Victorian Alcohol & Drug Association

Submission to Inquiry into Women's Pain

"Prescribed pain medication was not sufficient. My choices were suicide or find stronger pain relief. Heroin worked."

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About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body representing organisations that support people who have alcohol and other drug (AOD) needs in Victoria. We work to prevent and reduce AOD-related harms in the Victorian community by ensuring the people experiencing those harms, and the organisations that support them, are well represented in policy design, program development and public discussion.

We do this by:

- Engaging in policy development
- Advocating for systemic change
- Speaking on issues identified by our members
- Providing system leadership
- Creating space for professional collaboration in the AOD sector
- Maximising opportunities to build professional capacity and capability
- Keeping our members and stakeholders informed about issues relevant to AOD
- Supporting evidence-based practice that reduces AOD-related harms and maintains the dignity of those who use AOD (and related) services.

Acknowledgement of Country

VAADA acknowledges First Peoples as the traditional owners of the land on which we reside and work. We pay respect to Elders past and present and acknowledge that First Peoples have never ceded sovereignty to country. VAADA supports Voice, Truth and Treaty.

Acknowledgements

In preparation of this submission VAADA has prioritised the views of women that have lived and living experience of pain and substance use. We acknowledge the women who contributed to this paper and thank them for their courage and wisdom in sharing their views.

We also consulted with professionals working within the AOD sector and thank them for their advocacy and efforts in reducing harm for women experiencing pain in their daily work.

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Glossary

Alcohol and Other Drugs (AOD) – refers to any substance, including legal and prohibited substances including, but not limited to, alcohol, tobacco or pharmaceutical medications, consumed for their psychotropic or other effects, and which may be associated with compulsive patterns of use, dependence, and related harms.

AOD Sector – for the purposes of this submission, the AOD sector refers to agencies and organisations funded to provide support, services and treatments for AOD use by either the Victorian or Federal governments. Private providers of AOD treatment are out-of-scope.

Domestic and Family Violence (DFV) – is defined under the Family Violence Protection Act 2008 (Victoria), as a pattern of behaviour in any relationship used by one individual to gain or maintain power and control over another. This includes intimate partnerships (current or former spouses and dating partners) as well as 'family-like' relationships and extended kinship connections. The abuse can manifest in various forms, including:

- Physically or sexually abusive
- Emotionally or psychologically abusive
- Economically abusive
- Threatening
- Coercive
- In any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person

This definition acknowledges that an individual's experiences of violence can be significantly influenced by their race, ethnicity, gender identity, sexual orientation, disability, age, socio-economic status, and immigration status.

Children and young people can directly experience DFV or witness DFV within their environments.

Introduction

The Victorian Alcohol & Drug Association (VAADA) is pleased to make this submission to the Inquiry into Women's Pain in Victoria. Whilst the relationship between pain and drug use and dependence is well-documented, policy and service responses remain insufficient, particularly regarding women's pain and AOD. Currently, neither clinical area – pain management and addiction medicine –employ a gender-based lens. That is, there is a lack of gender-informed and responsive options to meet women's drug use and women's experiences of pain. It is no surprise, then, that women's pain in the context of drug use and dependency is under-serviced.

In Victoria, there are only three publicly funded dedicated women's AOD services:

- Bridgehaven – a women and children's residential rehabilitation service (Salvation Army)
- Women's Alcohol and Drug Service (WADS) – a specialist AOD and maternity service (Royal Women's Hospital)
- Curran Place Mother and Baby Withdrawal Unit (Uniting)– 4 beds for newborns (14 mths and younger and their mothers undergoing withdrawal)

This is in stark contrast to the number of gender specific services in other States and Territories. For example, NSW funds 11 women-only programs and Western Australia funds 4 residential programs and a range of other non-residential, women-specific programs.

It is also of note that the Coronial Inquest into the death of Veronica Nelson in 2023 recommended that the Victorian Department of Health, in collaboration with relevant Aboriginal Community Controlled Health Organisations and other stakeholders, prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence. This work is yet to be undertaken.

Currently, there is limited research into the comorbidity of pain and substance use, and no services offering specialised pain management for women with a history of AOD use. In Victoria, the sole medical detox unit addressing AOD alongside comorbid physical health issues at Eastern Health is not gender-specific. In short, women with comorbid AOD and pain management issues have very limited options for services that respond to their unique needs.

This submission aims to highlight the relationship between women's pain and substance use and outline actions that will address gaps in the current approach to the management of women's pain and minimise harm related to substance use.

Summary of recommendations

1. Enhance resourcing for Addiction Medicine Specialists to provide education and support about drug dependence in the context of women's pain to medical professionals.
2. Invest in research related to the intersections of women's pain and substance use and dependence with a focus on lifting workforce capability.

