Access to Pain Medicine and Addiction Medicine services in Rural areas are even worse than patients living in metropolitan areas.

In South Australia there is a two year wait to see a Pain Clinic in a Public Hospital

The Drugs and Alcohol Service of South Australia has a cap on the number of patients it will see. Currently the cap is full and it is rare to get anyone onto the public program unless they are coming out of prison, are pregnant, have HIV, **AND of course**, live in metropolitan Adelaide.

There are about 50 private prescribers. Most are full. At present the only methadone prescribers that will accept any patients are myself, as a specialist and a GP in Moonta.

Even if a prescriber can be found many, most, chemists do not 'dose' provide methadone maintenance therapy. There is no legal impediment but the chemists choose to avoid dealing with drug-addicts.

Opiate dependent patients wanting to go into a treatment program are prevented by lack of access to prescribers, lack of access to chemists, the failure of Governments to provide more than the methadone/buprenorphine leaving all the dispensing costs to the patient/client.

This commonly is $30 a week. As most patients are on a pension this is a considerable expense.

I have patients I see who come from as far away as Broken Hill in NSW or the goldfields of Victoria as the cannot easily access other prescribers.

I provide a addiction, pain and psychological services. Part of which involves managing opioid analgesics. These often are an essential part of the management of acute and terminal pain and are increasingly used and abused in the treatment of chronic non-cancer pain, such as acute low back pain — usually recurrent and often prolonged.

This comes with increasing rates of harmful use and diversion. Rural GPs often have to maintain an opioid regimen for patients in pain with little training.

They may attempt to walk a tightrope of neither wishing to under-treat pain nor wanting to create an addiction.

Despite 20% of GP consultations involving chronic pain few GPs receive specific training in this or addiction.

As opioids can reduce pain levels in the immediate post-dose period they can seem to be the answer but significant improvement in levels of pain and function occur in less than 26% of long-term users. In fact, population epidemiological studies suggest opioids do not improve any of the key outcome treatment goals — pain relief, improved quality of life or improved functional capacity.

Opioid-induced changes in "affective tone" change the way that patients manage the usual emotional response to their pain. There are also opioid side-effects. Opioids have been associated with endocrinopathies, suicides, inadvertent overdoses and sleep apnoea.

A major problem is hoarding of or diversion of medication, as many as 60% of patients taking opioids hoard them.

Among university students given opioids for acute pain, 27% reported diverting them. Some (18%) of those abusing opioids obtained them from just one doctor.

Most opioid abusers obtain their stock not from dealers but from family or friends. They may be given freely (56%), purchased (9%) or stolen (5%). The person providing the opioids usually (82%) obtained them from just one doctor.

The increasing use of opioids in chronic non-cancer pain follows successful pharmaceutical company research, marketing, funding of professional and consumer organisations and of professional education.

Opioid sue in chonic non-cancer pain was rare until1999. Now 86% of the opioid market is for chronic non-cancer pain treatment. Of concern is that we are creating recurrent opioid addicts. A prospective US study from 2001-2005, demonstrated that about half of all past opioid abusers became long-term prescription opioid users.

Now with the use of prescription opioids for non-cancer pain, 29% of entrants to opioid substitution therapy units say their primary opioids are those introduced to them by doctors for pain management.

Most GPs have very strong aversions to opioid addicts or being associated with them professionally. This makes it hard to get help. If you are in pain that is fine if you look as if you are abusing them 'Go away'

GPs and rural GPs, who live wuith their community need proper support and resources. Thye need help with initial screening, preventive monitoring, minimisation of hoarding and diversion, and advice about how to safely dispose of unused opioids.

In addition to that the MEDICARE rebates for addiction medicine specialists are so low that they make quality practice unviable and threaten the existence of the new medical specialty.

Australia has about 169 Addiction Medicine specialists, of those only eight have registered with Medicare since the specialty was given access to Medicare Benefits Schedule (MBS) item numbers 104 and 105 (group A3) in November last year.

Most claim through item numbers attached to their base specialty, commonly general practice or psychiatry.

Of note, using the Addiction Medicine item numbers, specialists receive $70 for an initial referred consultation plus $35 for a follow-up at 85% of the MBS rebate.

