Appendix D Qualitative evidence

Study	Anderson 2013[22]
Aim	To examine patient and health professional understanding of what it is like to use antidepressants from initiation of therapy and to determine factors that influence decisions about adherence to antidepressants in terms of perceived outcomes and determining factors that influenced their views.
Population	A maximum variation sample of eighty people with different types of depression and treatment experiences, different age groups, ethnicities, and social classes were recruited from a wide variety of locations across the UK. Adults n=42; male/female:16/26 age range: 20-75 Young people n=38; male/female:9/29; age range: 16-27
Setting	University of Oxford
Study design	Secondary analysis of qualitative interview transcripts.
Methods and analysis	A supplementary secondary analysis of the Healthtalkonline database exploring patients' experiences of using medicines for depression was performed. Interviews of the primary study were held at the University of Oxford. The data had been previously coded into broad codes of experiences of medicines and side-effects, decisions about treatments etc. In the new analysis that was performed, a more in-depth focus was taken on emergent issues around the use of antidepressants which were not addressed or only partially addressed by the primary research. Thus, data about issues around antidepressant use was examined in more depth. In the initial study interviews ranged from 90-180 minutes and were audio or video recorded, transcribed and returned to the participants for review. Emerging themes were identified using a 'modified grounded theory' approach and multiple levels of analysis. The researchers coded the complete transcripts exploring the data for broad themes regarding the use of medicines across the data set as well as themes unique to antidepressants. Statements referring to similar topics were categorised together to form a basic coding framework which was extended as the content within each category increased. This process was iterative; whereby it was repeated until no new statements relating to antidepressants could be found. The concepts from the data were developed into new themes; two researchers and a public health doctor and academic pharmacist met to discuss emergent themes and develop a preliminary coding framework which was applied to another subset of transcripts and inter-rater reliability checks were made by the researchers. All transcripts were then coded by the main researcher and were then checked by the other researcher.

Study	Anderson 2013[22]
Findings	**Information on their need for ATDs**
	Many participants said that being prescribed ATDs was vital for them and gladly accepted the treatment option, with the medicines being viewed as important to maintain a normal life in a few cases. However, a tension was observed between participants' feeling that it was essential to take the antidepressant and whether it was actually needed for example with some reporting feeling reluctant and apprehensive about taking their prescribed antidepressants, thinking their effects are likely to be short term, that they are not going to help resolve the depression or because of concerns over their side-effects. Many raised concerns about whether or not they actually needed their medicines **before treatment initiation**. Some people resisted taking antidepressants and many respondents' accounts revealed **dilemmas and uncertainty about use of medicines continued as treatment progressed.**
	Support stopping ATDS
	Some participants talked about not wishing to be on ATDs for life but not yet being able to come off them.
	Information on the long-term adverse effects of ATDs
	Some participants were worried about the dangers of being on the drugs long-term and questioned why they are not told about 'the dangers.' Many reported various side effects which they considered most troubling to them such as dizziness, sleep disruption. Many highlighted they had lost their thinking capability and/or memory as a result of long-term antidepressant medicines or experienced unexpected difficulties in performing their routine work while they were taking medicines. Adverse effects often appeared to amplify the degree of dissatisfaction with doctors or the health care system or altered their medicine behaviour (e.g., leading to discontinuation or withdrawal).
	General information about the medicine & their condition
	Participants expressed strong views about wishing to be informed about their actual health conditions and medicines **before treatment initiation** Disconnected relationships with doctors were precipitated if patients were less informed about their health conditions and their prescribed medicines. A persistent tension was observed between 'what was promised' and 'what was actually delivered' in practice. Patients' expectations of their antidepressants were primarily expressed in terms of testing out the medicines and/or validating them by gathering information on them. Lack of information on their ATDs appeared to be a key issue of dissatisfaction for many respondents' expectations of them. Respondents often sought information from the health care system or public sources and often felt the information they received from doctors was inadequate. Very few participants reported receiving helpful verbal information from their doctors; most reported receiving little or no information about depression and their antidepressants (e.g., side effected, length of treatment, expected treatment outcomes and benefits). Participants reported seeking out information from other sources, such as books, broadcasts, media, the library, friends and the Internet.