3. Incorporate gender-specific actions into the development of Victoria's incoming Alcohol and Other Drugs Strategy (as part of the AOD Statewide Action Plan).
4. Resource a cross-sector partnership between peak bodies for AOD, women's health, pain and General Practice to collectively lead capacity building in women's pain and AOD across these interrelated areas.
5. Enhance funding for the provision of gender-specific AOD treatment pathways in Victoria including culturally specific AOD services for Aboriginal women and those from priority populations.
6. Co-design the development of a gendered stigma audit tool that supports healthcare providers in identifying stigmatising policies and practices.
7. Develop an implementation plan to support the utilisation of SafeScript for safe and responsible use of medication for women with pain and support medical professionals with guidelines to support women with pain management options when drugs of dependence are contra-indicated.
8. Resource the AOD sector to enhance capacity for working with trauma including the development of access pathways to trauma-related statewide services.

Part 1: Literature Review

Pain and substance use

Pain is the most common symptom of disease and injury. A protective mechanism, in its simplest form, pain is a response to harmful stimuli that assist humans to navigate and survive their environment. However, the experience of pain is highly complex: highly subjective, both shaping and shaped by how we experience our bodies and environment and governed by a complex interplay of physiological and psychological processes.

The multifaceted nature of pain also reflects societal and cultural norms and expectations as well as the systems surrounding pain management. Managing chronic or idiopathic pain, which lacks clear biological origins, frequently involves using analgesic medicines to alleviate symptoms such as opiates, non-steroidal anti-inflammatory (NSAIDs), benzodiazepines and gabapentinoids (the latter mostly for idiopathic and nerve pain). The complex relationship between chronic pain and substance use, both in Australia and globally, has received increased attention in recent years, not least due to the opioid overdose epidemic that has devastated North America.

Chronic pain is associated with an increased risk of opioid and alcohol dependence[1]. Recent data from Deloitte Access Economics[2] shows that more than 68% of GP pain management consultations end in pain medication being prescribed. Most of the medicines used for pain management have psychotropic and dependence-forming properties and have limited efficacy in the management of chronic pain conditions. They are often associated with secondary health complications, especially when used long-term[1].

However, our social reliance on pharmacotherapeutic approaches to manage pain are long-standing, existing within a cultural context that prioritises a lifestyle of activity and purpose, which significantly shapes pain-related communication, assessment, and treatment decisions[1]. This, in turn, results in pain management models that favour interventions focused on curing rather than comprehensive, multi-disciplinary care. This can impede effective treatment, particularly for pain patients from vulnerable backgrounds. It is imperative that we expand social and cultural understandings of pain, both specifically in relation to physician attitudes and practices in pain management and more generally[3].

The management of pain with medications, particularly opioids, has been identified as a significant driver of substance dependence and related harms. Studies have found a high prevalence of chronic pain among individuals misusing prescription opioids, estimated at 48-60%[4]. Conversely, rates of opioid use in chronic pain populations vary widely from 0.05% to 81%[4]. Inadequate or inappropriate pain management can reinforce marginalisation and lead to risky self-medication or an overreliance on short-term pharmacological solutions without multi-disciplinary and/or supplementary supports[4]. The co-occurrence of chronic pain and substance dependence presents challenges in treatment, including opioid-induced hyperalgesia (increased pain sensitivity) and tolerance[5].

In addition to prescribed medications, many people use non-prescribed substances such as prohibited drugs and alcohol to manage their pain[2]. This practice is particularly prevalent among those with chronic pain conditions where traditional medical treatments have proven

inadequate[6]. The use of non-prescribed substances introduces additional complexities, including increased risk of substance dependence and associated health harms[7].

Gender and pain

The differences in the experiences of pain between men and women have been studied extensively. Researchers highlight the complex history of gender and pain, noting that women often report higher pain sensitivity and more frequent chronic pain conditions than men[8,9,10,11]. Women also face significant pain related to menstruation, pregnancy, and childbirth and are overwhelmingly at greater risk of pain-related disability[1]. Women are also more likely than men to experience migraines, tension headaches, facial pain, musculoskeletal pain, and pain from osteoarthritis, rheumatoid arthritis, and fibromyalgia, and to develop chronic pain syndromes following trauma[9,10]. Research has identified that women are more likely to have their pain dismissed, minimised or denied as hypersensitivity or psychological by healthcare providers [9,11].

Researchers additionally identify greater investment is required within clinical research into pain and related issues, which frequently excludes women resulting in understandings of disease and treatment modelled on the male experience without accounting for sex-related considerations[7].

Women and substance use

Research from NIDA[12] (2020) indicates that, compared to men, women use drugs differently respond to them differently and face unique treatment barriers, such as increased stigma and difficulties finding childcare or receiving treatments not adequately tested for women. It also found women may be more likely to take prescription opioids without a prescription to pain, even when men and women report similar pain levels and are more likely to misuse prescription opioids to self-treat for other problems such as anxiety or tension[12].

