comorbidity. The first step in this process was to tap into the knowledge base of clinicians that have considerable experience in providing care for patients that are experiencing comorbidity difficulties. The main aim of the PARC General Practitioner Comorbidity Survey was to identify key issues that are important to consider in establishing a set of 'best practice' principles for the care of patients with comorbidity. This survey involved a large number of GPs with experience in substance use and mental health issues and was conducted to achieve a number of objectives as listed below.

Objectives of the GP Comorbidity Survey:

- Explore issues in the detection and assessment of patients experiencing comorbidity difficulties.
- Determine general approaches and specific interventions that are useful in the general practice treatment of patients with comorbidity.
- Explore issues in the referral of patients with comorbidity.
- Identify areas of change that will enhance the level of care provided to patients with comorbidity in general practice.

Methods

The survey was designed to probe approaches that GPs might use to common situations in general practice where they see people presenting with coexisting substance use and mental health problems. The survey contained a total of 5 sections each containing questions that reflected the objectives of the survey (see Appendix A for a copy of the survey). Each of the first three sections involved a sequentially presented example of a common general practice scenario involving a patient experiencing comorbidity difficulties. The fourth section asked the survey respondent to provide de-
identified details of a similar presentation of comorbidity that they had recently encountered in their own clinical practice. Open questions in each of these sections asked the respondent to provide details regarding detection, assessment, general approaches, specific interventions, and referral. The doctors completing the survey were asked to provide answers that would reflect what they would expect of an average GP that has a broad case load and who hasn’t a particular special interest in the area of comorbidity. The fifth section contained a final set of questions that explored the respondents views on the issues of training and future changes regarding the care of patients experiencing comorbidity difficulties in the general practice setting.

The survey was aimed at GPs with a reasonable degree of interest and experience in the areas of mental health and substance use. A list of suitable doctors was compiled through the Australian Divisions of General Practice. Potential respondents were contacted via phone initially and were then mailed the survey and a cover letter explaining the survey process and inviting them to participate. The survey required approximately 90 minutes to complete and a reply paid express envelope was provided to assist its return. Application was made with the RACGP to award CME points for respondents and all participants were provided with a summary of the key findings. A total of 25 GPs with Inner Metro (5), Outer Metro (6), Major Regional (5) and Rural and Remote (8) practices completed the survey with a response rate of approximately 65%.

Analysis of the returned surveys involved a mixture of qualitative and quantitative approaches aimed at placing some degree of order on the responses provided for the open questions. Questions from the first four sections were grouped based on the specific topic that they were exploring - Detection, Assessment, General Approaches, Specific Interventions, or Referral. Initially responses were categorised and then tallied to calculate the frequency of a given response type across the four sections. These frequencies are represented graphically in the following section to show the relative importance of a particular response category. In some instances the total number of one type of response exceeds the number of respondents. Eg in figure 6.5 under specific approaches there were 35 responses of the type “discuss/use pharmaco-therapy”. With all the response types the response numbers reflected numbers of GPs responding as much as numbers of responses, except where the number of responses was >25. Except with the response types where the total numbers exceeded 25 there was little repetition by single responding GPs within one response type.

Results

Approaches to detection and initial assessment

“You may not get much with a first presentation, maybe [you] need to just ‘leave the door open’ for follow-up next time. Sometimes if you push too hard they will never come back.”

Primary Mental Health Care Australian Resource Centre       July 2002
When a GP initially sees a patient that they suspect may be experiencing some type of comorbidity difficulty there is a number of key areas that are important to assess. The relative importance of issues to be considered in the detection and initial assessment process are represented in Figure 6.1.

**Figure 6.1.** General areas of inquiry that may assist in the detection of patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP Comorbidity Survey.

The GPs involved in the survey indicated the initial assessment process must include routine inquiry regarding the patient’s use of alcohol and other drugs including details of any prescription medicines. Equally important is the need for GPs to inquire about a patients' general level of health and life functioning, that is, how things have been going for them recently. This should then be followed by more specific inquiry into any areas where the person is experiencing difficulties in order to detect the presence of underlying substance use and/or mental health problems. This may include exploring their family or social situation, asking about any relationship, work or somatic
difficulties they are having, or if they are experiencing problems **sleeping**. This inquiry should be open and non-confronting with expression of empathy and attentive listening to create the beginnings of a therapeutic relationship. It is this type of approach to initial assessment that will lead to accurate detection and assessment of the problems underlying attendance.

**Approaches to targeted assessment of substance use**

During the assessment of comorbidity it is essential for GPs to gain a clearer and more detailed picture of the patients substance use. The most important aspects of substance use assessment for a patient with a coexisting mental health problem are represented in Figure 6.2.

![Comorbidity in General Practice - Assessment of substance use](image)

**Figure 6.2.** Specific areas of inquiry that are useful in the assessment of substance use for patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP Comorbidity Survey.

When assessing substance use it is important that GPs initially establish the **pattern of use** (ie. how much, how often etc). It is also important that GPs inquire about **feelings towards substance use** and the **reasons for this use**. Further assessment may
include asking the patient to describe the **effects of their substance** and what has happened if they have **attempted to decrease** their use. Determining the best approach to managing comorbidity may be enhanced by exploring with the patient how their use of substances **interacts** with their mental health (and vice-versa).

**Approaches to targeted assessment of mental health**

On the other hand it is also essential for GPs to gain a clearer and more detailed picture of the patient’s mental health problem. The most important part of this assessment is to inquire directly about any psychological/psychiatric features that are obvious or may be underlying other symptoms (eg. depression, anxiety, mania, etc). Other important aspects of mental health assessment for a patient with coexisting substance use are represented in Figure 6.3.

**Figure 6.3.** Specific areas of inquiry that are useful in the assessment of mental health for patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP Comorbidity Survey.

Assessment of mental health in the context of substance use should always include evaluation of **self-harm risk**. This assessment may also include to inquiry regarding **personal past history** and **family history** of identified mental health problems. Assessment of the current psychiatric features may include evaluation of present **mood** and **level of self-esteem** as well as exploration to reveal **underlying causes**. Once again the comorbidity management approach may be enhanced by exploration of how
substance use interacts with mental health (and vice-versa). This is particularly relevant if substance use is an attempt to self medicate the mental health features.

**General approaches to management**

“It is the relationship that is therapeutic and useful, GPs probably combine good listening skills with a number of simple interventions from problem solving, CBT, motivational interviewing and supportive therapy models of counselling to develop this therapeutic relationship.”

GPs may use a number of different non-specific approaches when they are involved in the care of patients. When initial assessment has led the GP to suspect the presence of comorbidity there are a number of 'general approaches' to comorbidity that may be useful without beginning specific therapeutic interventions. The most important aspects of general approaches to the management of comorbidity are represented in Figure 6.4.

![Figure 6.4. Non-specific approaches that are useful in encounters with patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP comorbidity survey.](image)

When attempting to engage a comorbidity patient it is important to ensure that they understand the assessment and diagnosis that has been made and to determine that they are actually ready to change their behaviour. The GP may begin by establishing regular contact with the patient and offering general counselling around some of the
issues raised during the assessment process. The GP may then begin to discuss with
the patient their need for change and the treatment options that are available.
Throughout this entire process the GP should seek to establish and enhance their
therapeutic alliance with the patient so that current and future interactions will be
beneficial.

The delicate nature of the relationship between GP and patient with comorbidity is
illustrated by the following comment.

“[Patient’s with comorbidity are] usually unreliable patients that fail to attend
regularly for care. They deny having a substance abuse problem and hence
won’t seek counselling. It is important to be supportive and to deliver
information, but the patient has to decide that they need to change if any
successful interaction is to occur.”

There is a need for GPs to accept that interventions will only be effective when the
patient is ready.

Specific approaches to management

“To manage patients with comorbidity, GPs need to be trained in managing both
drug addiction and psychiatric problems. Most drug users I deal with have some
comorbid psychiatric issues and most psychiatric patients are involved in misuse
of various drugs.”

There are a number of specific approaches that GPs may utilise when treating patients
with comorbid mental health and substance use problems. The most frequently used
approaches are represented in Figure 6.5.

In a majority of situations GPs will use pharmacological options to manage
comorbidity. Treatment using medication involves discussing this option with the patient
before beginning them on a course of anti-depressants, tranquillisers, anti-psychotics,
etc. as required. Similarly, GPs may look to review the medication that a patient is
already taking. For a patient that is not ready to begin specific treatment the GP may
provide educational materials, use psycho-educational techniques or simply provide
a warning regarding the risks of substance use. Specific psychological/psychiatric
interventions that may be used include motivational interviewing, self-esteem
counselling and problem solving approaches. Cognitive behavioural therapy (CBT)
is also considered to be a very useful approach for patients experiencing comorbidity
difficulties. However, most responses indicated that it is not effective for GPs to use CBT
themselves and that it is better to refer the patient to a psychiatrist, psychologist or
psychotherapist for this style of intervention. Specific approaches to substance use
include monitoring the level of use, and attempting to reduce this level by beginning a
Figure 6.5. Specific interventions that are useful in treating patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP comorbidity survey.
reduction program, for example a gradual reduction program. GPs may also use anti-craving drugs in an attempt to reduce and eventually eliminate a patient's use of substances.

