

Chronic Pain and AOD

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Chronic pain is under-assessed, under-diagnosed and under-treated, mistreated or untreated. Older adults and women are over represented. Waiting times for specialist publicly funded services are on average over 180 days. Service provision in rural and regional areas of Victoria is limited. The lack of appropriate and accessible pain management services often results in people developing avoidable alcohol and other drug (AOD) problems, thereby clogging up AOD services. This in turn leads to extended wait times in AOD treatment and has further impacts on the broader health system, including ED waiting times. The Victorian Government needs to urgently assess the response of the public health system to chronic pain and invest in expanding chronic pain treatment options.

This paper will outline the issues relating to the nexus between chronic pain and alcohol and other drugs (AOD). Chronic pain is a debilitating health condition which adversely impacts upon the health of many Australians at great cost to the economy and society. There are issues in accessing appropriate specialist pain medicine treatment. The long term prescription of opioids carries a number of risks. These issues relate to the increasing pharmaceutical death toll in Victoria as well as an ever increasing older population which evidence indicates experiences a higher prevalence of chronic pain compared to the general community.

Recommendations

1. A tiered multidisciplinary model for managing chronic pain as outlined by the Royal Australasian College of Physicians (2009) and the National Pain Strategy be established which would involve a range of medical and allied health professionals
2. Enhanced referral and three-way communication pathways between AOD, pain medicine and primary health care
3. Increase the health literacy, and build the capacity of community-based support programs as well as telephone and online assistance for individuals experiencing chronic pain and comorbid chronic pain and AOD dependency
4. Pain Medicine services receive additional resources to match community need with a view to reducing the waiting time for publicly funded services to not more than 90 days
5. A real time prescription monitoring system be introduced and should be evaluated regarding its efficacy in reducing harms associated with pharmaceutical misuse including mortality
6. Increase the clinical capacity of the AOD sector to provide treatment for individuals who are experiencing opioid dependence and chronic pain
7. Resourcing should be provided to prioritise the needs of individuals experiencing chronic pain in Victoria's new Area Based Pharmacotherapy Networks

What is chronic pain?

Chronic pain is commonly defined as continuous or recurrent pain experienced for three months or longer within the preceding six months (Painaustralia 2010, p 54; Duncan 2012, p 10) and is separate from acute pain, which often occurs as a result of damaged tissue (Painaustralia 2010, p 2). Chronic pain does not refer to cancer-related pain in this paper unless specified.

Key Issues

High prevalence and significant impact of chronic pain

- In 2007, approximately 3.2 million adult Australians had experienced chronic pain costing \$34.3 billion, with projections predicting this increasing to five million adult Australians by 2050;
- Women are more likely to experience chronic pain (Painaustralia 2010, p 18); people aged under 35 years experiencing chronic pain are at greater risk of opioid dependence (Cohen and Wodak 2010, p 13);
- Ageing is associated with increased prevalence in chronic pain (Painaustralia 2010, p 18);
- Pain has been cited as Australia's third most expensive health problem and an 'undiscovered health priority' (Duncan 2012, p 10);
- Chronic pain has an adverse impact upon physical and psychological wellbeing, capacity to work and is related to suicidality (Hogg, Gibson, Helou, DeGabriele and Farrell 2012, p 386). Chronic pain is also associated with increased health care utilisation (Meghani, Polomano, Tait, Vallerand, Anderson and Gallagher 2012, p 6); and
- Chronic pain is associated with a range of adverse social determinants, such as unemployment, low education and disability (Painaustralia 2010, p 19); it creates barriers for injured workers returning to work, with 82 per cent of this cohort not returning to work within six months due to unresolved pain issues (RACP 2009, p 21).