In Australia, research highlights a complex relationship between women, pain, and substance use. Women with chronic pain often report histories of abuse, which is associated with increased somatic symptoms and substance use[1,13]. Persistent pain in women has been found to affect multiple social domains, including psychological distress and causes difficulties in emotional connectedness[1,14]. Research by Campbell[1] (2017) found that women prescribed strong opioids for pain have complex demographic and clinical profiles, with two-thirds of their participants reporting that their pain had impacted their employment status, one in six reported barriers to pain treatment, and one-third unable to afford non-opioid prescription pain treatments. This aligns with other findings suggesting that chronic pain leads to socioeconomic disadvantage[2]. Research also identifies that women who experience multiple pain conditions, also experience poor physical health, and nearly half met the criteria for moderate to severe depression, with substantial minorities experiencing anxiety, agoraphobia, suicidal behaviour, and substance use disorders[1,15].

Patterns of and reasons for substance use among women are important indicators of how the experience of pain can be a significant risk factor for substance dependence and related harms. These patterns also indicated a disparity in the way in which women engage with the systems that are designed to support their pain, highlighting the need for tailored approaches in treatment and support services[1,16]. Research further indicates that women predominantly use

substances as a coping mechanism for psychological pain, navigating negative and/or traumatic experiences, stress, depression, and anxiety, rather than for experimentation or social defiance[17]. This bidirectional relationship between assault and substance use in women puts women at increased risk of trauma, mental illness and substance use[18]. This finding is further supported by the high rates of co-occurring mental illness and substance use disorders observed among women in prison[19]. Lynch et al. [20] (2013) found that women who use substances are more likely to exhibit co-occurring mental health issues such as mood disorders, anxiety, PTSD, and eating disorders while NADA[21] report that between 20-30% of women who consume alcohol also meet the diagnostic criteria for mental health disorders. Navigating care pathways in Australia is complicated due to the confluence of mental health disorders and substance use[21].

Gender, pain and substance use

Addressing the intersection of chronic pain, substance use, and gender-specific experiences is crucial for developing comprehensive and effective healthcare strategies that meet the diverse needs of individuals affected by these issues. Studies in both humans and animals have identified neurological differences between men and women relating to the experience of pain[23]. This finding is significant in terms of appropriate treatment models for women's pain with substances of dependence, as it identifies that the neurological map associated with pain in women has enhanced sensitivity compared to males. This enhanced sensitivity impacts the pharmacokinetic actions of medications which, in turn, has implications for overdose risk and treatment outcomes. Despite this evidence, this knowledge is not reflected in either policies or practices relating to pain management, AOD and their co-occurrence[7,23]

While opioid-like analgesics can be effective for pain management, they also carry risks of developing tolerance, dependence, and addiction[24]. Developing dependence on analgesic medications can lead to an array of harms, including dependence, use of prohibited substances, criminalisation and others. The US opioid epidemic is the most salient example of dependence on prescription drugs leading to prohibited substance use and dependence, and the myriad harms this entails[25]. Substance dependence, especially that involving prohibited substances, is associated with multiple health, social and economic harms, both to individuals, communities and society broadly.

The use of substances by women experiencing pain underscores the interconnectedness of different pain types, illustrating how experiencing one type of pain can increase the risk of developing multiple other pain experience.

Physical pain and substance use

Research identifies a pattern of persistent opioid use following hospital discharge in Australia, with women comprising approximately 50% of patients continuing opioid use post-discharge[26]. Hayman et al[27] (2017) found that women in Victoria were prescribed opioids at a higher rate than men, and they represented two-thirds of opioid-related hospital admissions between 2006 and 2013. These statistics underscore the high demand for pain management with analgesics among women and their heightened risk of developing opioid dependence.

Sex differences in pain analysis and treatment further complicate this relationship[28]. In the US, there has been a significant increase in opioid overdose deaths among women aged 30–64, with reported deaths increasing by 260% since 2017. The rate of drug overdose deaths involving any opioid increased by 492% during this period. Specific drugs saw even higher increases: synthetic opioids (1,643%), heroin (915%), benzodiazepines (830%), prescription opioids (485%), and antidepressants (176%)[29]. Globally, fatal overdose rates related to opioids and methamphetamines among women are increasing[30]. Despite high opioid use in the US, only 10% of women received healthcare services in 2017, likely contributing to transitions to prohibited substances such as heroin and fentanyl[25].

Alcohol use is also closely linked to chronic physical pain, exacerbating the condition over time[18]. Co-occurring mental health conditions such as anxiety, depression, and PTSD further complicate the management of physical pain and substance use[6]. This complex relationship between substance use and physical pain often stems from traumatic experiences and stressful life circumstances, emphasizing the need for comprehensive approaches in both pain management and substance use treatment[24].

Psychological pain and substance use

Psychological pain is often reported as being more intense than physical pain, a crucial consideration in understanding suicidality[18]. Neuroimaging studies show overlaps in brain activation patterns for psychological and physical pain, indicating shared neural pathways[31]. Traumatic events like assault and witnessing violence as well as childhood maltreatment significantly contribute to psychological pain and mental health issues in women[32,33]. Such pain often leads to substance use as a coping mechanism, exacerbating existing psychological distress[34]. Substance use is recognised as a survival strategy but comes with significant risks, as early trauma and alcohol dependence together worsen clinical outcomes[32,35].