Study	Anderson 2013[22]
	Doctor-patient relationship/ need for advocacy & mutual decision making
	Participants referred to dissatisfaction with the doctor-patient interaction in terms of lack of attention or acknowledgement on the part of the doctor (for example, dismissive reactions or pre-occupation with note taking) and superficial responses. Examples included thinking that the physician did not spend enough time with them, did not communicate with them, did not listen well to them, did not supply them with up-to-date information about their medicines and did not behave as if the relationship were a partnership. Respondents described how some doctors decided too quickly to prescribe antidepressants, so curtailing discussion. Many were dissatisfied with the working style of their doctors experiencing dismissive attitudes or reporting that the extent to which their condition was real was challenged by their psychiatrist.
Limitations and applicability of evidence	Overall CASP rating: very minor concerns (due to the potential influence of the researchers on the findings not being discussed and very minor concerns over potential bias in recruitment with participants having already been selected for a different project). No concerns over applicability

Study	Anderson 2015[21]
Aim	To explore people's experiences of starting antidepressant treatment. This paper combines data from three qualitative research studies, in which the main focuses were slightly different: UKa & Australia studies focussed on 'Experiences of depression' and the UKb study focussed on 'Experiences of using antidepressants.'
Population	Men and women who had taken antidepressants for depression. n=114 total sample size (n=108 interviews conducted); M:F 45:69 This paper combines data from three qualitative research studies: UKa (2003-04) n=38; M:F 16:22 UKb (2012) n=36; M:F 13:23 Australia (2010-11) n=40; M:F 16:24 Age groups in years (total sample n=114): 20-29 n=25; 30-39 n=33; 40-49 n=27; 50-59 n=22; 60-69 n=9; 70-79 n=7; 80-89 n=1

Study	Anderson 2015[21]
	Ethnicity (total sample n=114): White British n=61; Anglo Australian n=26; Black n=1; Asian n=1; American n=1; British Indian n=1; Jewish n=2; British Iranian n=1; White European n=5; White Irish n=2; Chinese n=1; European Australian n=2; Hispanic n=1; Malaysian n=1; Rwandan n=1; Vietnamese n=1; Chinese Anglo Australian n=1; Anglo Canadian n=1 Stratification: Starting; Antidepressants (all)
Setting	UK and Australia
Study design	Thematic analysis of interviews; combined analysis of three qualitative studies (all conducted by the authors)
Methods and analysis	This paper combines data from three qualitative research studies that the authors conducted in the UK (studies (1—UKa) and (3—UKb)) and Australia (study (2); total sample size n=114). Participants were recruited for the original studies through a variety of routes including newsletters, websites, support groups, word of mouth and via health practitioners. Most interviews were conducted in participants' homes with just the interviewer and participant present, using a narrative style with subsequent prompting on topics including responses to a diagnosis of depression and being prescribed an antidepressant. Interviews were digitally recorded and transcribed verbatim. Participants were interviewed until no new themes arose. Both the original studies, and the analysis for this paper used a qualitative interpretive approach combining thematic analysis with constant comparison. Relevant coding reports from the original studies (generated using NVivo) relating to initial experiences of antidepressants were explored in further detail, focusing on the ways in which participants discussed their experiences of taking or being prescribed an antidepressant for the first time.
Findings	**Sources of information**
	While in the past it had been difficult to find information about medicines being prescribed, the internet makes it a lot easier to access relevant health information. Participants had used the internet to find information about different types of antidepressants and side effects, as well as to find out about others' experiences with them.
	Experiences of others
	Participants talked about how finding information about others' experiences with antidepressants helped them. People found that using internet forums to learn of others' experiences with the drugs helped them understand their own experience better.
	Information and support through consultation
	Some participants described positive experiences of consultations in which there was a good discussion of the patient's views, fears and apprehensions and previous experiences of taking antidepressants. For these participants, being listened too and given sufficient time and information was universally recognised as positive and valuable, and key to the trust and rapport established between them and their health practitioner. These initial dialogues appear to be key to people