Issues in accessing appropriate treatment for chronic pain due to service system limitations

- There are challenges accessing specialist pain clinics (Hallinan, Osborn, Cohen, Dobbin and Wodak 2011, p 317) including extensive wait times (the average wait time for publicly funded specialist pain medicine clinics is 184.3 days); often many individuals receive treatments of varying efficacy for a number of years before accessing these clinics (Painaustralia 2010, p 22). Patient wellbeing further deteriorates due to lengthy delays in receiving a pain assessment (Hogg et al, p 386);
- The use of pharmaceuticals to treat chronic pain is widespread yet the efficacy of this practice is not comprehensively supported through evidence;
- GPs often rely on opioid analgesics in managing patients with chronic pain (Cohen and Wodak 2010, p 11), however only one in three individuals suffering severe chronic pain benefit from prescription opioids (Duncan 2012, p 13);
- Between 3.27 – 11.5 per cent of patients prescribed opioids for chronic pain develop dependence and/or other complications (Ling, Mooney and Hillhouse 2011, p 301); and
- In 2012, pharmaceuticals were involved in 305 of 367 drug deaths in Victoria (Coroners Court 2013), up from 275 of the 367 drug deaths in 2011. In 2013, pharmaceutical contributions increased again to 310, of 374 drug deaths. Opioid analgesics were involved in 209 drug deaths in 2012, up from 183 drug deaths in 2011, and 140 in 2010 (Coroners Court of Victoria 2012; 2013).

Pharmaceutical contributions to acute drug toxicity deaths – Victoria

	Pharmaceutical contribution	total drug deaths
2013	310	374
2012	305	367
2011	275	367

Introduction

Chronic pain is a pervasive issue and to date has not featured prominently in policy discussions. It has been cited as Australia's third most costly health challenge and described as the 'undiscovered health priority' (Duncan 2012, p 10). The National Pain Strategy cites that 3.2 million Australians have experienced chronic pain at a national cost of \$34.3 billion (Painaustralia 2010, p 18).

Access to specialist pain medicine treatment is highly challenging, with a range of convoluted service system pathways coupled with lengthy waiting times (on average over 6 months) (Painaustralia 2010, p 22). The lengthy wait times exacerbate the adverse health and welfare issues that often co-occur with chronic pain.

Often, GPs prescribe powerful prescription medication (typically opioids) to increase the wellbeing of those experiencing chronic pain; pharmaceuticals are often used as an initial response when best practice indicates that non-pharmacological options should be prioritised. Many of these prescription drugs can result in dependency and misuse can result in death. The shift in Victoria from a high prevalence of illicit to pharmaceutical drugs in mortality statistics is indicative of the potential risks underpinning inadequate access to pain treatment and/or appropriate pain management. This highlights the need to ensure that opioids and other pharmaceuticals – which, when used appropriately can enhance the wellbeing of individuals experiencing chronic pain - are readily available to those in need but also overseen by a robust and accountable system staffed by appropriate professionals.

The Royal Australasian College of Physicians (RACP 2009, pp 6 – 7) list a range of actions to reduce the harms associated with problematic opioid use and substance dependency, which include the provision of multidisciplinary services and greater access to pain medicine and addiction services, guidelines directing practice for co-occurring AOD and pain issues, the development of a real time prescription monitoring system and greater access to pharmacotherapy.

This paper will assert the Victorian Alcohol and Drug Association's (VAADA) position on pain management for chronic pain and outline a range of recommendations which will aim to improve the wellbeing of those experiencing chronic pain and reduce the harms associated with pharmaceutical misuse. It will reflect on issues relating to chronic pain in the general population as well as the additional complexities of co-occurring AOD dependency issues.

Chronic pain in Australia

The National Pain Strategy (Painaustralia 2010, p 1) indicates that one in five Australians will experience chronic pain during their lifetime and that 80 per cent of individuals experiencing chronic pain are not receiving the most optimal treatment. This is in part related to challenges in accessing specialist pain medicine, the absence of a multidisciplinary approach to pain management, as well as a lack of uniform training in pain management throughout the broader health sector. The National Pain Strategy calls for an interdisciplinary approach to chronic pain, and cites contemporary evidence highlighting the need to set chronic pain within a chronic disease framework, with a view to addressing the social, physical and psychological contributing factors (Painaustralia 2010, p 13).