Psychological pain profoundly affects self-perception and relationships, particularly for trauma survivors[20,24,32]. Psychological pain is exacerbated by intersecting factors like race, gender, and socio-economic status. Women from communities experiencing structural disadvantage often face trauma compounded by discrimination, marginalisation and other forms of structural exclusion, factors that increase the risks associated with substance use and fatal overdose[30]. The short-term relief provided by substance use contrasts with the long-term challenges of maintaining treatment, compounded by systemic biases in healthcare[30]. Research consistently shows a strong connection between psychological pain, and substance use among women in Australia and internationally[37]. Trauma exposure increases the risk of developing substance use complexities, while substance use can also increase predisposition to further trauma, empowering a vicious cycle of harm[24,37].

The prevalence of comorbid mental health presentations in Australian substance use treatment settings is high, with mood and anxiety presentations being particularly common[38,39]. These findings highlight the urgent need for integrated, trauma-informed approaches in substance use treatment for women, addressing both psychological pain and the resulting substance use.

Psychophysiological pain and substance use

Psychophysiological pain, sometimes referred to as psychosomatic pain, where psychological distress manifests as physical symptoms and vice versa, is significant in women's health, however, it is often overlooked[40]. Women are disproportionately affected by conditions like migraine, rheumatoid arthritis, fibromyalgia, and bladder pain syndrome[40]. Conditions such as vulvodynia exemplify this complexity, involving central hyperexcitability and emotional distress rather than tissue damage[40]. Healthcare providers' tendency to psychologise women's pain in conditions like vulvodynia can lead to feelings of devaluation and inadequate pain management[40].

This systemic dismissal of women's pain reflects broader gender biases, contributing to diagnostic delays and inadequate treatment and exacerbating both physical and psychological burdens[41]. As detailed with experiences of psychological pain, women with psychophysiological pain often use substances as a coping mechanism, increasing their risk of substance dependency and complicating treatment[6]. Addressing these challenges requires gender-responsive approaches in both pain management and substance use treatment, including specialised clinics and integrated care models[40].

Complex secondary implications for women who experience pain and substance use

Research also shows that women with substance use dependence experience a higher risk of a range of harms, including mental illness, housing insecurity and domestic and family violence[30]. In short, poorly managed pain can result in women experiencing significant and complex harms, heightened risks, and comorbidities.

Women facing inadequate pain management often transition to self-medication with alcohol or prohibited substance use, which can lead to a range of other social and health challenges. The common health and welfare comorbidities with substance use are well documented and include legal issues, family violence, mental illness, brain injury, disability and housing instability amongst others. Meyer[62] (2021) highlights that 98% of incarcerated women have endured victimisation and trauma including acquired brain injuries and 85% experienced domestic and family violence. While exact figures on criminalised women with pain histories in Victoria are lacking, indicative data suggest significant correlations based on a social determinants of health model, and the connection between our incarcerated women, and their use of substances to manage pain.

Pain is a deeply distressing experience, and people will go to great lengths to alleviate it. As documented, this understanding is widely accepted. However, this knowledge is not supported by social policy. For example, the 'war on drugs' approach to AOD regulation unjustly stigmatises some individuals for attempting to relieve their pain when they do so without the support of a healthcare provider. The exploitation of women who use drugs intersects with gender roles and poverty, perpetuating cycles of drug use and imprisonment for marginalised women and youth[16]. Australia's drug policies stigmatise people who use substances, including those using substances to manage pain including in cases of domestic and family violence[42]. The complex interplay of gendered violence, substance use, and discrimination exacerbates the

marginalisation of women within a punitive framework, rather than the alternative evidence-informed health framework, which sees substance use as a response to pain[43,44].

The National Drug and Alcohol Research Centre in Australia has highlighted the need for services that not only address substance use but also provide comprehensive support for related issues such as healthcare, housing, mental health, and domestic violence[42].

As detailed above, substance use has been identified as a tool for managing pain, whether physical, psychological or psychophysiological[16]. Addressing substance use in women requires a nuanced understanding of women's experiences of pain, the challenges they face in accessing effective pain management, and how pain and substance use intersect with other gendered hardships such as domestic and family violence.

Ironically, the presence of substance use is often a significant barrier to accessing crucial support services[44,45]. Studies by Birgin et al. (2022) and Cyrus (2021) show that service providers may hesitate to assist women experiencing both family violence and substance use due to a web of intersectional systemic biases. These circumstances result in a 'double bind', where the presence of substance dependence further hinders access to appropriate supports and management[46].

Pain management in Australia faces many challenges, such as societal reluctance and reliance on medication for pain, as well as difficulty accessing specialist and multi-disciplinary pain management. Addressing the biological, psychological, and social factors that contribute to pain and substance dependency would lead to more comprehensive and effective management approaches generally (i.e. regardless of gender). For women, tailored interventions that consider these sex and gender-specific factors are essential for improving women's pain management and reducing their risk of substance dependence and related harms.