Study	Anderson 2015[21]
	developing a sense of agency with respect to their decision-making about taking antidepressants. Having a good relationship with a doctor was an important indicator of whether people would discuss their need for information about adverse events.
	Taking an antidepressant for the first time
	Participants talked of wanting to find out more information before taking their first antidepressant tablet. In the absence of information from their doctors, some participants were reluctant to start their subscription. One participant described having second thoughts about starting their antidepressants after reading an article online; in this case, a second chat with their GP was required before deciding whether to take the drug.
	Expectations
	This study found that people can feel unsure about what to expect once they take the antidepressant, and that it can be difficult to make decisions and think things through when very ill with depression. People were uncertain about how long it would take for the antidepressant to take effect, the extent to which it might help, and about what to expect in the first few weeks. They were concerned that it could make them feel worse rather than better and fretted over how long they would need to take an antidepressant for.
Limitations and applicability of evidence	Overall CASP rating: No concerns Mostly applicable to review but primarily focussed on patient experience

Study	Choi 2021[84]
Aim	To explore older adults' willingness to stop or lower the dose or frequency of their chronic benzodiazepine with the goal of developing a patient centred intervention to support older adults during deprescribing.
Population	Adults aged 60 years and older who had been taking benzodiazepine for at least 3 months for insomnia or anxiety. Recruitment continued until thematic saturation reached. n= 21; male/female/transgender: 6/14/1; white/black: 20/1; age (mean, SD): 66 (4.7) years; Completed interviews: 20/21 (1 interview not completed due to technical difficulties)
Setting	Enrolled from the authors institutional research recruitment website (includes more than 60, 000 community members who are interested in participating in research) between September and November 2019.
Study design	Qualitative study

Study	Choi 2021[84]
Methods and analysis	Semi structured interviews (in person or telephone) which were audio-recorded and transcribed. Themes were identified that related to older adults' willingness to consider deprescribing their benzodiazepine, if recommended by their prescriber in a hypothetical scenario. Other outcomes included their use and perceptions of taking benzodiazepine and experiences attempting to stop. Interviews were audio recorded and transcribed verbatim by a health care transcription service. A code book was developed based on the interview guide and formed the basis of the themes from the interviews. It was adjusted to include any topics that emerged iteratively. Three transcripts were analysed thematically using inductive and deductive coding by both authors. Coding and discussion of discrepancies were performed on each of 3 transcripts before continuing. There was agreement in coding between second and third transcripts. Time for interview: Mean 32 minutes
Findings	**Information on withdrawal symptoms and relapse to their health condition if deprescribing**
	Participants frequently reported concerns about withdrawal symptoms or a relapse in their health condition if they were to stop taking the medicine. One participant worried that it would result in worse symptoms of anxiety than initially experienced. Participants were hypothetically asked about lowering the dose or frequency of their benzodiazepine rather than completely discontinuing and most accepted this (n=12) idea. For example: "I wouldn't have a problem with that". Five participants had some concerns but would been willing to try this approach, 2 were sceptical and 2 were resistant to this suggestion.
	Information on consequences of long-term use
	Several participants reported concerns about long-term use of the medication, such as "I don't think I'm immune to dependency problems".
	Information and support on discontinuation
	Experiences of attempting to stop included relapse symptoms (4 participants) and withdrawal symptoms (3 participants). Others, that did not have these personal experiences, had concerns due to witnessing problems from family or friends or from reading about stopping benzodiazepines. Participants were asked if they were willing to consider discontinuing in a hypothetical scenario of which most common response was resistance (n=10). A few participants (n=4) expressed some concern about discontinuing their medication but would do so if the doctor recommended it.
Limitations and applicability of evidence	Overall CASP rating: minor concerns (minor limitations due to the concerns over the recruitment strategy; recruitment though the institutes recruitment site designed for people interested in participating in research). No concerns over applicability.