Chronic pain and an ageing population

Chronic pain is a pervasive problem in older people (McCracken and Jones 2012, p 861; Painaustralia 2010, pp 18-19) and is 'under-assessed, under-diagnosed, and under-treated or mistreated' (Gibson and Lussier 2012, p s24; Painaustralia 2010, p 21). Adding to these issues is the over representation of older people in rural and regional areas coupled with a disproportionately low quantum of GPs (Nissen, Kyle, Stowasser, Lum, Jones, Mclean and Gear 2010, p 35). Over 20

per cent of Australians over the age of 65 experience pain with half of the number suffering moderate to severe pain. Older people generally have reduced tolerance for pharmaceutical opioids, and as such alternative treatment modalities must be availed to this population (Painaustralia 2010, pp 15 – 16).

Chronic pain and social disadvantage

A strong association, though not causal, between chronic pain and social and economic disadvantage has been established (Bonathan, Hearn and Williams 2013, p 161) with the National Pain Strategy (2010, pp 18 – 19) noting that demographic elements evident in chronic pain sufferers include low levels of education, being in receipt of health benefits, lack of private health insurance and high levels of unemployment. Bonathan et al (p 160) note that limited education and employment opportunities can contribute to psychological factors which can increase the likelihood of experiencing chronic pain. These populations are further at risk as they experience reduced access to appropriate medical assistance and may rely on pharmaceutical remedies (Bonathan et al 2013, p 161). There are significant challenges for rural and regional communities in accessing effective pain management treatment (Painaustralia 2010, p 21). This is particularly problematic given that rural-based employment carries a greater risk of injury inducing chronic pain and that rural communities are 23 per cent more likely than the general community to experience back pain (National Rural Health Alliance 2013, p 1).

Individuals experiencing AOD dependency may encounter challenges in accessing pharmacological responses for the treatment of chronic pain (Arora et al 2013, p 575). This is problematic given the prevalence of chronic pain amongst injecting drug users, with research indicating a rate of 20 per cent at the point of survey (Cogger, Dietze and Lloyd 2013). These populations should not be prohibited from accessing pain management treatment involving pharmaceuticals and should be provided with careful supervision and support.

Population health planning is necessary to clearly identify social determinants which contribute and coexist with chronic pain with resources allocated in response to population need. Other links, such as whether specific types of employment result in greater prevalence in chronic pain should be identified with government and industry leading responses to this issue.

Service Gaps – waiting in pain

The National Pain Strategy cites a range of service system issues which contribute to access and equity limitations in pain management. These include wait times, fractured referral pathways, discharge processes from a pain management clinic and a lack of pain medicine specialists (Painaustralia 2010, pp 23-24). The following section details these and other challenges facing individuals experiencing chronic pain and highlights the need for a multi-disciplinary approach to pain management, as recommended in the National Pain Strategy.

Multidisciplinary pain management model

There are significant shortcomings in the health system for managing chronic pain (Painaustralia 2010, pp 21 - 22). To address these shortcomings, the National Pain Strategy (Painaustralia 2010, pp 23 – 25) proposes a multidisciplinary and multi-tiered approach to pain management, with four levels of care. This involves a range of medical and allied health professionals, including but not limited to pain medicine specialists, addiction medicine specialists (at the tertiary and secondary levels) and at the primary care level, GPs, working in a multidisciplinary team with physiotherapists, clinical psychologists or other allied health professionals all with special training in multidisciplinary pain management. This approach would enable the provision of care based on the needs and complexity of the patient. Those with low level needs would receive services such as pain education, self-help and online support, while the provision of care from a multidisciplinary team with a range of health providers including pain medicine specialists would be provided for those

with more complex needs. The National Pain Strategy (Painaustralia 2010, p 24) advocates for the provision of training for GPs opting to become involved in such a network.

VAADA supports the development of a multidisciplinary tiered model which would also promote collaboration between a range of medical specialisations, including pain medicine, addiction medicine and psychiatry. The Victorian Pharmacotherapy review supports this approach, with the recommendation that pain management be 'core business' for specialist services and that linkages be supported and resourced between general practitioners and pain management specialists (King, Ritter and Berends 2011, pp 80-81; Mitchell (2013) as well as the AOD sector, especially in cases where substance dependence is evident.