Survey respondents seemed to consider that the role of the GP includes the provision of comprehensive care that is limited only by the individuals own “time, skill and desire”.

Referral

Reasons for referral

The GP Comorbidity Survey considered closely the issue of referral for patients with comorbidity. GPs provided a number of reasons why they may choose to refer a comorbidity patient, these are represented in Figure 6.6.

Figure 6.6. Reasons why GPs consider referring patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP comorbidity survey.
The most common reasons for referring patients with comorbidity included a lack of progress despite treatment and the presence of a significant risk of self-harm. Further reasons for referral included the presence of a serious psychiatric condition (eg. schizophrenia, bipolar disorder etc.), the presence of major psychiatric features (eg. severe levels of depression, anxiety etc.) or to address serious underlying issues (eg. childhood sexual abuse). Similarly GPs may seek to refer a patient in the case of serious substance addiction, particularly if it is established that serious withdrawal effects are likely. Other reasons for referral included request by the patient (or their family), lack of time or skill on the part of the GP and if the doctor found that they were unable to engage a particular client. Positive reasons for referral included the availability of a suitable service or if the GP believed that the patient would benefit from the addition of specialist expertise (eg a cognitive-behavioural therapist).

Where to refer

The next step in the referral process is to decide where to refer patients with comorbidity, these are represented in Figure 6.7.

Figure 6.7. Services that GPs consider useful when looking to refer patients with coexisting mental health & substance use problems. Graph indicates the relative importance of a particular item (number of times each response was mentioned) as revealed by the GP comorbidity survey.
The most common specialists that GPs considered suitable to refer patients with comorbidity to were **psychiatrists** and **psychologists/psychotherapists**. GPs may also refer comorbidity patients to a **drug & alcohol specialist** or a **community mental health service**. Other places of referral that were considered useful include **support groups**, **family & community services** and **social workers**.

**Barriers to referral**

“He was accepted by the local mental health team when he attempted suicide but later was dismissed when it became known that he was a poly drug user & abuser. Patients with comorbidity are often **ignored** by A & E, by psychiatric departments and by drug & alcohol programs, everyone thinks someone else should deal with them.”

A number of barriers may prevent the successful referral of patients with comorbidity to a given specialist service. These barriers are represented in Figure 6.8.

**Figure 6.8.** Barriers that inhibit successful referral of patients with coexisting mental health & substance use problems. Graph indicates the relative
importance of a particular item (number of times each response was mentioned) as revealed by the GP comorbidity survey.

The main barriers to referral of comorbidity patients were the **cost of services** and the lack of **availability of suitable services**. Other barriers included **patient fears**, generally stigma associated with seeing a psychiatrist, as well as **waiting times**, and lack of interest or general **reluctance** on the part of the client.

**Enhancing the quality of care provided for patients with comorbidity**

The current quality of care provided by GPs treating patients experiencing comorbidity difficulties is variable and depends largely on the expertise and interest of the individual practitioner. A number of suggestions have been made by the GP Survey respondents. These suggestions have been collated to guide future changes that are aimed at enhancing the level of care provided to patients with comorbidity by all practitioners working in general practice.

**Key improvements - General**

Enhancing the quality of care for patients with comorbidity requires:

- Acceptance by all practitioners that there is such a thing as ‘comorbidity’ and that recognising its presence in patients is important and useful.
- Encouragement for GPs to regard patients with comorbidity as a ’challenge’ rather than ’giving up’ on them.
- Continuing efforts to change the perception of mental health and substance dependency in the community to remove the stigma associated with these problems.
- Further funding for programs and research focussed on comorbidity.
- Financial rewards for GPs seeing patients with comorbidity and using longer consultations.

**Key improvements - Training**

Enhancing the quality of care for patients with comorbidity requires:

- Formal training in the area of comorbidity at an undergraduate and graduate level.
• Seminars and case conferences (intra- & inter-divisional) to provide continuing medical education to practising clinicians regarding useful approaches to common types of comorbidity problems.

• Peer support/debriefing for emotionally demanding and frustrating cases.

• Increases in the level of training that all doctors receive in the areas of Psychiatry and Alcohol and Other Drugs to increase their knowledge on how to handle both substance abuse and mental health issues.

• Teaching of basic interview and counselling skills for all medical students including the use of active listening, empathy, and open questioning.

• Development and dissemination of clear assessment and management protocols that aid the detection and treatment of patients experiencing comorbidity difficulties.

**Key improvements - Referral**

Enhancing the quality of care for patients with comorbidity requires:

• Increased availability of suitable external assistance for patients experiencing comorbidity difficulties. These services should be able to encompass the challenges of people with both mental disorder and substance use within their own resources or through collaboration with other agencies.

• Development of clear guidelines for the referral of patients with comorbidity including an outline of services and individual practitioners that are able to provide suitable support.

• Improved interaction between GPs and specialist services including greater acceptance of patients with comorbidity, quicker appointments, phone-support, case-conferencing and information sharing.

• Improved crisis intervention support for GPs and their patients.
CHAPTER 7 Primary Health Care Meetings: 
Consultation Phase 2

Introduction

Primary care agencies are the front-line of health care provision and are often the first and only point of contact for many people experiencing coexisting substance use and mental health problems. The PARC Comorbidity Project aims to provide a review of mental health/substance use comorbidity from a general practice perspective. As part of this process it is important to place general practice into its primary care context in order to understand all of the issues relevant to the care of people experiencing comorbidity difficulties. A number of formal and informal meetings were held with professionals, carers and consumers in an attempt to draw on the knowledge of people that have had some experience of comorbidity in the broader primary health care setting. The aim of this consultation phase was to explore some of the issues surrounding the primary health care needs of people experiencing coexisting substance use and mental health problems and to determine how GPs currently meet these needs.

Methods

Discussion groups and semi-structured interviews were used to determine the problems and successes that occur when people with coexisting substance use and mental health problems try to access help. There was a particular focus on the role that GPs may play in the provision of assistance.

This consultation process included representatives from the following Agencies:

**Second Storey** - an organisation that provides care for adolescents experiencing a variety of health related issues including substance use and mental health problems.

**Mental Health Resource Centre** - an umbrella agency that supports a number of smaller mental health support groups. Representatives from the following agencies were present at one of the centres group meetings.

- Schizophrenia Fellowship (SA)
- Roofs SA Housing Association (housing advocacy for mentally ill)
- The Association of Relatives & Friends of the Mentally Ill (SA)
- Mood Disorders Association (SA)
- Anorexia Bulimia Nervosa Association (SA)
Byron Place Day Centre - a community based support agency for the homeless

City Homeless Assessment & Support Team - An inner-city outreach service

St Vincent de Pauls - an inner-city shelter for homeless men.

All of the people involved in this second consultation phase possessed extensive experience with obtaining and providing primary health care for people with coexisting mental health and substance use problems. This phase also involved a number of parents that have been involved in the care of a son or daughter experiencing comorbidity difficulties. Special thanks goes to all the people involved in this process, especially the consumers themselves and their representatives.

Key issues raised

General

People experiencing comorbidity difficulties access help through a number of primary health care agencies including:

- General Practitioners & Family Clinics
- Hospital based Emergency services
- Ambulance services
- Drug & Alcohol services
- Detox and long term drug rehabilitation centres
- Alcoholics Anonymous and other self-help groups
- Private & other Non-Government Organisations
- Family and Youth Services
- Police officers, courts
- Schools, teachers, & school counsellors

In general there is a need to ensure that all of these service providers are aware of some of the important issues that are related to comorbidity. Education of primary care providers is required to improve detection and allow earlier intervention in order to prevent people from developing more extreme comorbidity problems and to minimise harm. As outlined in other sections of this report, other primary care services need to appreciate the complex interplay between mental disorders and substance use when assisting people with comorbidity.

People experiencing comorbidity difficulties find it difficult to make and keep appointments and access suitable help. There is a recurring theme among comorbidity
sufferers that the only way to stop an alcohol or drug use problem is to do it your-self with out relying on help from any service. This is consistent with the stages of change model where people change their behaviour when they decide to rather than when others think they ought to.

It is important for people experiencing comorbidity difficulties to be able to access suitable help and support as they need it. Primary health care workers need to be able to access a knowledge base of services that are available and suitable for people experiencing comorbidity difficulties.

There is a need to raise community awareness about comorbidity issues so that people become aware of the potential negative interplay between substance use and mental health problems.

**Issues specific to general practice**

Most (or all) clients with relatively established comorbidity would not consider going to their GP for help.

Negative perceptions have been created over time as GPs have overlooked or ignored mental health and substance use problems. There is almost a situation where the client does not mention the problem and the GP does not ask about it.

Patients present to their GP mainly with physical problems. Issues that may be underlying mental health and/or substance use problems are often left unassessed, unaddressed and untreated.

GPs need to identify comorbidity when it is present so that both the substance use and the mental health problem (and their overlap) may be addressed and so that the patient is able to understand that the two are connected.