Study	**Cooper 2013[94]**
Aim	To describe the experiences and views of those self-reporting over the counter (OTC) medicine abuse, and why medicines were taken, how they were obtained, and associated treatment and support sought.
Population	People self-reporting OTC medicine abuse (primarily codeine-containing products) n=25; 13 women 12 men; age range 20s-60s; 9 out of 25 were using medicine at time of study. Drugs/products: Nurofen Plus (n=8), Solpadeine (n=5), Co-codamol (n=5), other codeine prescriptions (n=3), as well as other products, some in combination, including Paramol, Sudafed, Feminax, Phensedyl, Syndol, Nytol and Panadol ultra.
Setting	UK, via two internet support groups
Study design	Qualitative study using in-depth mainly telephone interviews
Methods and analysis	Purposive sampling was used to ensure that a range of ages, gender, medicines used, reasons for initial use (genuine or experimental) and treatment and support options were represented. Individuals describing only prescribed medicines were excluded and since the aim was to capture self-perception of OTC medicine addiction, a dependency screening measure was not considered appropriate. Recruitment was done via two internet-based support groups for those affected. A total of 25 interviews were undertaken over an 18-month period between 2009 and 2010, reflecting a slow uptake, considered to be due to the hard-to-reach nature of this group. Final sample was determined by theoretical saturation being reached in emergent themes. Interviews were conducted by telephone in all but two cases, and were digitally audio recorded then fully transcribed and anonymised. Analysis of transcripts involved an initial process of open coding, which was also informed by the themes from the available literature and the interview schedule. Axial coding between participant transcripts was then undertaken using the constant comparison process which involved reading and re-reading transcripts to identify links between emerging codes and participants and their characteristics. A final process of further refining of themes was undertaken until these provided explanatory accounts of the data.
Findings	**Support groups**
	Attempts by participants to address their OTC medicine addiction included internet support group help in all cases, as well as NHS GP consultations, specialist NHS drug and alcohol treatment services, a private clinic, counselling, self-management and narcotics anonymous. Perceived benefits of these varied, with initial self-treatment, for example, often being considered ineffective and there was a view that several services, particularly narcotics anonymous and specialist drug services, were not suited to OTC medicine addiction. Two online support groups, Overcount and Codeinefree, appeared to be particularly relevant in attempts to self-treat, and appear to have been found during general searches of the internet for information about their addiction. The two websites

Study	Cooper 2013[94]
	were perhaps the most positively received of all the options available to participants based on their experiences, and provided treatment options, including specific advice with direct communication from website staff and participants and also generic information on the websites and from others' posts. The websites offered a positive confirmatory function for many, although participants' level of engagement with the sites varied considerably and while some continued to actively interact, others stopped after the initial confirmatory aspect.
	Information and addiction warnings
	All participants were asked for their views on how OTC addiction could be prevented, and issues were identified in terms of the overall availability of OTC medicines, the use of information and particularly addiction warnings and the balance between professional and personal responsibility. The addition of addiction warnings to packets was considered relevant only to those not already addicted. This view was held by those interviewed both before and after the addiction warnings were introduced and for those still taking OTC medicines at the time of the study, there was a lack of awareness. There was little awareness of regulatory changes relating to pack sizes in the UK from those interviewed after the changes, but a view that, like warnings, these may have some benefit, but only to those who did not already have a problem.
	GP involvement
	GP involvement led to both positive and negative comments although some participants had specifically not sought GP advice, due either to poor existing relationships or, linked to the hidden nature of this issue, concerns about their addiction being recorded. Many participants felt that their doctor considered OTC medicine addiction to be less serious than other addictions and something not to be concerned about or suited to simple self-management.
	Referral to specialist services
	More positively, others described being referred by their GP to specialist drug and alcohol services, and these were associated most often with those taking considerably higher doses of medicine and occurred also from self-referrals and court orders. The overwhelming experience for all participants was that such services were not set up to accommodate those with OTC addiction and several factors were evident. The mixing of clients with different addictions was considered a problem, and there was a perception that staff viewed OTC addiction as a lesser problem, and also lacked experience.
Limitations and applicability of evidence	Overall CASP rating: No concerns. Moderate limitations due to applicability: study focussed on over-the-counter medicines and people describing addiction experiences with only prescribed medicines were excluded