Recommendations

1. *A tiered multidisciplinary model for managing chronic pain as outlined by the Royal Australasian College of Physicians (2009) and the National Pain Strategy be established which would involve a range of medical and allied health professionals*
2. *Enhanced referral and three-way communication pathways between AOD, pain medicine and primary health care*
3. *Increase the health literacy, and build the capacity of community-based support programs as well as telephone and online assistance for individuals experiencing chronic pain and comorbid chronic pain and AOD dependency*

Pain management clinics

There is a paucity of pain medicine specialists. Provisions should be made to expand the workforce (Painaustralia 2010, p. 30; Dunlop 2011, p 332). The National Pain Strategy indicates that in doubling the resources, the capacity of the pain management service system will expand four fold; wait times would reduce to two months and the cost of service delivery would be reduced (Painaustralia 2010, p 30).

Issues relating to access to pain medicine specialists also contribute to the system failures and a lack of integration between pain and addiction medicine services, often resulting in patients being transferred between services with little coherence (Dunlop 2011, p 332).

Waiting times

The National Pain Strategy indicates that the average waiting time for publicly funded chronic pain management is 184.3 days, with the longest wait time being over 18 months in duration; this is not inclusive of the time spent where an individual has experienced chronic pain yet not sourced adequate treatment. These long delays contribute to entrenched social isolation and unemployment, with research indicating that the chances of an individual returning to work after two years out of employment are minimal (Painaustralia, 2010, pp 22 - 23). The NSW Pain Management Plan 2012 – 2016 recommends a wait time of not more than three months (NSW Ministry of Health 2012, p 11).

Recommendation

4. *Pain Medicine services receive additional resources to match community need with a view to reducing the waiting time for publicly funded services to not more than 90 days*

Disconnected referral pathways

The National Pain Strategy indicates that the referral practices of GPs vary in response to chronic pain (Painaustralia 2010, p 23), with 'complex' patients experiencing even greater challenges in accessing the appropriate service (Dunlop 2011, p 332). This may impact upon access to the appropriate treatment and result in the patient disengaging from health services if they are not experiencing any benefits, contributing to further isolation and exacerbation of pain issues. Such

practice results in a situation where those with the highest need also experience the most significant barriers to health services (Browne et al 2012, p 3).

The challenges evident with referral pathways are exacerbated by stigma (Duncan 2012, p 11); many individuals experiencing chronic pain are concerned that this illness may be viewed with scepticism by some cohorts. This very legitimate concern creates additional barriers to accessing appropriate treatment.

GPs and pain management

The majority of treatment for chronic pain is undertaken at a primary care level (RACP 2009, p 51), with opioids commonly being prescribed to manage this issue (Cohen and Wodak 2012, p 24). Of all primary care patients, 19.2 per cent experience chronic pain (Henderson, Harrison, Britt, Bayram and Miller 2013, p 1); to this end, it is crucial that opportunities which foster closer links with GPs and pain medicine specialists are enhanced.

GPs providing pharmacotherapy are ideally placed to oversee any pain issues which their patients experience and should be able to work collaboratively with pain medicine and other relevant health professionals to provide multidisciplinary pain management, with minimum reliance on medication. These patients are likely to have a higher level of tolerance to opioids, requiring higher dosing to manage chronic pain (McCullough 2013). Further training and education for GPs in multidisciplinary pain management should be provided (Painaustralia 2010, p 31) and GPs should be encouraged to access existing training opportunities.

Pharmacists and pain management

Pharmacists play a key role in assisting community members experiencing chronic pain as they provide a local and accessible interface with the community as well as access to a range of pharmaceutical (prescription and non-prescription) medications. They also have the capacity to provide a monitoring role with their customers and to facilitate 'self-management' of chronic pain (Painaustralia 2010, p 24). Pharmacist should be able to provide individuals with information on a range of treatment options, including non-pharmaceutical.