GPs need to take an individual approach to patients experiencing problems with comorbidity, as they are not all the same - each individual has their own concerns and needs that must be met.

When assessing substance use it is important to explore the patients’ reasons for their use and to discuss the effects of this use on their mental and physical health.

Some GPs have been found to be better in their approach to comorbidity than others. A list of GPs with a special interest in areas relevant to comorbidity would allow other providers to refer their patients to someone that will be able to help them.

It is even more important to raise awareness and knowledge 'across the board' so that all GPs become confident in identifying and managing patients with comorbidity issues (even if this treatment involves merely detection and harm minimisation with optional referral to a specialist if desired by the patient).
There are problems with continuity of service between GPs and other primary health care providers. Specifically there is a lack of integration, little or no communication between providers and the GP, no resource sharing, lack of long term service (no formal arrangements), and often little or no follow-up and support.

A number of confidentiality issues were raised, namely that GP-patient confidentiality prevents the sharing of essential information with other providers resulting in a significant reduction in the standard of care provided.

**Summary**

General practice represents just one of many groups that can potentially provide services for people with comorbidity. There are several other agencies that provide services that are relevant to the health of people with comorbidity.

However people with comorbidity and their families and/or carers have been critical of the quality of care provided by both general practitioners and other health sectors, citing reluctance or inability to address the underlying issues for people with comorbidity, inadequate knowledge and skills regarding management and poor inter-professional communication as major obstacles to effective care.
CHAPTER 8 Focus Groups: Consultation Phase 3

Introduction & Method

It is has been stated that the most efficient way of assessing and utilising the considerable knowledge and significant experience of service providers in different sectors is to bring them together to exchange dialogue and information (McDermott & Pyett, 1993). This was the premise behind the two comorbidity focus groups that were the third phase of the PARC Comorbidity Project consultation process. The aim of these focus groups was to exchange ideas regarding some of the key issues that have arisen from the review of the literature, the GP survey and the primary health provider and carer/consumer consultations.

Two multi-disciplinary focus groups were held, one in Adelaide, and one in Orange in the central west of NSW. An adequate mix of both metropolitan and regional professionals and consumers and carers was ensured through this process.

Both meetings involved a selection of key people with an interest in comorbidity and a considerable degree of experience including General Practitioners, GP methadone prescribers, mental health professionals, drug & alcohol professionals and consumers and carers (see Appendix B for a full list of participants). The project manager (Dr Chris Holmwood) and project officer (Damian McCabe) were present at both meetings to guide open discussion around 6 key questions.

1. How do GPs recognise and diagnose comorbidity?
2. What is involved in the assessment process and in determining management?
3. How do GPs develop priorities for management?
4. What treatments do/should GPs use?
5. What issues are there with referral?
6. What future developments would be useful?

Prior to the focus groups, participants were sent a brief precis of the topic of 'Comorbidity in General Practice' and a copy of the questions that would form the basis for the discussions. Proceedings were audio-taped. Notes were taken during the meeting by both the facilitator and the project officer. Records of the meeting were independently written by both project personnel using the audio-recordings as an aid memoir. Their findings were then combined into the following summary. Audio-recordings were then erased as agreed with the participants in the focus group.

While this summary has been structured by the authors, its content and tone are intended to reflect those of the focus group participants.
Key Findings

Recognition and diagnosis

“There is a need for GPs to recognise and label comorbidity because it forces them to do something about it”

The term ‘comorbidity’ can be seen as a construct that enables practitioners to understand the interactions between mental health and substance use issues and to determine treatment approaches that will address the entire problem.

Patients with mental health problems and substance use problems are sometimes considered to be ‘difficult to deal with’. A GP may be aware that there is an issue underlying the patient’s condition but may be unwilling or unable to explicitly acknowledge the problem. Reasons for not acknowledging comorbidity include concerns with the time required to address the problems once they have been identified, the effort required to do this, lack of the required skills, inability to access the resources needed and an unwillingness to confront the patient with the reality of their predicament.

GPs may be currently reluctant to recognise that comorbidity exists in some circumstances. Assessment may therefore be incomplete. Raising GP awareness of comorbidity as an issue is the first step. Given the right training and a supportive economic environment, recognising and diagnosing comorbid substance use and mental health problems and using established strategies to provide effective care will follow.

The development of a strong therapeutic alliance can be difficult but nevertheless is extremely important. Many patients with comorbidity may have never had a stable doctor-patient relationship so this may be one of the most essential things to establish initially.

“An effective doctor can be as good as an effective drug.”

To establish a therapeutic relationship a GP should try to develop rapport and trust from first contact with the patient by:

Using basic patient centred interviewing methods including active listening
Expressing empathy, warmth and acceptance
Remembering that patients are rational beings and do things for reasons that are logical to them
Ensuring confidentiality.
Listening to a person describe their own problem as they see it
Not making any pre-suppositions
Seeking clarification of specifics - be inquisitive

Remembering every single person is different

Avoiding being confrontation

The development of an effective therapeutic relationship will facilitate disclosure but sensitive questioning can be helpful. It was suggested that GPs should ask about substance use in a way that normalises the behaviour. In addition because substance use is so prevalent GPs ought to use a routine set of questions regarding this for all patients; in particular those with an emerging mental health related problem.

In addition to direct questioning, there are various triggers that may aid the detection of comorbidity, these include:

Patient not responding to other treatment

Details of trauma

Signs of intoxication

Direct questioning regarding problems the patient is experiencing

Repeated requests for pain relief

Non specific physical presentation…fatigue, headache, etc.

Family history of either problem

Given that comorbidity is so common it should perhaps be one of the first things that GPs consider if they are working with a patient with a mental disorder. The GP needs to be persistent and follow up on these cues either during the current consult or a later one.

There is a definite need to assume comorbid links - if a person is experiencing problems with mental health, then ask about substance use. And vice versa, if a person is using substances then ask about problems with their mental health.

With regards to diagnostic labelling several points were made:

In general practice diagnoses are not unitary but occur along a continuum of symptomatology, behaviours and disability. It is very important not to talk just in terms of strict diagnostic categories as comorbidity refers to two or more processes that are causing distress, without each necessarily being clear diagnostic entities.

"It is important to label the condition not the person"

It is preferable that patients perhaps not be regarded as having specific diagnoses but rather a series of problems or issues that are related to their comorbid substance use and mental health problems.

Diagnostic terms were seen as convenient but potentially dangerous because they may reinforce prejudices, especially if the label is personal and not attached to the problem the person is experiencing. Once a person gains a diagnostic label it is often very
difficult even for professionals to look past this. For example once a patient is labelled as a 'drug abuser' the health care professional using this label may not see a comorbid mental health problem that is interacting with their substance use.

On the other hand recognition and diagnosis in some ways forces both the clinician and the patient to face the reality of what is actually going on and may be the catalyst for effective action.

**Assessment**

As implied from the earlier list of suggested approaches that might facilitate the development of a therapeutic relationship, GPs need to have an interest in their patients and their particular experiences.

“GPs need to have an inquisitive approach to their patients…”

For example, a doctor realises from their patient notes that a person has been taking a lot of Serapax and suspects benzodiazepine dependence. What he finds through some specific questioning is quite different:

Doctor: "Rita tell me about why you are using these tablets?"

Patient: "To help me sleep"

Doctor: "What sort of problems are you having with your sleep?"

Patient: "The voices keep me awake, doctor"

The patient is behaving in a rational way in response to the problems she is experiencing.

One advantage of general practice is that doctors are usually able to see patients across a number of appointments. The general practice approach to assessment should be cumulative and longitudinal so that the doctor can gain an idea of the 'bigger picture'.

Patients often do not visit their GP specifically for a substance use or mental health problem but come in for other health problems. GPs can use this attendance to develop rapport and trust and to establish a doctor-patient relationship that may allow them to work on the comorbidity.

Part of the assessment process should be to gather information from the client regarding the interaction of the two conditions - how does their substance use influence their mental health problem and vice versa.…”what do you think is your problem? When you are feeling down…what do you do with your drinking then? How do you feel when you’ve done that? Do you feel better or worse?
It is important to understand the patient's understanding and level of insight regarding the underlying issues and their feeling regarding their need to do something about these problems. Determining a patient's motivation or 'readiness to change' is an important part of the comorbidity assessment process.

There is a discomfort with alcohol and other drug use among GPs that reflects similar views within our society. There may be general agreement between GPs and their patients that this territory won't be examined. When we consider the other intimate issues that GPs and their patients often openly discuss ……sexuality, prostate, bowels etc, this avoidance is curious.

When assessing substance use GPs should:

- **Ask questions** routinely about drug and alcohol use
- Try to establish a comprehensive list of **what the person takes** - how much, how often
- **Not assume the use of a substance is deleterious** but remember that even use of small amounts of substances may be dangerous
- Explore the **reasons** why a patient uses substances (their belief behind the use)
- Explore the **effect** that **each substance** (prescribed and non-prescribed) has on the patient and their life including side effects, benefits and costs

**Determining priorities for management**

In determining a treatment approach it is necessary to develop some agreement with the patient over priorities for management as the patient may have different ideas to the doctor or their ideas may change over time.

