Falling Through the Cracks: Managing Concurrent Pain and Substance Use

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Symposium aim: To explore the intersection of pain and substance use through primary care, specialist pain management, pharmacy and lived-experience perspectives, and to identify how health systems can improve outcomes for people living with pain and substance use disorder (SUD).

PRESENTATION 1: General practice and prescription opioid dependence — supporting people living with pain and opioid dependence

Presenting Author: Dr Hester Wilson

Introduction: People living with chronic pain and opioid dependence often have complex, overlapping needs that sit uncomfortably within health systems divided between pain care and alcohol and other drug (AOD) services. General practice is where these needs most often converge. GPs support people over time, helping them navigate pain, dependence, and the realities of daily life.

Method: The mixed methods research utilises qualitative studies with GPs and patients, and practice-based approaches to reviewing long-term opioid use, managing chronic pain, and providing opioid dependence treatment (ODT) in general practice.

Key Findings: GPs provide relational and longitudinal care for people in ODT, grounded in trust, continuity, and shared decision-making. Managing comorbid chronic pain and opioid dependence is challenging, with GPs reporting challenges initiating sensitive conversations,

limited confidence and skills and concerns about impacts on therapeutic relationships, all which can hinder diagnosing opioid dependence and ODT engagement.

Many people receiving ODT also require support for persistent pain. In practice, this means balance safety, function, and quality of life, while minimising harm. Fragmentation between pain and AOD systems complicates this work, leaving GPs to bridge gaps without consistent guidance.

Stigma further affects treatment engagement and outcomes. Non-judgemental, ongoing care from a trusted GP is central to improving experiences and results, as is access to multidisciplinary supports like pain services, psychological care and addiction expertise.

Discussion and Conclusions: Caring for people with pain and opioid dependence is core general practice work. Effective care supports function, stability, and quality of life, with ODT providing a foundation for safer pain management. GPs require greater structural and clinical support.

Implications for communities, practice and policy: We need better integration between services and settings; expanded multidisciplinary access; reduced stigma; and policy that recognises GP led, person-centred care as key to pain management within ODT.

PRESENTATION 2: Pain management models and engagement in people with opioid dependence: Approaches in specialist pain clinics

Presenting Author: Dr Tim Ho

Background: People with chronic pain and prescribed opioid dependence often fall through the cracks between pain and addiction services. Many don't meet opioid use disorder criteria, limiting access to opioid treatment programs, and others may not be offered a pain management program, or may struggle to engage with standard programs. GPs frequently coordinate opioid tapering, but broader multimodal multidisciplinary supports are not always available.

Description of Model of Care: This presentation reviews multidisciplinary pain management models within pain clinics, including stepped and matched-care approaches that align program intensity with patient need. It considers how standard pain management programs and opioid treatment programs apply to people with co-occurring chronic pain and prescribed opioid dependence, and where consensus on diagnostic criteria and modified integrated care pathways is required to improve access tailored opioid treatment and pain management.

Implementation: Pain management programs can improve function, mood, self-management and healthcare use when appropriately matched to patient need. However, people with high distress, trauma histories or repeated experiences of stigma may not benefit from standard psychoeducational or CBT-heavy group models without preparation, relational engagement and coordinated medication planning. Inconsistent diagnostic criteria

further contribute to fragmented care.

Discussion and Conclusions: The central implementation challenge is engagement and requires establishing safety, trust and readiness. Trauma-informed approaches may help by recognising shame, threat responses and the need to “meet before we move.” Standard pain and opioid treatment models remain important, but require adaptation and better integration for patients with prescribed opioid dependence and chronic pain.

Implications for communities, practice and policy: Clearer diagnostic frameworks and shared care pathways are needed between pain services, addiction medicine and primary care. Policy should support integrated, non-stigmatising models that distinguish prescribed physiological dependence from uncontrolled opioid use, while improving access to tailored pain management, opioid dependence treatment and trauma-informed care.

PRESENTATION 3: Managing pain in the context of substance use disorder: a case series from community and regional hospital pain services

Presenting Author: Pene Wood

Introduction: People with a history of substance use disorder (SUD) can have variable experiences when presenting to health services for pain management, including for acute and persistent (chronic) pain. They may encounter fragmented, risk-averse, and at times stigmatising care. These experiences can be influenced by limited clinician experience and knowledge, misinformation, service availability, regulatory concerns, and implicit bias. Pain services are often required to balance analgesia, safety, and equity within systems not designed to support clinical complexity.