Comorbid AOD dependency and chronic pain

Individuals experiencing AOD dependence and chronic pain present an array of complex challenges for GPs and other medical practitioners treating chronic pain. AOD dependence can raise a red flag with regard to an increased likelihood of harm arising from the misuse of medication and concerns regarding practices such as 'doctor shopping'. These individuals should not be denied access to the appropriate prescription medication, but precautions must be taken for optimal results to ensue. The prescription of opioid analgesics should not be undertaken until other non-pharmacological treatment options have been considered (RACP 2009, p 38). The RACP (2009, p 38) provides useful points for consideration in managing individuals experiencing comorbid AOD dependency and chronic pain with opioid analgesics.

Many individuals with AOD dependency issues use multiple substances, both licit and illicit. This creates further challenges in the treatment of chronic pain. Recent mortality data from the Victorian Coroners Court (2013) provides a breakdown of other substances contributing to the 312 acute drug toxicity deaths which involved oxycodone between 2000 and 2012. The most prevalent substances were diazepam (a benzodiazepine) which was present in 145 of the 312 deaths and alcohol which was present in 79 oxycodone related deaths. Consideration of the use and impact of these and other substances is necessary by the treating medical practitioner. Mortality resulting from acute drug toxicity with other opioid analgesics, such as methadone and fentanyl, are likely to share similar characteristics to oxycodone with regard to the presence of other drugs. This underscores the reality that individuals with AOD dependency issues who experience chronic pain

may be using a range of licit and illicit substances. Poly drug use should be a consideration in decisions regarding prescribing pharmaceuticals for treating chronic pain.

The RACP (2009, p 6) partly ascribes the misuse of pharmaceutical opioids by heroin and other illicit drug using populations on 'substantial unmet demand for treatment of opioid drug dependence'. At a system level, the RACP (2009, pp 6 – 7) calls for service integration to provide a multidisciplinary response to chronic pain, the use of clinical guidelines for prescribing opioids with effective sanctions, the implementation of a real time prescription monitoring system and enhancing Victoria's pharmacotherapy system. Actioning these recommendations would contribute to safer prescribing practices and provide better outcomes for individuals experiencing co-occurring chronic pain and AOD dependence.

Recommendation

5. *A real time prescription monitoring system be introduced and should be evaluated regarding its efficacy in reducing harms associated with pharmaceutical misuse including mortality*

AOD treatment services

The nexus between the use of pharmaceuticals and pain management necessitates the involvement of AOD treatment services in providing treatment for individuals experiencing co-occurring chronic pain and AOD dependence. The AOD sector must be provided with the resources to ensure that they can provide AOD treatment whilst accounting for necessary treatment of chronic pain. This requires building the capacity of the sector to address these complex issues and integration with pain medicine and other related health service sectors.

The current reforms impacting Victoria's pharmacotherapy system has resulted in an area based model with five separate regions (Department of Health 2013, pp 6 – 7). Each region should ensure that individuals experiencing chronic pain transitioning into the pharmacotherapy system are provided with additional support. Given the nexus between opioids and the risk of dependence (Department of Health 2013, p 5), these networks must ensure that health care providers treating chronic pain are key stakeholders in the reform of the pharmacotherapy system.

Recommendations

6. *Increase the clinical capacity of the AOD sector to provide treatment for individuals who are experiencing opioid dependence and chronic pain*
7. *Resourcing should be provided to prioritise the needs of individuals experiencing chronic pain in Victoria's new Area Based Pharmacotherapy Networks*

Pharmaceuticals and pain management – benefits and risks

Over the past decade, the misuse of pharmaceutical opioids has increased significantly, largely in accord with international trends (Nielsen, Bruno, Lintzeris, Fischer, Carruthers and Stoové 2011a, p 291). A range of national and international sources have relayed concerns regarding the prescription of opioids for chronic pain (Duncan 2012, p 13; Nielsen 2011, pp 233-234; Coroners Court of Victoria 2012; Nicholas, Lee and Roche 2011, pp 41-42; Ling, Mooney and Hillhouse 2011, p 301, 304; Vijayaraghavan, Penko, Guzman, Miaskowski and Kushel 2012, pp 1141-1142). These concerns range from the development of dependency, varying efficacy, compromised immune systems and concerns among GPs regarding training for, and capacity to manage, chronic pain.