When determining treatment, GPs should:

- **Negotiate** the **problem definition**
- Determine the patient's **long term viewpoint** or outlook
- Ask about the patient's **priorities**, this will necessarily uncover the patient's readiness for change.
- Assess the presence of specific **dangers** (eg. suicide risk)
- Determine the level of surrounding **support** available (eg. family)
- **Match** approach to patient's motivational status
- Look to **minimise harm**
• Utilise a stable relationship with the patient - establish regular appointments

• Develop a good contextual knowledge of available resources, information sources and services

• Offer options to the patient and have them decide what they want to do

• Accept that a client may not be motivated to do anything at all about their substance use.

• Always consider that this level of motivation may change in the future and that often the GP must be content with waiting for these opportunities to arise. This requires a certain level of comfort with doing nothing (except waiting):

"GPs need to have confidence with uncertainty, these problems are not concrete"

**Specific treatment approaches to comorbidity**

"GPs need to pace their approach to the patient's level of understanding of the problem and negotiate with them as to what can be done"

As outlined above level of understanding and readiness for change are closely interwoven. Inevitably the direction and speed of therapy will be determined by the person’s priorities.

However there needs to be a balance between an extreme laissez faire approach and the need for benevolent but paternalistic intervention. Assertive follow-up is important for patients with comorbidity that have chaotic lives - targeted recall should be conducted for certain patients if they miss appointments. This may involve collaboration with other services and agencies if available and appropriate.

Once again the GP needs to have a long term approach to people with comorbidity related problems. Look to name all the problems, establish a list, and then deal with one of them at a time as opportunities arise. GPs cannot expect things to change immediately. But in the meantime:

“DO NO HARM … If they come in with one problem they shouldn’t go away with another one”

In some cases the use of psychotropic medication (especially benzodiazepines) while assisting in the short term management of symptoms, actually exacerbates the patient’s problems. It is important that doctors (GPs and others) do not contribute to the problem.

GPs may take an educational approach and offer advice to their patients, but there is a difference between offering meaningful advice and preaching. Doctors should avoid
preaching to a patient as it is confrontational, the more confrontational a doctor is, the poorer the patients outcome.

Care should be taken even offering advice on an issue, if the patient does not identify an issue as a problem then there is little point preaching to them. The patient needs to recognise that something is a problem and want to do something about it before anything can really be done.

For example - when exploring substance use, the doctor may find that the patient considers their drug use to be beneficial. If the patient believes that their drug use is beneficial then perhaps some education may help….for instance some information on the interactions between cannabis and psychotic disorders. But if they then still feel the same way then there may be little more that the doctor can do at that time.

If ambivalence is detected regarding the need for change then motivational approaches such as motivational interviewing may be used to help move the person towards considering beginning treatment.

“it is not a once and for all phenomenon but rather a process….Sometimes you just have to implant the thought into their mind…you don’t always have to sit there and drive it into them…”

Motivational interviewing is a very powerful tool that should not only be used for drug and alcohol issues; it should become a generic skill that may be used in approaches to all types of problems.

There is a need to develop guidelines for useful, brief and effective treatments that may be utilised in general practice approaches to comorbidity.

Specific treatments already exist for mental disorders (pharmacotherapy, psychoeducation, structured problem solving, cognitive behavioural therapy etc.) and for substance use problems (motivational interviewing, anti-craving drugs, home detox, behavioural approaches etc.).

For patients with comorbidity (and all patients) adherence with psychiatric medication is an issue. GPs need to ask if people are actually taking their medication, and if not, what the reasons for this might be. Adherence may be enhanced through establishing a therapeutic relationship (trust), matching of medication to symptoms, and proper explanation of side effects and reasons for the use of the drug.

Side effects influence medication adherence, outlook on life, and vary from patient to patient so GPs need to pay attention to the side effects and other problems that the patient is experiencing with their medication and make the effort to adjust dosage etc.
Anti-craving medications (acamprosate, naltrexone etc.) are powerful therapeutic agents that are not widely used by GPs but may be useful for patients with strong addictions.

It may be reasonable for GPs to perform home detox as clear protocols for successful approaches exist to support them. The GP should utilise the assistance of alcohol and other drug services when conducting home detox, establishing good communication is essential.

Modifying or stopping substance use should not be the only treatment goal. It is an initial positive step but a person experiencing comorbidity will still have a number of issues to deal with including their coexisting mental health problem. The GP will need to look at what other changes the patient would like to make and use the motivation surrounding the detox to engage them in other therapy.

Brief, non-pharmaceutical approaches to comorbidity outlined above:

- Have a role in general practice - although considerable debate exists
- May not be as effective as other approaches for some people
- Are best to achieve substance use reduction in people who are not addicted
- May be useful to change one thing
- May be used to tackle some of the issues underlying comorbidity
- May fortify and extend other treatment approaches
- May improve medication adherence
- Should be used as part of a multi-faceted approach to comorbidity treatment

It is quite possible to perform brief Cognitive Behavioural Therapy in general practice but the skills need to be learnt and its effectiveness depends on the ability of the individual GP. Similarly, structured problem solving may be used to teach patients skills that will assist them in coping with everyday predicaments.

Regarding evaluation of progress, asking a person if they are enjoying life more - and what are they enjoying, will allow the patient to develop their own judgements regarding whether the interventions are working.

With all treatment approaches relapse is always possible (or probable) and the doctor should accept this as part of the normal cycle for people with substance use related problems. Clinicians need to remember that they are dealing with not one but two chronic conditions, it is most important to maintain the therapeutic alliance - 'to keep the door open'.
Referral

Referral can be a delicate matter in cases of comorbidity and GPs need to be straightforward in their approach.

Regarding referral, GPs may:

- Refer to a GP colleague for required back up eg. methadone
- Refer to secondary service for required specialist support eg. detox
- Consider NGOs as well as government agencies
- Promote the use of self-help and peer support groups - particularly in rural areas
- Be honest in their approach to and reasons for referral
- Reinforce positive reasons for referral
- Try to reduce as much as possible the number of different doctors involved in managing a patient (eg in group practices); particularly in the case of more severely ill patients
- Remember that patients with borderline personality disorders may be sensitive to rejection
- Develop a care plan when appropriate
- Establish means for information sharing with the agency they refer to

In situations of shared care the assignment of a 'primary carer' needs be negotiated and then made explicit - the GP may assume this role in the majority of situations.

Burnout and counter-transference

Sustained involvement with a patient with complex and severe problems with comorbidity may lead to a breakdown in the doctor-patient relationship that creates problems with management.

GPs need to be honest regarding the treatment relationship particularly if the relationship is becoming harmful to the therapeutic process and there are difficulties with interactions. One idea maybe to ask the patient how they think they are getting along.

For example, if the doctor has reached a therapeutic dead-end and is feeling negative about the patient then they need to explain the reasons for referral:
“How do you think things are going? We don’t seem to be getting anywhere…we seem to be at a dead end at the moment…what do you think we ought to do from here?”

The focus groups were emphatic that referral in these circumstances should be transparent and based on an agreement between patient and GP.

**Future developments**

A GP with generalist skills may not currently have the specific training, or interest to detect and manage coexisting mental health and substance use problems. Many GPs that are able to provide the level of care needed are already fully-booked with their share of patients and do not have the time to provide further care to other people. There is a definite need to raise awareness of comorbidity issues across the board so that every GP may contribute to the care of patients with comorbidity in some way. Points made by the group participants are listed below.

**Regarding education, training and research:**

- Any guideline development should be aimed at the generalist GP
- **Specific skills based training** should be provided for interested GPs
- Basic skills such as **patient centred interviewing, structured problems solving and motivational interviewing** should be taught within the medical school curriculum
- There is a need to involve the **Divisions** in establishing systems of peer support, feedback and training for GPs on comorbidity issues
- There is a need to continue to increase the level of training in **drug & alcohol issues** provided to medical students, interns and established GPs
- There is a need to **conduct research and establish evidence bases** for general practice approaches to comorbidity. Evidence based research should focus on what individual GPs do and how this alters outcomes. For example while these groups asserted that confrontation never works it is unclear whether this has actually ever been subjected to empirical trials.
- There is a need to establish systems for **sharing information** regarding comorbidity issues between GPs, Divisions, mental health professionals and alcohol and other drug professionals.
Regarding ‘the system’:

- Problems currently exist regarding **financial reimbursement** for GPs using longer consultations when providing care for patients with comorbidity.

- The use of the EPC items needs to be encouraged. The case conferencing and care planning items are useful but can be difficult for GPs to use; individual practices need to establish processes to use these new items with assistance from their Division.

- Further changes to the reimbursement procedures for GPs using longer consultations are required to remove the penalties for those GPs delivering high quality care.