Part 2: Perspectives from Women with Lived and Living Experience of Pain and Substance Use, and those within the AOD Sector

VAADA consulted with 32 women via a series of individual consultations and an open survey platform for women who have experienced pain and used substances of dependence. This was followed by a consultation with people currently working within the AOD sector and a series of discussions with AOD professionals and cross-sector peak bodies.

The following themes were identified because of these consultations which have informed our recommendations.

Patterns of substance use and experiences of pain

Amongst the women consulted and reinforced by the consultation with AOD colleagues, the predominant substances used by women experiencing pain included opiates (prescribed and illicit), alcohol, benzodiazepines and cannabis. Multiple women described experiences of polysubstance use and the use of illegally sourced pharmaceutical drugs to manage their pain.

Aligning with the research on pain experienced by women, those consulted had experienced pain across all three domains (physical, psychological and psychophysiological). Of particular interest is the number of women who identified with more than one pain experience, highlighting the complex relationship between physical, psychological and psychophysiological pain.

Women consulted identified a persistent theme of a lack of understanding of the nature and implications of pain. Women experienced disbelief, felt overlooked, and often belittled by the range of remedies suggested to address their pain. Women expressed feeling invalidated and ignored when they reported that their medication wasn't working or wasn't meeting their needs and this further exacerbated their distress and complicated treatment. This is best reflected in the words of the women consulted:

> *"Sometimes they tell me to just take a warm bath or use a heat pack. They don't understand how much pain I'm in"*
>
> *"No one has accepted that I have pain…They have all told me that it is all in my head"*
>
> *"One of the major reasons why I have been dependent on different substances over my lifetime is because of my chronic pain"*
>
> *"Internal struggle between staying pain free and staying abstinent"*
>
> *"I medicated myself with alcohol at first…used them (drugs)for the psychological pain"*
>
> *"Misdiagnosis is a big issue" alongside "long-term pain medication being prescribed for hormonal issues"*

Women explained that the *'disability'* experienced from being in pain directly impacted their sense of self and, therefore, their mental wellbeing. Women frequently reported that the health system's lack of understanding not only exacerbated their physical pain but also contributed to psychological distress. Healthcare providers' dismissal and belittlement left many women feeling isolated and unsupported in their health journeys. This lack of understanding and empathy has profound implications for women's health outcomes, highlighting the need for healthcare providers to be educated on the unique pain experiences of women with substance use issues.

The limited knowledge healthcare professionals had about the interaction of substances on pain and different treatments was another significant barrier. Women often transitioned from self-medication to prescribed medication without addressing the underlying cause of pain.

The nature of the pain experience was also reflected through the 'core ingredients' that women expressed as essential for the type of service that they felt would be most helpful. Women emphasised the need for comprehensive, compassionate care that addresses both physical and psychological aspects of pain.

> *"We need services that understand the full picture—both the physical and the mental aspects of pain"*

In summary, there is a critical need for a paradigm shift in the healthcare system towards a more holistic and integrated approach to pain management. This includes educating healthcare providers on the unique pain experiences of women, the complex interactions between pain and substances, and the importance of empathetic, patient-centred care. By addressing these gaps, the healthcare system can improve diagnostic accuracy, develop more effective treatment plans, and enhance the overall wellbeing of women experiencing chronic pain and substance use challenges.

Recommendation 1: Enhance resourcing for Addiction Medicine Specialists to provide education and support about drug dependence in the context of women's pain to medical professionals.

A Bi-Directional Relationship

Participants' reflections on the trajectory of their pain and substance use indicated a bi-directional relationship between pain and substance use. Women identified experiences of pain (psychological, physical, and other) both preceding and following substance use and dependence.

Reflective of the bi-directional relationship it was evident that the use of substances for women with pain was not just for potential analgesic effects but often to manage the psychological pain they experienced as a result of physical pain and feeling 'unheard' by the system.

Several women identified a cyclical relationship between the two conditions because of ineffective treatment of pain, its cause, and the prescription of drugs of dependence. This bi-directional relationship underscores the complexity of managing pain and substance use concurrently. One participant encapsulated this cyclical relationship by stating:

> "Pain drove my substance use then substance use drove my pain....strange relationship."

> "My psychological pain is the cause of my substance use, When I use substances, it stops me from remembering, reliving, stops me from overthinking all the dumb stuff in the past, and what was done to me, and all of the hurt that I have caused"

> "I am physically struggling, which is putting me under pressure with my pain psychologically"

> "My physical pain affects my mental health, and my mental health affects my physical pain. It's a cycle that no one seems to understand"

Multiple women described being bounced between services and systems without resolution of their pain. This combination of experiences of pain and negative system interactions significantly impacted their pathway to drug dependence and difficulty in achieving their recovery goals.

Enhanced mechanisms for identifying the nature of this relationship across multiple systems of health and wellbeing are essential to creating effective interventions to improve outcomes for women.

Recommendation 2: Invest in research related to the intersections of women's pain and substance use and dependence with a focus on lifting workforce capability.