Neilsen et al (2011a, p 292) cite the existence of hidden populations of pharmaceutical opioid users. This population is likely to consist of a higher proportion of women (who experience higher prevalence of chronic pain (Painaustralia 2010, p 18)), not attending AOD treatment services, and as a point of difference to illicit drug using populations, are less likely to inject opioids compared to heroin users. Nielsen et al (2011, p 294) undertook a study of AOD treatment service users and

identified that those who had used pharmaceutical opioids (but not heroin) were more likely to have had their first prescription for a pain related issue. Nielsen et al (2011, p 293, 297) reveal that pharmaceutical opioid using populations are fairly similar with regard to a range of health and welfare elements to heroin using populations.

Pharmaceuticals play a crucial role in enhancing the wellbeing of those experiencing chronic pain. The evidence is varied regarding efficacy although some common themes emerge, which include:

- Non-pharmacological treatments should be considered prior to the use of pharmaceutical opioids in treating chronic pain (RACP 2009, p 38);
- Opioids are effective in treating chronic pain as a short to medium term measure;
- Research is inconclusive on the use of opioids as a long term means of treatment for chronic pain (Cohen and Wodak 2011, p 11);
 - Long term opioid use can be effective if the patients are carefully monitored by a professional with sound clinical skills in the 'principles of opioid prescribing and in the assessment and management of risks associated with opioid abuse, addiction, and diversion' (Nicholas et al 2011, p 42);
 - Long term pharmaceutical opioid analgesic use may be ineffective for dealing with chronic pain (Darnall, Stacey and Chou 2012, p 1181);
- The Victorian Coroners Court (2012) has indicated that chronic pain is associated with mortality involving opioid analgesics such as oxycodone;
- Only one in three individuals suffering severe chronic pain benefit from prescription opioids (Duncan 2012, p 13);
- In America, 95 per cent of prescriptions for longer acting opioids are prescribed for chronic pain (excluding cancer related pain) – the proportion is not known for Australia (Nicholas, Lee and Roche 2011, p 40);
- A real time prescription monitoring program may reduce incidences of doctor shopping, enhance positive prescribing practices (Roxburgh, Bruno, Larance and Burns 2011, p 284), identify patients with AOD issues and identify GPs with poor prescribing practices (RACP 2009, pp 6 – 7);
- The proportion of 'unsanctioned' pharmaceutical use is unclear (Hallinan et al 2011, p 317); and
- Unmet demand for pharmacotherapy may result in individuals misusing pharmaceutical opioid analgesics (Hallinan et al 2011, p 318; RACP 2009, p 6).

This paper details a number of actions necessary to improve the health and wellbeing of individuals experiencing chronic pain. This involves the allocation of additional resourcing to pain management services and the Area Pharmacotherapy Networks in order to address unmet demand issues. A multidisciplinary tiered approach to pain management (tertiary, secondary, primary and community care as recommended in the National Pain Strategy) should be implemented. GPs should be encouraged to participate in multidisciplinary pain management training. Non-pharmaceutical options should be the first line of treatment for chronic pain rather than pharmaceuticals. This will necessitate the development of more robust referral pathways between relevant stakeholders. Furthermore, AOD treatment services require additional resources to cater for the increasing pharmaceutical related demand.

Work should be undertaken to improve the health literacy of consumers and various 'self help' options should be developed, such as online support¹. These actions will exert downward pressure on the increasing Victorian pharmaceutical death toll and increase service access for individuals experiencing chronic pain.

¹ The NSW government has developed a useful website for individuals experiencing chronic pain:
<http://www.aci.health.nsw.gov.au/chronic-pain>

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Disclaimer

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