Study	De Sola 2020[106]
Aim	To explore the experiences of people with chronic non-malignant low back pain undergoing long-term treatment with opioids
Population	Adults suffering from chronic non-malignant low back pain and receiving long-term treatment (>3 months) opioid n= 15; male/female: 6/9; aged 40-88 years;
Setting	Pain Clinic in Spain
Study design	Qualitative study
Methods and analysis	Semi-structured interviews: analysed by qualitative content analysis and developed categories and themes. Two researchers read the transcripts independently and assigned codes which were then compared and refined to form categories. Interviews were recorded, transcribed verbatim and anonymised. Interviews conducted until thematic saturation. If a topic that was not included in the interview guide arose spontaneously then it was added and asked in subsequent interviews. Data analysis inductive and the category construction was data driven without an initial hypothesis to guide the preliminary coding and development of categories. The analysis of the results followed the biomedicalization framework.
Findings	**Need for empathy/acknowledgement of pain**
	Participants believed the extended time taken for diagnosis and treatment was a consequence of the pain being invisible. Pain could be invisible on an individual level when it was ignored or minimised by the individuals in pain. On a social level, participants described how family members become indifferent when used to seeing them in pain and subsequently lack empathy. Participants described that the severity of the pain was minimised when there were no physical signs. “They’ve seen me in pain for so long… I think ‘if they could know how much pain I feel’ but they see me every day in the same situation, and they’ve become used to seeing me in pain”. People described the challenges to get health care professions to believe and take their pain seriously. Participants explained that only when their pain presented in physical signs such as mobility issues or through several attendances where they believed. This led to long waiting times and delays before receiving appropriate care.
	Support in decision making Most participants described being given little or no information about the new medication they were prescribed and often couldn’t distinguish between medications that were opioids or other drugs.
	Some participants described adverse effects and reflected on difficulty on stopping treatment, yet still favoured the pain relief opioids offered. Participants mentioned adverse effects in terms that seem to reflect a lack of understanding that

Study	De Sola 2020[106]
	could be associated with a lack of information from health care professionals. Overtime, participants adopted a more active role in developing coping strategies and described ways to help relieve pain, (resting, weight loss, exercising, other medications). They progressively became more active in decision making related to pain management and less reliant on opioids alone. Medication related decision were frequently made without consulting the health care professionals.
	Family support
	Family support was considered essential when dealing with chronic pain and its emotional burden. However, being dependant on their help raised perceptions of being a burden to their family. Sometimes participants felt neglected, especially when their families got used to seeing them in pain.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the role of the researcher not being discussed). No concerns over applicability.

Study	Eveleigh 2019[120]
Aim	To explore the attitudes of patients, who are using antidepressants long term without a proper current indication, towards the discontinuation of these drugs, and to explore their attitudes towards the discontinuation advice they received when participating in an RCT.
Population	A purposive sample of participants from the intervention group of a cluster-RCT of patients on long-term antidepressant (ATD) use (defined as 9 months or longer) without a current indication (no psychiatric diagnosis); as part of the intervention group, they had been provided advice to stop antidepressants. n= 16; male/female: 5/11; mean age (range) 57 (women: 31-76; men: 51-79) years, using a variety of antidepressants including various types of SSRIs, Tricyclics and other antidepressants; n=7 participants intended to comply with the discontinuation advice during the RCT and n=5 of these actually discontinued during or after the RCT.
Setting	General practice
Study design	Qualitative study
Methods and analysis	In-depth semi-structured interviews conducted via telephone lasted 15-20min; were performed by a physician who was a trained interviewer; were audio-recorded and transcribed verbatim. Interviews were analysed using thematic analysis which was carried out inductively using a qualitative software package. Analysis began once data collection commenced as an iterative process based on the ‘constant comparative method’.