Method: This practice-based case series describes patients presenting to a community health pain clinic and a regional hospital pain service between January and June 2026 with co-morbid pain (acute or persistent) and a history of SUD. Cases were purposively selected to reflect diversity in pain type, substance use history, and care pathways. Each case was analysed using a structured framework that examined presenting conditions, clinical course, management challenges, outcomes, and opportunities for improvement.

Key Findings: Across cases, recurring challenges included limited access to non-pharmacological pain management options, inconsistent approaches to opioid risk management, variable clinician experience with pharmacological treatments for SUD, and patients’ needs and preferences not always being prioritised. Clinician discomfort navigating the intersection of pain and SUD was common, contributing to uncertainty and fragmented care.

Discussion and Conclusions: The cases highlight how current models of care frequently place the burden of navigating risk, coordination, and service gaps on patients and individual clinicians. Even well-intentioned practices can inadvertently exacerbate harm where systems lack flexibility, continuity, and integrated addiction expertise.

Implications for communities, practice and policy: These real-world cases underscore the need for integrated, multidisciplinary pain services that centre consumer preferences, embed addiction expertise, and expand access to non-pharmacological interventions. Policy and service redesign should prioritise continuity, shared decision-making, and workforce support to improve outcomes for people living with pain and SUD.

PRESENTATION 4: Pain management for people with OUD – what does the evidence show, and what is important to people when receiving pain management

Presenting Author: Dr Louisa Picco

Background: Co-occurring chronic pain and opioid use disorder (OUD) are highly prevalent and present considerable challenges for effective treatment. Non-pharmacological interventions are one approach. This presentation aims to synthesise the current literature and explore consumer experiences and preferences related to non-pharmacological interventions for people with concurrent chronic pain and OUD.

Method: A scoping review was conducted using Medline, Embase, Scopus, CENTRAL, and grey literature searches. Studies examining non-pharmacological interventions for adults with concurrent chronic pain and OUD were included. This was complemented by face-to-face workshops with consumers with chronic pain with recent opioid dependence treatment experience. Workshops explored experiences of receiving pain treatment, along with their preferences for non-pharmacological interventions and preferred delivery settings.

Key Findings: Ten studies were included and related to mindfulness (n=3), cognitive behavioural therapy (CBT) (n=1), physical therapy (n=1), digital health (n=1) and multimodal (n=3) non-pharmacological interventions. Mindfulness, physical, and multimodal interventions appeared to have the greatest reductions in pain severity and intensity. Workshop participants reported inconsistent access to non-pharmacological interventions, with massage and physiotherapy being the most commonly accessed. Stigma emerged as a significant barrier to accessing and receiving care, substantially impacting consumers' experiences. Consumers expressed a strong preference for receiving non-pharmacological pain treatment within existing alcohol and other drug services, emphasising the importance of person-centred, non-judgmental, individualised care, delivered within a flexible pain management program.

Discussion and Conclusions: Evidence for non-pharmacological pain interventions in people with concurrent pain and OUD are limited. Co-designing interventions with consumers is essential to addressing their needs, while also addressing known barriers such as stigma which can hinder treatment engagement and care.

Implications for communities, practice and policy: Consumer involvement is critical to developing tailored, accessible, and effective non-pharmacological pain interventions for people with chronic pain and OUD.

Discussion Section: The discussion will centre on the shared challenges that arise where pain and substance use disorder intersect, drawing together insights from primary care, pain medicine, pharmacy, research and lived experience. Discussants will include presenters and Sarah Lord from Harm Reduction Victoria, who will consider the presentations through a lived-experience lens. Anchored in real-world cases, the conversation will explore how fragmented systems, stigma and regulatory pressures shape care, often placing the burden of coordination and risk management on patients and individual clinicians. Audience participation will be encouraged to identify what currently feels unworkable and to explore what meaningful collaborative care between GPs, pain services, AOD and pharmacists could look like in practice, with the aim of informing more compassionate, coherent and effective models of care.