What women need

The journey through pain management for women sheds light on the systemic challenges within the healthcare system. For example, one participant spoke of her experience of being started on antidepressants as a 'quick fix' only later to receive a diagnosis of fibromyalgia. Whilst the use of anti-depressants may be indicated for fibromyalgia, the ease of access to this medication before understanding the cause of symptoms is indicative of how women describe their experience in accessing the health care system for pain, particularly with psychophysiological pain.

> *"Every time I try to get help for pain, the GPs want to put me on antidepressants"*

This approach fails to adequately listen to and validate women's experiences and preferences, revealing a systemic disconnect between patient needs and the treatments provided. This is reflected in the participants' statements:

> *"GPs don't take women's pain seriously…No one is listening"*

> *"Listen and take notes and hear what I am saying. Believe me, don't dismiss something because we can't see it"*

Stakeholders also revealed difficulties accessing AOD withdrawal and rehabilitation services because of their pain. A lack of acknowledgement of the implications of abstinence for an individual with co-occurring pain and substance use when the drugs of dependence were the person's only pain management strategy, was reported. Alongside the physical pain associated with withdrawal that exacerbates an individual's experience of pain, there was a lack of acknowledgement of post-acute withdrawal symptoms and the pervasive stigma surrounding pain, especially when related to a history of drug dependence. Women report that the intense physical and emotional pain of withdrawal is often overlooked, and there is a total lack of medical withdrawal support for clients who disclose a history of drug dependence.

> *"The pain of withdrawal is glossed over"*

This highlights the healthcare system's reliance on medication for pain without a thorough understanding or exploration of alternative treatments.

Stakeholders called for a paradigm shift towards trust, ethical care, and patient-centred approaches within the healthcare system, and targeted destigmatising campaigns.

They emphasised the need for more ethical, client-centered communication between services and programs focusing on trust and ensuring that care pathways align with patient needs and preferences. It highlights the importance of empowering women with the knowledge and agency to navigate their treatment options effectively.

"More ethical, client-centered communication between services and programs, as well as GPs"

Consultations with women clearly identified that some of the most sought-after features of treatment for their co-occurring pain and substance use were simple to provide, including time, connection, validation and listening. The complexity of most women's experiences highlighted that a service offered without these elements would invariably result in part of the puzzle being missed and thus the issue becoming even more entrenched.

It is important to acknowledge that the nature of the health system can make the introduction of these requirements challenging and that the lack of these elements is commonly not a result of the individual clinician's lack of intent or capacity. Consulting with medical professionals, it was clear that the requirement for short appointments and limited access to addiction studies within undergraduate medical degrees are not supportive of these elements.

Recommendation 3: Incorporate gender-specific actions into the development of Victoria's incoming Alcohol and Other Drugs Strategy (as part of the AOD Statewide Action Plan).

Recommendation 4: Resource a cross-sector partnership between peak bodies for AOD, women's health, pain and General Practice to collectively lead capacity building in women's pain and AOD across these interrelated areas.

Systemic barriers and oppression

Women shared powerful examples of the intersectional challenges they faced in terms of managing pain, substance use, and systemic barriers. These narratives highlight the urgent need for a collaborative, informed, and coordinated approach to healthcare.

The experiences shared by stakeholders underscore the complexity of managing pain and substance use in the face of systemic barriers. These barriers include not only the stigma and lack of support within the healthcare system but also the risk of exploitation and additional trauma that women face.

Whilst it was acknowledged that substance use is often used as a coping strategy for pain, this coping mechanism was also identified by women as being weaponised at time. Several examples of exploitation and the relationship between pain, substance use, family violence and trauma were cited.

"When I started using, the guy refused to teach me how to use because he said that then I could do it whenever I want. I learnt, and now it has been even harder to give up"

"I experienced family violence. We both used substances, but they made me pay for my substance use"

The psychological impact of these experiences is profound, often leading to feelings of entrapment and severe mental health challenges.

This powerful metaphor reflects the intense psychological distress experienced by individuals who are not only managing pain and substance use but also the trauma of substance use exploitation and violence – wrapped within a system that ignores their experience of pain. The use of self-medication techniques as an alternative to a responsive and empathic healthcare system was strongly evidenced amongst women consulted.

> "When I can't access my prescription medication due to overuse, I use [prohibited] drugs."

> "I used alcohol to 'control' the pain. Before long, it controlled every aspect of my life. I would also take extra opioids than prescribed at times."

These narratives highlight the need for a healthcare approach that is not only informed and coordinated but also deeply empathetic. It is crucial to recognise the intersectional nature of these challenges and to develop systems and practice strategies that address the underlying causes of pain and substance use, including the systemic barriers and exploitation that exacerbate these issues.

Additionally, women also noted challenges with accessing NDIS support due to systemic barriers and misunderstandings about pain, having a significant impact on functional living. These challenges significantly impacted their pathway to drug dependence and difficulty in achieving their recovery goals.

Recommendation 5: Enhance funding for the provision of gender specific AOD treatment pathways in Victoria including culturally specific AOD services for Aboriginal women and those from priority populations.