> Dr Richard Hallinan, a Sydney addiction specialist at the Byrne Surgery, Redfern, said that the current Medicare rebates only allowed for “6-minute medicine”. He said most patients with addictions do not have the means to pay private gap payments.
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> “Addiction medicine specialists don’t dare register with Medicare because it would dramatically reduce the rebates available to their patients”, said Dr Hallinan, who has written a Comment article for this week’s *MJA InSight*. (1)
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> “The irony is that the Department of Health has simultaneously recognised and strangled a new specialty.”

Dr Alex Wodak, director of the Alcohol and Drug Service at St Vincent’s Hospital, Sydney, said addictions were chronic, complex problems requiring thorough, time-consuming consultations and that the poor remuneration placed “the evolving specialty at risk”, with only about 10 current trainees nationally. These training positions are in metropolitan areas.

Under funding is essentially indirect discrimination against a vulnerable group of patients, even more so to the rural patients, whio have the stigma of dependence and NO access to services from GPs, pharmacists let alone a qualified specialist. For $35 a consult how can Addiction Services be attracted to rural areas. And even if they were if there is no on-going support what is the point.

Without private addiction treatment sector patients can only go into the overstretched public sector. Or in South Australia’s case NOWHERE.

Consequently, rural GPs are left to deal with difficult addiction [and pain] cases without additional training or support.

A spokeswoman for the Department of Health and Ageing acknowledged that addiction specialist group A3 item numbers did not reflect the time they

needed to spend with patients. She said the Medical Services Advisory Committee was currently considering a proposal for time-tiered specialist consultation items for addiction medicine specialists, but an exact timeline for this process to be finalised was not possible.

Given this will be going to a newly established committee, I expect it will be years before any change occurs.

Why would anyone leave a better paid, less demanding area of medicine to work with 'second class' patients? I have been told only a 'second class doctor' would do that.

Addiction specialists need access to time- and complexity-based item numbers, similar to those offered to GPs and psychiatrists and access to the support of mental health nurses and allied health services.

Pain and Palliative Care specialist also need access to these items and services because they are also dealing with the enormous increase in the consumption of prescription opioid analgesics and the problems of unsanctioned use, including prescription shopping, diversion and injection, and harms including addiction and overdose deaths.

With the use of prescription opioid use being 'OK' for chronic non-cancer pain in the closing decades of the 20th century we now see in the US and Canada, that prescription opioids kill more people than heroin and cocaine combined. Unfortunately, Australia is not far behind.

Rural deaths from suicide are higher than in metropolitan areas, similar death from opioid abuse without treatment is adding to the cost of living in the country.

Australia has a strong track record in drug policy and harm reduction, Australia should be well positioned to avert this crisis in the making.

The 2009 RACP Prescription Opioids Policy [I was a member of the working party] made a number of key recommendations for dealing with the problem. :

- Doctors and pharmacists need a real-time comprehensive information service about previous supply of opioids to patients. The potential exists for the Pharmaceutical Benefits Scheme to provide monitoring systems for this purpose. Without this GPs and pharmacists are flying blind in the face of prescription shopping.
- Opioid regulation across the states and territories is not consistent and with national registration it is even more problematic with 'patients' swapping form state to state.
- Generally accepted guidelines for use of opioids in chronic pain DO NOT exist
- Addiction treatment services need to expanded and extended into rural areas to meet the needs of a new, largely hidden, population of opioid-dependent people who have never used heroin.

- Even in the cities waiting times for opioid pharmacotherapies are long and the large cost of supervised dispensing is unsubsidised.
- At travel to the nearest chemist that will dose you in a rural area and treatment is effectively.
- Treatment in pain clinics is unacceptably long [more than two years] around the country, and not often available in the country at all because there are very few pain specialists in private practice. The rebates are twice that of an Addiction Specialist but without doing procedures it is impossible to cover costs.

This is not a public health disaster waiting to happen — it's already happening.

Please note:

Addiction Medicine was initially recognised by the Health Minister, Tony Abbott, in 2005. I 2009 Nicola Roxon confirmed the AMC recommendation but it was only in 2010 that rebates were made available.

Addiction Medicine's workforce profile is small, with ageing members and a van shingly small trainee intake, most work in public sector, or within their previous field, to maintain their income. Few will attempt private practice.

It was hard to recruit doctors when there was no specialist recognition. With specialist recognition and a Medicare rebate is less than any other NON-procedural speciality it is almost impossible to attract trainees.

Treating people in pain or addicted saves money and improves productivity. The work is important and complex. It requires the skills of a Pain Physician, a psychiatrist and it helps to have a good understanding of the law.

These skills are needed everywhere but in rural areas the lack is most acute

Rhys Henning