"GPs will never do particularly well in anything that requires time…the inclination to practice ‘better medicine’ with its subsequent economic punishment is less appealing"
CHAPTER 9 Validation of Guiding Principles: Consultation Phase 4

Introduction

Initial principle development

Extensive consultation with a range of ‘experts’ (consultation phases 1 & 2) and a review of relevant literature led to the identification a number of key issues in the general practice management of comorbidity. Two multi-disciplinary focus groups (consultation phase 3) were conducted to discuss these issues and to develop an idea of how GPs might best approach comorbidity. This process provided the basis for development of an initial set of principles to guide GPs in the management of people with coexisting substance use and mental health problems. A total of twenty-five initial principles were defined under the following six headings - 'Underlying Assumptions', 'Initial Detection', 'Assessment & Diagnosis', 'Management', 'Pharmacological Approaches', and 'Referral'. The aim of this final consultation process was to validate a set of basic principles that will guide the provision of care to general practice patients experiencing coexisting substance use and mental health problems.

Methods

Principle validation process

The final step in the development of these guiding principles was to seek some consensus regarding their use. This involved further consultation with the GPs that had been involved in the initial consultation processes. A brief survey was created listing each of the initial principles with a five-point Likert scale to allow the respondent to indicate the extent to which they agree or disagree with each of the principles. In addition, space at the end of each section was provided for the respondent to make comments regarding the principles under that heading. These surveys were then posted to the 30 general practitioners that had been involved in the original GP survey and the focus groups. A cover letter thanked the respondent for their assistance and invited them to participate in this principle validation process. Reply paid envelopes were provided for the return of completed surveys.

A total of 22 surveys were returned with a response rate of 75%. Scores were used to measure the degree to which respondents agreed or disagreed with each of the initial principles. These scores and the comments that were provided were used to develop the initial principles into a final set of 'Principles for the assessment, diagnosis and
management of patients with coexisting mental health and substance use problems in
general practice'.

Anchors on the Likert Scales were as follows:

1 - Strongly Disagree
2 - Disagree
3 - Neutral/unsure
4 - Agree
5 - Strongly Agree

Means and standard deviations were calculated. Means reflects the degree of
agreement with the principles. Standard deviation reflects the level of agreement across
the respondent group.

Results

Assumptions underlying these principles

Patients are rational beings and do what they do for reasons that
‘have meaning’ to them.

\[ m = 4.1 \quad SD = 1 \]

Comments:

- Patients with active psychosis may be a small exceptional group.
- There is lots of 'logic' in drugs used with regard to patients' psychiatric
disturbances. Patients have usually identified an agent which at least partially
'treats' their psychiatric disorder.
- The difficulty is identifying what that meaning is.
- 'Rational beings' and 'have meaning' are not the same thing at all….the reasons
may be delusional or irrational. Psychiatric patients are usually not rational during
their psychosis - that is one of the features of psychosis.
- 'Rational' and 'have meaning' imply cognitive motives. Motives may be
emotional or subconscious.
Mental health and substance use problems can be either acute or chronic conditions but generally require the use of long-term management approaches by GPs.

\[ m = 4.2 \quad SD = 1.1 \]

Comments:
- Brief interventions can be effective.

It is important to recognise that substance use and mental health problems frequently coexist and that complex interactions between the two can have serious consequences for the health and well being of the individual patient.

\[ m = 4.9 \quad SD = 0.4 \]

Comments:
- The difficulty is identifying how mental illness or psychological traits interact with recreational drugs and then trying to determine how to give the patient ways and psychological means to take a different path.
- Both must be treated together.

The diagnosis and management of comorbidity in general practice leads to significant improvements in patients' health and wellbeing.

\[ m = 4.4 \quad SD = 0.8 \]

Comments:
- The ideal would be for GPs to adequately manage the comorbidity issues but the reality is that there is little time in which to do this. Management in general practice is effective, and can often be broken into a series of small interventions, recognising a process of change.

Additional comments on these assumptions:
- People are more likely to present to their GP when they are distressed and there is a significant risk to the patient in missing an opportunity to help improve the situation.
- There is a lack of appropriate training and work experience in this field.
• These assumptions are ok for an 'ideal GP setting'.

• I have my own assumptions based on my experiences and the patients that I have seen over the years. GPs can certainly influence and assist in improving patients' health and wellbeing in comorbidity, but whether this is significant is debatable.

Initial detection of comorbidity

Development of rapport is the first essential step in working with people with coexisting mental health and substance use problems.

$m = 4.8$ $SD = 0.4$

Comments:

• However there are exceptions, especially when the patient presents a risk to themselves or to others.

Active listening skills and a patient centred method are both essential for the development of rapport with patients.

$m = 4.8$ $SD = 0.4$

Comments: None

When a person has been identified as having a mental health related problem the GP should automatically inquire about alcohol and other drug use.

$m = 4.7$ $SD = 0.5$

Comments:

• Not 'automatically' but routinely.
When a person has been identified as having problematic use of alcohol or other drugs the GP should automatically inquire about difficulties with mental health.

$m = 4.5$ $SD = 0.7$

Comments:
- Not 'automatically' but routinely.
- Obviously, unless the person is currently high or intoxicated.

GPs should routinely ask about alcohol and all other drug use (ie. prescribed and non-prescribed) with all new patients

$m = 4.6$ $SD = 0.5$

Comments:
- Time permitting

The GP should consider the presence of both a mental health problem and a substance use problem when:

there is lack of improvement with either condition despite treatment

$m = 4.5$ $SD = 0.5$

Comments: None

there are problems with keeping appointments

$m = 4.1$ $SD = 0.6$

Comments:
- Heavy drug use alone will do this.

there are frequent requests for analgesics and/or benzo’s

$m = 4.6$ $SD = 0.6$

Comments: None
there is frequent attendance
m = 4.0 SD = 0.8
Comments:
• This is more likely to reflect mental health disorder than combined disorder.

presentation involves mainly non-specific somatic symptoms eg. fatigue
m = 4.1 SD = 0.8
Comments:
• Or history.
• This is more likely to reflect mental health disorder than combined disorder.

presentation or details of trauma involves signs of intoxication
m = 4.5 SD = 0.7
Comments:
• This is more likely to indicate drug use disorder than mental health disorder.

there is a family history of either or both of these problems
m = 4.3 SD = 0.6
Comments: none

Additional comments on principles of detection:
• Despite attending to all the risk factors listed, detection of drug abuse can be a big problem when the use is denied. If agreed to, blood tests (eg. LFT, FBC & urine screen) can be very helpful.
• Most of the points mentioned above are very important to identify. However, patients are often unwilling to disclose the extent of their drug and/or alcohol use.
Patients are may be resistant to the idea of, for example, depression with chronic pain, that is the relationships involved in comorbidity.

- Comorbidity should always be suspected if either psychiatric or substance abuse issues are found to be present.

**Assessment and diagnosis of comorbidity**

Assessment and diagnosis of patients with comorbidity is best undertaken over the course of more than one consultation

\[
m = 4.4 \quad SD = 0.7
\]

Comments:

- Usually.

- As with most psychiatric diagnoses, diagnosis of comorbidity needs to be considered as 'diagnosis under evolution' and will often change over a course of time.

Assessment should incorporate inquiry into difficulties the patient is experiencing in general life functioning (eg. health, work, school, home etc.)

\[
m = 4.5 \quad SD = 0.5
\]

Comments:

- Time permitting.

- This process will make it problem centred, not diagnosis centred.

The assessment and diagnosis process should be flexible and avoid the use of strict diagnostic categories

\[
m = 4.3 \quad SD = 0.7
\]

Comments:

- Should be patient centred.
• GPs should become familiar with the various substance use disorder diagnoses as well as the diagnostic criteria for mental health disorders - it helps to familiarise with the terms used.

In addition to establishing usage patterns, GPs assessing substance use should determine:

if this use is causing any problems in everyday life functioning

\[ m = 4.6 \quad SD = 0.5 \]

Comments: None

the reasons why this person uses substances

\[ m = 4.5 \quad SD = 0.7 \]

Comments:

• However, may not always know the reasons why. Plus need good rapport with the patient and need to be sensitive in handling this.

how this substance use affects this persons mental health problem

\[ m = 4.5 \quad SD = 0.5 \]

Comments: None

Additional comments on principles for assessment:

• More time is needed - this takes a lot of time.

• Some patients are able to function extremely well in spite of excessive drug/alcohol use or with mental illness. However, the concomitant use of both may compound their ability to cope.

• Need to assess the impact on others eg. partner or children.
Management of comorbidity

GPs should assess the patient’s readiness for change prior to initiating management

\[ m = 4.2 \quad \text{SD} = 1.2 \]

Comments:
- Personalising the information to relate to presented problems can help here.
- May be useful to put in some examples eg. "well, alcohol can cause depression in some people, as well as poor sleep and nausea, all of which trouble you".

The patient’s readiness for change regarding the substance use may be different from that regarding the mental health problem

\[ m = 4.3 \quad \text{SD} = 0.8 \]

Comments:
- May be this could be put in a more patient centred way - "Perceptions about the degree of problem attributable to either substance use or the mental health issue may differ between the GP and the patient. Similarly, readiness to change in each area may be different, some seeing a need to address both issues, others discounting the role of either mental health issues of substance use.