Stigma

It is clearly evident that one of the key drivers for the limitations related to adequately addressing women's pain and substance use is stigma. Women cited multiple experiences of stigmatising attitudes that negatively impacted their motivation to seek support for their AOD use and resulted in minimisation of their pain.

> *"Sometimes I don't ask for the medications when I need them because I'm worried that they will think I'm just drug-seeking"*

> *"I got called a doctor shopper, nothing they could do"*

The feelings of judgment appear to be amplified for women who described a sense of *"not being taken seriously, being disregarded"* in terms of their pain, and then being *"shamed for seeking drugs to manage their symptoms"*. This pervasive stigma surrounding pain that is not visibly evident is further amplified by healthcare professionals' reluctance to diverge from a medication-focused approach, often dismissing the individual's pain as irrelevant, absent, or psychosomatic without thorough investigation or consideration of alternative treatments.

Women shared stories of general practitioners (GPs) acting as *"drug dealers"* and the absence of meaningful support during critical times of need, underscoring a systemic failure to offer compassionate, patient-centred, timely care. Women expressed frustration with the availability of medications and described instances where they *"felt pressure to accept prescriptions [they]*

didn't want or [felt they] didn't need." Additionally, it was strongly noted that all women did not feel they were adequately advised of the addictive nature of the medications they were being prescribed or the risk associated with withdrawal. Women reported that they were then 'punished' for developing a dependency on the same medications. These experiences underscore a critical need for healthcare providers to prioritise patient communication and ensure the underlying presenting issue is addressed with the medication being prescribed.

Women often experience limited access to appropriate medical care and face barriers to obtaining prescribed medications due to concerns about addiction or misuse. Instead, they resort to using prohibited substances to alleviate their pain, driven by desperation and the failure of traditional medical approaches to adequately address their needs.

> *"Once I was unable to access prescription medication [pharmaceuticals] I moved to similar substances from the street or the web."*

The stigma attached to substance use further isolated the women consulted, exacerbating feelings of shame and guilt. Moreover, these women frequently encounter punitive responses from healthcare and community services, including being 'dobbed on' to authorities or denied necessary medical treatment. This experience was also true for women using prescribed medications for pain management. This reinforces a cycle of mistrust and reluctance to engage with healthcare and community service providers, perpetuating their reliance on prescribed and prohibited substances for pain relief.

Women felt that community services had little understanding of medications, and their effects, and felt as though they were excluded from receiving support or punished for their substance use. This appeared particularly true for some women on opiate-based pharmacotherapy who experienced stigma when accessing healthcare services for their pain. We heard examples of women who were not provided adequate pain relief during labor because of substance dependence, and whose treatment for physical pain was insufficient as a result of risk-aversive practices as opposed to responsive care. This perception that health professionals cannot be trusted, contributes to feelings of alienation and reluctance to seek necessary medical help, whether that be for support for the dependency on the medication they are prescribed, or for any complexity within their experience. Addressing this issue requires healthcare providers to build trusting relationships with all patients, ensuring confidentiality and support rather than exacerbating fears of punitive measures. Addressing these systemic issues requires a compassionate and non-judgmental approach from healthcare providers, prioritising harm reduction strategies and tailored pain management plans that acknowledge the complex realities of women's lives.

Only through such systemic changes can the barriers to effective care be dismantled and trust rebuilt within the healthcare system.

Recommendation 6: Co-design the development of a gendered stigma audit tool that supports healthcare providers to identify stigmatising policies and practices.

Prescription Drug Use and Abuse amongst women with pain

Most women identified that they had used prescription medication throughout their experience of pain, which would not be unusual in comparison to the whole population.

The progression of prescription drug use to misuse, then dependence, and possible commencement of prohibited substances without actually addressing the pain, is of particular concern.

> *"No one ever talked to me about how addictive codeine is"*

> *"It took 8 years to be diagnosed even though I presented with chronic pain each time. They did not believe me. Then, I was prescribed opiates which I used in increasing amounts. Then I was told I was an addict"*

These patterns of treatment appeared to incite feelings of being disbelieved and overlooked by women.

Conversely, women reflected challenges in accessing appropriate medication for pain via general practitioners. The issue of risk appeared to be the driver for this challenge in that many GPs are now reluctant to prescribe drugs of dependence and if they do so it is often time-limited and again without a plan to address the cause of the pain. This challenge led some women to use other substances of dependence to manage.

> *"GPs are reluctant to prescribe opioid pain relief which I find the best for management of my conditions."*

Of interest was the number of women who referred to SafeScript in their interviews without prompting. Women used terminology like 'being flagged' on SafeScript when describing the challenges they faced when attempting to access treatment for their pain. While the introduction of a real-time prescription monitoring service within Victoria was welcomed by the AOD sector to reduce harm, it appears that the lack of focus on culture and stigmatising attitudes in the implementation of SafeScript may have resulted in a system that is punitive rather than supportive for women experiencing pain who are often left to rely on prescription medication for relief as no other options are made available.

