“We’re not stupid, we’re just doing the best we can”: Australian GP perspectives on gabapentinoid prescribing, non-medical use, and dependence

Amy G. McNeilage[1,2], Suzanne Nielsen[2], Bridin Murnion[1,3], Claire E. Ashton-James[1]

[1]Sydney Medical School, The University of Sydney, Sydney, Australia, [2]Monash Addiction Research Centre, Monash University, Melbourne, Australia, [3]School of Clinical Medicine, The University of New South Wales, Sydney, Australia

Presenter’s email: amy.mcneilage@sydney.edu.au

Introduction: Gabapentinoid prescribing has increased substantially in Australia, alongside growing concern about non-medical use, dependence, diversion, and overdose risk, particularly in the context of polysubstance use. While prior qualitative work has examined lived experiences of use and dependence, little is known about how general practitioners (GPs) understand and navigate these risks.

Methods: Semi-structured interviews were conducted with 17 Australian GPs between January and March 2026. Participants practised across metropolitan, regional, and rural settings, including private general practice, community drug and alcohol services, and correctional health. Interviews explored gabapentinoid prescribing decisions, perceived benefits and harms, non-medical use, dependence, deprescribing, and broader system influences. Data were analysed using reflexive thematic analysis.

Results: Four interrelated themes were identified. First, prescribing was described as a pragmatic response to structurally constrained pain care, including short consultations, limited access to affordable allied health, and long specialist waitlists. Second, gabapentinoids were often positioned as a ‘safer alternative’ following opioid restriction, despite limited and inconsistent effectiveness and recognition of dependence and overdose risk. Third, harms were unevenly visible: GPs in addiction, correctional, and lower socioeconomic settings reported greater exposure to diversion, high-dose use, dependence, and polysubstance-related harms, while those in more affluent private practice often perceived these issues as uncommon. Fourth, prescribing involved therapeutic compromise and moral tension, as GPs sought to relieve suffering while acknowledging these medicines were often suboptimal.

Conclusions: Gabapentinoid prescribing in Australia occurs within a context of structurally constrained pain care and pressures to reduce opioid prescribing. Harm related to non-medical use and dependence may be concentrated in specific contexts, shaping divergent perceptions of risk.

Implications on communities, practice, and policy: Findings shift the focus from individual prescriber behaviour to structural accountability. Harm reduction efforts should prioritise equitable access to multidisciplinary pain care and focus on populations disproportionately exposed to dependence and polysubstance-related harms.

Disclosure of Interest Statement: *The authors declare no conflicts of interest. AGM receives an Australian Government Research Training Program Scholarship and a supplementary PhD scholarship from the Pain Foundation. SN is supported by an NHMRC Investigator Grant Fellowship (2025894).*