GPs and patients should negotiate problem definition and management options prior to determining management approach

\[ m = 4.5 \quad \text{SD} = 0.6 \]

Comments:
- I think you should agree on priorities with the patient.
- In some cases the patient may not perceive any problem - you may need to do some of the ‘problem definition’ and negotiation with family or concerned others.
- Unilateral decisions regarding direction/timing/content of treatment are usually non-productive.
Approaches to comorbid mental health and substance use management should:

reflect the patient’s reasons for use and the relationship between their substance use and mental health problem

$m = 4.3\ SD = 0.8$

Comments:
- Not always necessary but you should take this into account always eg. use of Camprol might not require focus on the reason why the person uses.

not necessarily involve abstinence as a goal

$m = 4.2\ SD = 0.6$

Comments:
- This depends on many factors.

possibly involve the use of anti-craving medications

$m = 4.1\ SD = 0.6$

Comments:
- Including opiate substitutes and other appropriate medications.

be directed towards harm minimization

$m = 4.4\ SD = 0.8$

Comments:
- This should be first on this list. All approaches to comorbidity should focus upon minimising harm to the individual, their family and community resulting from both the mental health and substance use issue.
- Drug use yes, mental health no.
- If the person is not wanting to change.
be based on the person's readiness for change and not necessarily on a pre-determined sequence

\[ m = 4.6 \quad SD = 0.6 \]

Comments:

- Needs to be flexible.
- Unless they need certifying.

involve the patient's family/relatives/carer where possible and appropriate

\[ m = 4.2 \quad SD = 0.7 \]

Comments:

- It is often useful to involve the patients family and/or an external support service in the treatment.

acknowledge that relapse may occur from time to time and that this does not necessarily reflect failure of therapy or lack of trying on the patient’s part

\[ m = 4.8 \quad SD = 0.4 \]

Comments:

- Relapse is very common and frequent - requires ongoing help from GPs etc.

Specific approaches to comorbidity that may be used by GPs should include:

the provision of information appropriate to the person’s stage of change

\[ m = 4.4 \quad SD = 0.5 \]

Comments:

- About substance use and mental health issues.
- Should be aimed at the level the person can understand.
structured problem solving  
m = 4.3 SD = 0.6  
Comments: None

motivational interviewing  
m = 4.5 SD = 0.6  
Comments: None

brief cognitive approaches  
m = 4.5 SD = 0.6  
Comments: None

brief behavioural approaches  
m = 4.1 SD = 0.8  
Comments: None

supportive therapy  
m = 4.6 SD = 0.58  
Comments: None

appropriate pharmacotherapy for individual mental disorders  
m = 4.6 SD = 0.5  
Comments:  
- For both the mental health and the substance use problem eg. Campral or Naltrexone for the alcohol problem, and then antidepressants in the subsequent anxiety/depression.
utilisation of external supports and resources when unsure of best approach

\[ m = 4.5 \quad SD = 0.6 \]

Comments:

- There are still problems in accessing external supports and resources.
- May include specialist mental health or alcohol and other drug staff to clarify management plans, counsellors for longer term issues, social workers etc.

Additional comments on principles for management:

- There is poor remuneration for GPs offering counselling.
- There is a lack of opportunity to develop counselling skills ie. expensive in time and cost and nor available in rural/semi-rural areas.
- People often attribute cause to something they have done, as in other health areas. This may not be the case, eg. psychosocial decline and isolation begin before cannabis use, and the subsequent voices are more consistent with schizophrenia than drug use. It is important to listen to the person with a critical trained mind, and gentle manner.
- Management of drug use is different to management of mental illness.
- Harm minimisation is a treatment strategy.
- The treatment program needs to be structured with regards to the individual patient and should definitely be flexible.

**Pharmacological approaches to comorbidity**

When considering pharmacological intervention for a mental health problem in a patient with a coexisting substance use problem the GP should:

- avoid prescribing benzodiazepines for more than a few days

\[ m = 4.0 \quad SD = 1.1 \]
Comments:

- Usually, however some drugs of dependence (eg. methadone) are appropriate.
- It is probably desirable not to prescribe for more than a few days but this can be extraordinarily difficult to achieve. Well used benzodiazepines are very effective medication.
- If possible, I believe that it is best to avoid Benzo's whenever possible, but they may be useful for short-term use.

**avoid prescribing other drugs of dependence**

\[ m = 4.0 \ SD = 4.1 \]

Comments:

- Normal rules regarding the use of addictive medications are not generally relevant to many of these patients. As level of functioning decreases reduces, usefulness of these rules also reduces.

**consider the adequacy of prescribed medications for the current disorder**

\[ m = 4.5 \ SD = 0.5 \]

Comments: None

**consider possible interactions between prescribed and non-prescribed drugs**

\[ m = 4.6 \ SD = 0.5 \]

Comments: None

**openly discuss side-effects of all drugs used**

\[ m = 4.5 \ SD = 0.5 \]

Comments: None

*If doctor shopping is suspected then the GP should:*
seek authorization from the relevant local drugs of dependency authority before prescribing

\[ m = 4.5 \quad SD = 0.9 \]

Comments:
- This is a legal requirement.

consider contracting the patient to obtain all prescription data from the HIC (ie “doctor shopping kit”)

\[ m = 4.5 \quad SD = 0.7 \]

Comments:
- In ACT organising a voluntary agreement is fairly easy. I wouldn't get into prescribing benzo's or dependency drugs unless the patient was prepared to go with this - there is no need to contact the authorities as well.
- Should avoid prescribing until adequate information is gathered, or supply only sufficient medication for overnight only - until a review is possible.
- Drugs of dependence and Benzos obviously require care when prescribing. Contracting the patient and seeking authority approval can be very useful tools. Most 'genuine' patients do not object to this approach.

If regular benzodiazepine use is established then the provision of a long acting type (eg. diazepam) is preferable to the use of short acting (eg. oxazepam)

\[ m = 4.6 \quad SD = 0.6 \]

Comments:
- Daily or controlled supply may be implemented until the pattern of use and safety with a larger amount of medication is established.

Additional comments on principles for pharmacological approaches:
- All approaches should be guided by the principle 'first do no harm'.
Need to ensure that the medication is, by the best available evidence, more likely to help than worsen or confuse the issue.

Need to consider the likely benefit balanced against all risks.

*Referral for patients with comorbidity*

**GPs should consider referral to a specialist service when:**

- **the patient is at significant risk of self harm/harming others**
  \[ m = 4.6 \quad SD = 1.0 \]
  Comments:
  But what specialist service can respond?
  May have to wait 2-6 months for a specialist referral.
  Without certification, suicidal patients cannot get help.

- **acute exacerbation of a psychiatric condition has occurred (eg. Schizophrenia, bipolar disorder etc.)**
  \[ m = 4.5 \quad SD = 0.6 \]
  Comments: None

- **serious drug dependence is detected**
  \[ m = 4.1 \quad SD = 1.1 \]
  Comments:
  Many GPs have been trained to treat serious drug dependence.

- **detox is required**
  \[ m = 4.0 \quad SD = 1.2 \]
  Comments:
For in-patient or complex detox.

While referral is necessary in cases where there is little response to treatment, or when the patient is at danger of self-harm, referral for detox is dependent upon the patients willingness to participate fully.

GPs should be able to manage outpatient detox in many cases.

**there is a lack of treatment response**

- \( m = 4.2 \ SD = 0.7 \)

Comments:

Or response is slow and a second opinion on management is required.

Lack of treatment response may reflect patients' motivation - referral is unlikely to help this.

**the patient would benefit from multi-disciplinary management**

- \( m = 4.4 \ SD = 0.7 \)

Comments:

Multi-disciplinary management can be very useful.

Multi-disciplinary management may be achieved through the use of EPC items.

Mostly, all patients would benefit from multi-disciplinary management, especially ones with more complex presentations.

**There should be good communication and sharing of information between GPs and other health professionals involved in the shared care of people with comorbid problems**

- \( m = 4.8 \ SD = 0.4 \)

Comments: None

**Referral either to specialised services or GP colleagues should involve openness with the patient regarding reasons for referral**

- \( m = 4.5 \ SD = 0.5 \)

Comments:

Should also include expectation or outcome.
But occasionally this may not be possible eg if the patient is demonstrating threatening behaviour.

**Additional comments on principles of referral:**

Appropriate referral to specialist care when working in an area of under-servicing is often very difficult with long waiting lists.

It would be a novelty to have someone to refer to for a psychiatric assessment. Psychiatric services generally do not recognise 'comorbidity' and almost never come up with a dual diagnosis.

**Discussion & Summary**

It is quite clear from the above responses that the general principles proposed have a high degree of acceptance amongst the GPs surveyed.

The comments have raised ambiguities and "exceptions" to the principles. Interestingly the principles with the least acceptance and the highest degree of variance of opinion (ie greatest standard deviation) were those related to the prescription of potential drugs of dependence:

- Avoid prescribing benzodiazepines for more than a few days.
- Avoid prescribing other drugs of dependence.

However, the mean Likert scores for these were still 4 reflecting general agreement, but the use of potentially addictive drugs, even in a controlled manner, is obviously contentious.