Access to treatment for women's pain was reported as often being inaccessible to women with pain who are vulnerable because of substance use or dependence. Allied therapies such as physiotherapy or specialist pain clinics were frequently cited as being too expensive for women to access. Even if access is possible, it was reflected that it is often only short-term and therefore does not adequately meet the needs of women with chronic or episodic pain.

One AOD specialist reflected on the need for more Addiction Physicians and Nurse Practitioners to ensure holistic care can be provided to women with pain and substance use. The ability for a woman to see an Addiction Physician, for example, would enable a tailored approach that is equipped to manage the delicate balance between the use of prescription medication and/or opiate replacement therapies and management of pain, amongst other health conditions. Ideally, an expansion of these workforces would also provide an opportunity for mentoring and secondary consultations to the broader medical profession.

Most women consulted were not presently on any opiate replacement therapy (ORT) such as Methadone, Suboxone or Long-Acting Injectable Buprenorphine (LAIB). Considering the large proportion of women who had been prescribed opiates and later become dependent, a potential opportunity for targeted research on the use of ORT for women with pain is evident. Use of ORT for pain is increasingly common amongst the broader population.

Consultations with AOD professionals also identified a missed opportunity for use of ORT with women with chronic pain.

Recommendation 7: Develop an implementation plan to support the utilisation of SafeScript for the safe and responsible use of medication and support medical professionals with guidelines to support women with pain management options when drugs of dependence are contra-indicated.

Trauma, pain and substance use

The connection between experiences of trauma, pain and substance use was almost universal amongst those interviewed and this experience was mirrored in consultations with those working in the AOD sector. Unfortunately, participants did not identify a healthcare system that appeared to have the awareness or skill to manage these presentations. Participants revealed that the lack of a supportive response to their experience of pain often triggered responses rooted in traumatic physiology including perceived lack of control, increased anxiety, irritability or avoidance.

"I feel like a prisoner of war, especially when I awake from my nightmares."

Whilst the AOD sector has invested in capability development related to trauma-informed care, the capacity for the AOD sector to implement interventions amongst those presenting with trauma is limited. Enhancing understanding of the nature of the relationship between pain, trauma and substance use will aid in the early identification of traumatic injury and reduction of harm from substances to manage pain and trauma.

Recommendation 8: Resource the AOD sector to enhance capacity for working with trauma including the development of access pathways to trauma-related statewide services.

Conclusion

This submission underscores the critical need for sex and gender considerations in pain management and the provision of AOD-related supports and services. Despite the wealth of evidence available, gaps in understanding sex differences in pain management and AOD service delivery persist.

Clinical research consistently shows that women experience more severe, frequent, and longer-lasting pain compared to men, yet their pain is often dismissed or inadequately treated. This is compounded by gender norms and biases, which influence how women's pain is perceived and managed by healthcare providers. In some cases, substance use serves as a coping

mechanism for managing pain, trauma and/or psychological distress, which if not responded to adequately, can lead to dependency, illicit substance use, adverse health outcomes, and in some cases, criminalisation. Women in under-serviced communities face additional barriers to accessing timely, appropriate and responsive support and treatment.

Current treatment modalities fail to integrate gender-responsive strategies, which are essential for improving treatment outcomes. These issues require a comprehensive and integrated approach that considers the multifaceted nature of pain, gender, and substance use. Gender-responsive strategies are crucial for developing effective treatment models – both for pain and substance use, especially when they co-occur. Internationally, there is a growing recognition of the need for gender-specific AOD services. Countries like the United States and some European nations have started to adopt gender-responsive approaches, recognising the unique barriers women face in accessing AOD treatment.

In Victoria, the limited availability of women-specific AOD services highlights the urgent need for expanding specialised clinics and integrating gender-responsive strategies into existing services. Addressing the gaps and biases in the treatment landscape is crucial for providing comprehensive care to women experiencing pain and substance use issues.

The recently announced development of a Victorian AOD Strategy represents an important opportunity to address these gaps. The strategy must adopt and incorporate a gender-based lens that recognises women's experiences and needs when it comes to pain management, substance use and the provision of related services.

This will enable pain management clinicians as well as the Victorian AOD sector to address the biological, psychological, and social factors that contribute to pain and substance use, leading to more comprehensive and effective treatment approaches and outcomes. Tailored interventions that consider and are responsive to sex and gender-specific factors are essential for improving pain management and reducing the risk of harmful substance use among women who experience pain.

VAADA, in providing this submission, hopes to bring specific attention to the relationship between pain and substance use. We look forward to supporting the responsiveness of health and wellbeing services for women, including those that support women experiencing pain.

Our recommendations indicate a need to apply an intersectional lens to the challenges women face that fosters a cross-sectoral, principled and evidence-informed approach to reduce the harms experienced by women who use substances and experience pain. This includes by balancing the challenge of adequately addressing pain whilst providing time, validation and effective solutions to the root cause of pain.

Our shared goal is to improve the health care of women experiencing pain.

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