The final set of principles is largely unchanged from the above that were presented through the survey but some minor changes have been made to incorporate some of the issues raised. In ideal circumstances these changed principles would have been presented to the respondent group for rating and comment again but the project has decided not to do this because of time factors, not to mention respondent fatigue.

The comments seem to fall into two broad groups.

Firstly are comments regarding the perception that there is a real tension within general practice between ideal management and the structures that GPs work within, their variable level of expertise, and the support services that are available:
“The ideal would be for GPs to adequately manage the comorbidity issues but the reality is that there is little time in which to do this.”

“There is a lack of appropriate training and work experience in this field.”

“There is poor remuneration for GPs offering counselling.”

“There is a lack of opportunity to develop counselling skills….expensive in time and costs and not available in rural/semi-rural areas.”

“It would be a novelty to have someone to refer to for a psychiatric assessment. Psychiatric services generally do not recognise comorbidity and almost never come up with a dual diagnosis”

The second group of comments seems to reflect the difficulties with working with people with severe comorbidity: the need to use harm minimisation rather than perhaps the ideal “curative” model, issues around trust and disclosure by patients and clinicians, especially where there is threatening behaviour, and the intuitive and opportunistic approach to their management based on changes in their readiness for change, their circumstances, and the level of trust between clinician and patient

“[Regarding openness during referral] but occasionally this may not be possible, for example, if the patient is demonstrating threatening behaviour.”

“[Regarding referral,] lack of treatment response may reflect the patients’ motivation – referral is unlikely to help in this situation.”

“[Regarding avoiding prescribing benzodiazepines for more than a few days] it is probably desirable not to prescribe for more than a few days but this can be extraordinarily difficult to achieve. Well used benzodiazepines are very effective medications.”

“[Regarding avoiding prescribing other drugs of dependence] normal rules regarding the use of addictive medications are not generally relevant to many of these patients. As level of functioning decreases, usefulness of these rules also decreases”

Where possible the nuances of these comments have been incorporated into the final set of principles without changing the substantive meaning. There are limits however to how principles can govern the individual circumstances faced by clinicians, their patients and families. In the end they need to be interpreted in light of individual circumstances.
CHAPTER 9 Final Principles

*Principles for the assessment, diagnosis and management of patients with coexisting mental health and substance use problems in the general practice setting.*

These principles have been developed from an extensive series of consultations with various stakeholders. They are based on consensus rather than empirical evidence, largely because at this time there is little evidence regarding the management of comorbidity in the general practice setting. They are also based on what is possible within the current health system; shared care arrangements for people with comorbidity problems are at present under-developed. When sophisticated arrangements of this type are developed in the future and become normal practice then they could well be incorporated into these principles. These principles should serve two purposes. Firstly they can form the basis of future education and training initiatives. Secondly they should form the basis for future research into the clinical management for people with comorbidity.

Finally these principles of management are just that…principles. They are guides and not dictates. Individual circumstances need to be taken into account and management refined to suit the best interests of the patient.

**Underlying assumptions**

Substance use and mental health problems frequently coexist. Complex interactions between the two can have serious consequences for the health and well being of the individual patient.

Appropriate diagnosis and management of comorbidity in general practice may lead to significant improvements in patients' health and wellbeing.

Mental health and substance use problems generally require the use of long-term management approaches by GPs. This long-term care may consist of a series of relatively brief interventions.

A patient’s behaviour is usually consistent with his or her underlying beliefs, perceptions and experiences.
Initial detection of comorbidity

Development of rapport is generally the first essential step in working with people with coexisting mental health and substance use problems.

Active listening skills and a patient centred method are both essential for the development of rapport with patients.

When a person has been identified as having a mental health related problem the GP should inquire about alcohol and other drug use.

When a person has been identified as having problematic use of alcohol or other drugs the GP should inquire about difficulties with mental health.

GPs should routinely ask about alcohol and all other drug use (ie. prescribed and non-prescribed) with all new patients over the first few consultations.

The GP should consider the presence of both a mental health problem and a substance use problem when:

- there is lack of improvement with either condition despite treatment
- there is frequent attendance
- there are problems with keeping appointments
- there are frequent requests for analgesics and/or benzodiazepines
- presentation involves mainly non-specific somatic symptoms eg. fatigue
- presentation or details of trauma involves signs of intoxication
- there is a family history of either or both of these problems
- the patient has a mental disorder OR a substance use disorder

Assessment & Diagnosis of comorbidity

Assessment and diagnosis of patients with comorbidity is best undertaken over the course of more than one consultation.

Assessment should incorporate inquiry into difficulties the patient is experiencing in general life functioning (eg. health, work, school, home etc.)

The assessment and diagnosis process should be flexible and should avoid the strict use of diagnostic categories.

In addition to establishing usage patterns, GPs assessing substance use should determine:

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• if this use is causing any problems in everyday life functioning
• the reasons why this person uses substances
• how this substance use affects this persons mental health problem

**General management of comorbidity**

GPs should assess the patient's readiness for change prior to initiating management.

The patient’s readiness for change regarding their substance use may be different from that regarding their mental health problem.

GPs and patients should discuss and negotiate problem definition and management options prior to determining management approach.

Approaches to the management of comorbidity should:

• be directed towards harm minimization
• reflect the patient's reasons for use and the relationship between their substance use and mental health problem
• not necessarily involve abstinence as a goal
• possibly involve the use of anti-craving medications
• be based on the person's readiness for change and not necessarily on a pre-determined sequence
• involve the patient's family/relatives/carer where possible and appropriate

GPs should acknowledge that relapse may occur from time to time and that this does not necessarily reflect failure of therapy or lack of trying on the patient’s part

**Specific approaches to the management of comorbidity**

Specific approaches that may be used by GPs should include:

• the provision of information appropriate to the person’s stage of change
• structured problem solving
• motivational interviewing
• brief cognitive approaches
• brief behavioural approaches
• supportive therapy
• appropriate pharmacotherapy for individual mental disorders and problematic substance use
• utilisation of external supports and resources when unsure of best approach

Pharmacological approaches to comorbidity
When considering pharmacological intervention in a patient with a coexisting substance use problem the GP should:

• Generally avoid starting benzodiazepines for more than a few days
• Avoid prescribing other drugs of dependence unless as part of a management plan aimed at harm reduction. eg in a methadone or buprenorphine program
• Consider the adequacy of prescribed medications for the current mental disorder
• Consider possible interactions between prescribed and non-prescribed drugs
• Openly discuss side-effects of all drugs used

If doctor shopping is suspected then the GP should:

• Avoid prescribing until sufficient information is gathered, or supply medication for overnight only, until a review is possible.
• Seek authorization from the relevant local drugs of dependency authority before prescribing
• Consider contracting the patient to obtain all prescription data from the HIC (ie “doctor shopping kit”)

If regular benzodiazepine use is established then the provision of a long acting type (eg. diazepam) is preferable to the use of short acting (eg. oxazepam). This may require daily dispensing.

Referral for patients with comorbidity
GPs should generally consider referral to a specialist service when:

• the patient is at significant risk of self harm/harming others
• acute exacerbation of a psychiatric condition has occurred (eg. Schizophrenia, bipolar disorder etc.)
• serious drug dependence is detected
• detox is required that may become complicated
• there is a lack of treatment response
• the patient would benefit from multi-disciplinary management'

There should be good communication and sharing of information between GPs and other health professionals involved in the shared care of people with comorbid problems

Referral either to specialised services or GP colleagues should involve openness with the patient regarding the reasons for referral.
APPENDIX A  GP Comorbidity Survey
Comorbidity Survey

There is some evidence on the primary care based management of substance use problems and mental disorders occurring as single entities. However there is very little evidence on the best way to approach these conditions when they exist together. Because of this we are trying to determine what might be termed “pragmatic best practice” in these situations. First off we are approaching a panel of GP's who have an interest in the substance use and mental health areas. By “pragmatic best practice” we mean what you think ought to be the approach to helping people with mental health/substance use comorbidity for the average GP who has a broad case load and who hasn't a particular special interest in the area. There are no right answers to these questions. This work is developmental and will form the basis for the development of some guiding principles for the GP management of people with co-morbidity.

There are five sections to work through, three case scenarios, a section requiring you to recall a patient that you have seen and a section with some general background questions. The scenarios are presented sequentially and each is interspersed with open-ended questions. Please answer the questions before proceeding so that you don’t get cued by the next section. It may be useful to cover the uncompleted sections with a piece of paper to avoid your eyes reading ahead accidentally. There will obviously be some overlap between sets of questions, if this is the case then proceed to the next piece of information in the scenario.

Name: ____________________________

Division: ____________________________

Address for Correspondence: ____________________________

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Section 1

Scenario - PAUL

Paul is a 26 year old man you have seen a few times over the past 5 years with intercurrent illnesses and a few sports related injuries. You see him one morning for removal of sutures from a large scalp laceration that he sustained after a fall outside a pub the week before.

He’s had a tetanus shot and feels fine. The wound is well healed. What kind of information might you try to glean from Paul while extracting his sutures from the mat of crust and hair that overlies the healed laceration?
It turns out that he fell after having an indeterminate number of drinks the previous Saturday night. When you ask, he has a pattern of drinking mostly when he is socialising. Weekends and social functions are the most common situations. He has about 10 or more standard drinks on these occasions (usually a couple of glasses of mixers, then full strength beer). Two years ago he has had a DUI conviction (BA 0.10 %) and had his licence suspended for 12 months. He also sustained a facial laceration after a pub brawl about 12 months ago where he came off second best.

Are there other questions you might try to get answers to here?
Besides having identified a potentially harmful pattern of drinking, might there be some type of underlying problem with Paul that needs to be identified? What things/problems/diagnoses come to mind?

1. 

________________________________________________________

___

________________________________________________________

___

2. 

________________________________________________________

___

________________________________________________________

___

3. 

________________________________________________________

___

________________________________________________________

___

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It turns out that Paul drinks when out to “calm his nerves”. Since his mid-teens he has been using alcohol to relieve the symptoms he has when he socialises. He also uses cannabis for the same reason but alcohol is more convenient and accessible. He admits to a couple of cones most weekends. What would your approach be to Paul?

Step 1.  
_______________________________________________________________  
_______________________________________________________________  

Step 2.  
_______________________________________________________________  
_______________________________________________________________
You briefly talk with Paul about his alcohol use and the emerging picture of social phobia. He’s amenable to seeing you again to talk. You get Paul back for a longer appointment and take a more detailed history of his social phobia. His main focus of anxiety is people thinking he’s a ‘nerd’ because he can’t easily make conversation. Both alcohol and dope help him a lot with this and in fact he has a broad set of friends. He hasn’t developed any other coping strategies and has no real avoidant behaviour. He has a supportive girlfriend. When asked he admits she’s been “on his back” to cut down on the alcohol.

What specific interventions might you use with Paul?

1. ____________________________________________________________

2. ____________________________________________________________

3. ____________________________________________________________
You give him a more detailed AUDIT questionnaire to complete on his alcohol consumption patterns. You give him some information on his social phobia as well as an explanation of how the alcohol consumption and the social phobia might be inter-related. You briefly discuss some of the treatment options for the phobia. Don’t forget you have Paul’s girlfriend as a potential ally. When asked, he certainly has been thinking about his alcohol consumption and the problems it has been causing him. He is amenable to trying to do something about the social phobia although he is a bit sceptical and thinks that it’s just in his nature to be shy and lack self confidence.

Where to from here? What do you think might be reasonable options for Paul at this stage?

1.

__________________________________________________________________________

__________________________________________________________________________

2.

__________________________________________________________________________

__________________________________________________________________________
3.

______________________________________________________________

__________________________

______________________________________________________________

__________________________

▲ Is there any particular sequence to the way that you would do things or recommend that they be done? If so please number the above in the order that you think they ought to be approached?

What factors might determine the priorities or sequence of management steps for Paul.

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

__________________________

What would make you decide to refer Paul?

1.

______________________________________________________________

__________________________

______________________________________________________________

__________________________

2.

______________________________________________________________

__________________________
3. Who would you refer Paul to?

1. 

2. 

3. 

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What are the barriers that you expect to experience with such referrals?

1. __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. __________________________________________________________
   __________________________________________________________
   __________________________________________________________
Scenario – Christina

Christina has moved into your area recently and has come in for the second time in three or four weeks for a script for oxazepam. Christina is a 48-year-old ethnic Croatian refugee who has been in Australia with her husband and three children for the past 13 years now. She has good English skills. This is only the second time she has come to the surgery. The first time you recommended that she book a longer appointment so that you could get a better past history and get your head around the oxazepam use. This time she books for ½ an hour. You are running on time for once.

What issues might you like to explore with Christina?

1. ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

2. ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

3. ___________________________________________________________________
What specific questions would you ask Christina?

1. ____________________________________________________________

2. ____________________________________________________________

3. ____________________________________________________________

4. ____________________________________________________________
It turns out that Christina has been depressed for the past 6 months. She has some anxiety symptoms. When her thoughts dwell on various negative experiences in her past she becomes acutely lacking in confidence and from time to time she gets panicky. This occurs in all types of situations but more commonly when she is going out. Over the past six months she has been becoming less sociable and more withdrawn, she has lost her enthusiasm for life and has lost 4 kg in weight. Her appetite is down. She has pervasive thoughts of lack of self worth and life’s futility. She has had suicidal thoughts but doesn’t dwell on these and because of the effect suicide would have on her children and husband she discounts this as an option. She felt like this back in Croatia when she was in her twenties. She was treated with medication there.

Christina was prescribed some oxazepam to help her sleep a few months ago by her previous GP. She has used the oxazepam more frequently as it has helped with the panicky feelings that have developed but the relief is short-lived. She sometimes feels a bit anxious when she is low on the oxazepam and she feels she relies on it somewhat.

Christina is married. Her husband who was previously a public servant is a floor polishing contractor. She works part-time for the Telephone Interpreter Service as she is quite bilingual. There are no acute financial problems. They have three children, aged 10, 13 and 15 years.

What might your approach to treating Christina be at this stage?
What [if anything] would you do about the oxazepam?

Is there any particular sequence to your management or would you do several things in parallel? Please describe.
What might help you determine the sequence or priorities in management?

What would prompt you to refer Christina?
Who would you refer her to?

What are the barriers that present themselves in these referrals?
What role do you think is reasonable for a GP in the future care of Christina?
Section 3

Scenario - Andrew

Andrew is a 28 year-old man who has had schizophrenia for the past 7 years. He has some persistent paranoid delusions that he keeps to himself. He doesn’t seem to have a lot of positive symptoms but he certainly is withdrawn and only socialises with one or two friends who live in the same block of units in which he lives, as well as his immediate family. Andrew smokes 2 packets of cigarettes per week. He also uses cannabis three or four times per week. He has a couple of plants that do nicely on the sill of the north-facing window of his unit. He receives his depo-neuroleptics from your practice. He was previously on a Community Treatment Order until 12 months ago but this has been revoked. He now turns up for his medication every two weeks. He has been stable the last three years, but his quality of life is not that great. He receives a Disability Pension.

Do you think that his cannabis use is a problem? Please elaborate.
What extra information might you want to determine whether this is a problem?

If you think that it is a problem, then what would your approach to this cannabis use be?
If you don’t think that it is a problem then what type of situation would make you concerned and perhaps want to intervene specifically?

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What strategies might you use to help him reduce his cannabis usage (and perhaps to cut down on his tobacco use)?

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What services might you refer him to if he were willing?

Are you aware of problems with accessing these services?
Section 4

Actual example from your practice

Recall a case that you have encountered in your clinical practice in the past 3 months that is similar to the three that have been outline in the previous sections. We are specifically interested in a case where the patient presented with both substance use and mental health features.

In a de-identified format, please provide details/notes regarding this person initially presented.

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Regarding detection, what cues alerted you to the possibility of both a Substance Abuse and a Mental Health problem in this patient? (This might include contextual knowledge and actual features of the presentation)
Regarding assessment, how did you proceed to assess this patient? What key questions did you ask? How did your recognition of co-morbidity influence your assessment?

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Regarding treatment, what were your treatment ideas/plans and how did you proceed in implementing these? What referrals did you consider/make? What interventions did you consider/make? What factors did you consider in deciding care with this patient?
Regarding outcome, describe the follow-up that you had with this patient. What features were you able to use to assess change? Were there improvements in this patient? What do you think allowed/prevented improvement in this patient? What are your thoughts/feelings regarding your role in this patient’s care?
Section 5

Additional Questions.

Are you aware of any formal recommendations, guidelines or research informing the management of patients with dual diagnosis/comorbidity? Please detail.

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Have you been involved in any formal training on the area of co-morbidity or dual diagnosis?

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Other than formal training, how have you gained your knowledge in handling patients that present with co-morbid substance abuse and mental health problems?

What do you think would help increase your knowledge and confidence in handling these types of patients?
Overall, what are the major issues in General Practice management of co-morbidity patients? What changes do you believe would help address some of these problems and improve future encounters.
Thank you for completing this questionnaire.
APPENDIX B

FOCUS GROUP PARTICIPANTS
Adelaide - South Australia

Dr Catherine Pye - General Practitioner (Mt Gambier)
Dr Rene Pols - Psychiatrist (Southern Mental Health, Adelaide)
Dr Paul Williamson - Drug & Alcohol Medical Officer (Warinilla, Adelaide)
Dr David Jones - GP Methadone Prescriber (Adelaide)
Dr Chris Wurm - GP Psychotherapist (Adelaide)
Ashley Halliday - Consumer representative (Adelaide)
Anne Smith - Consumer representative (Adelaide)

Orange - New South Wales

Dr Rod MacQueen - Alcohol & Other Drug specialist (Orange)
Chris McGuiness - Alcohol & Other Drug worker (Lyndon Detox Unit, Orange)
Maureen Connelly - Mental Health Nurse (Cadia House, Orange)
Dr Nick O’Ryan - General Practitioner (Canowindra)
Dr Adrian Zambo - GP Methadone Prescriber (Orange)
Sue Moffat - Carer/family member (Orange)
Lisa Carruthers - Consumer representative (Orange)