Study	Eveleigh 2019[120]
	Coding was carried out independently by two of the authors. When consensus was not reached a third author was consulted
Findings	**Information on their need for medication & potential harms (long-term adverse effects)**
	Some participants described their antidepressant use as supplying an otherwise deficient substance. This substance was perceived as 'needed' to function normally as this deficiency caused the depression, resulting in the acceptance of lifelong dependency. The belief to be suffering from a chronic condition, and thus in need of lifelong medication emerged as a factor influencing discontinuation. Antidepressants were also described as being a natural and bodily substance, thus 'it surely could do no harm.' Others felt it could not be healthy to use antidepressants forever and were worried about long-term adverse effects.
	Information on the duration of medication
	Mentioning the limited duration of antidepressant usage at first prescription was found to facilitate the tapering process, with patients accepting discontinuation advice reporting they knew from the start that they would stop as soon as possible and that their GP made it clear the ATD is only a temporary solution that will help but that the problem lies elsewhere.
	Discontinuation advice
	The antidepressant discontinuation advice that had been given to patients was seen by some as the nudge needed to start tapering their antidepressant. It was reported that without the advice some would have kept taking the medication and that advice prompted them to think that it should be possible to stop and thus maybe they should try. For patients already questioning their use, advice can provide the validation needed to think they can do without medication. It also emerged that attempts to discontinue were frequently made without informing or receiving guidance from GPs.
	Information on relapse & recurrence
	Fear of recurrence or relapse was a great barrier to attempt to discontinue. Participants were afraid of reliving the negative feelings they had in the past and anticipated this recurrence if they were to discontinue. Others described the fear of disturbing the balance or equilibrium they had achieved.
Limitations and applicability of evidence	Overall CASP rating: Moderate concerns (due to the potential impact of the researcher on the findings not being explored and issues with data richness with themes mostly supported by limited information and single quotes). No concerns over applicability.

Study	**Frank 2016[134]**
Aim	To explore patients' perspectives on opioid tapering.
Population	Adult primary care patients who were currently or had previously been, on chronic opioid therapy (COT) n=24; 11 male, 13 female; mean age 52 years (range 31-73). Six participants (25%) were on COT and not tapering, 12 (50%) were currently tapering COT, and 6 (25%) had discontinued COT. The mean duration of opioid therapy was 7.7 years (SD 5.9). All participants were English-speaking. Substrata: Opioids; Currently taking or stopping
Setting	Three Colorado health care systems (Academic medical centre, Safety net hospital and a Veterans Affairs medical centre)
Study design	Qualitative study using in-person, semi-structured interviews.
Methods and analysis	Interviews were audio recorded, transcribed and analysed in ATLAS.ti. A team-based, mixed inductive and deductive approach was used, guided by the Health Belief Model. Emergent themes were iteratively refined with input from a multidisciplinary team.
Findings	**Knowledge of risks of opioid medications**
	When asked about specific concerns related to opioid medications, patients were generally aware of opioid overdose as a potential complication but did not perceive themselves to be at risk. The majority of patients described a long history of opioid medication use without prior overdose and cited this as evidence of their ability to safely take opioid medications. Patients attributed overdoses to others using opioids in risky ways or overdosing intentionally rather than accidentally. Among patients who were currently tapering or who had discontinued opioid medications, non-described overdose risk as a primary motivation for opioid tapering.
	Social support during tapering
	Among patients who were currently tapering or had discontinued opioid medications, social support was described as critical for initiating and sustaining a long, difficult process. One woman described her husband's important role in helping her identify symptoms such as poor self-care as side effects of her opioid medications. Another patient described the support she received from her family to manage the day-to-day decision-making while tapering high-dose opioid therapy. Several patients identified the potential benefits of support from other patients who could share their experiences with opioid tapering.
	Relationship with health care provider

Study	Frank 2016[134]
	Many patients who had experience opioid tapering identified a positive relationship with a trusted provider as a key to their willingness to initiate and their ability to sustain opioid tapering. Providers were praised for attributes such as being supportive, non-judgemental, flexible, and accessible.
Limitations and applicability of evidence	Overall CASP rating: No concerns No concerns over applicability

Study	Goesling 2019[142]
Aim	To identify themes pertaining to former opioid user's experiences before, during, and after opioid cessation
Population	Included adults between 18 and 70 years of age, a history of taking opioids every day for 3 months or longer and no current opioid use. Exclusion criteria: non-English speaking, current medical or psychiatric condition that would prevent meaningful participation, a history of recreational opioid use, involvement in litigation relating to current pain condition, prior use of opioid medication was for surgery related pain only and most recent opioid use was over 10 years ago. Patients were also excluded if tramadol was the type of opioid they previously used, suboxone or buprenorphine was used as replacement opioids when transitioned off opioids or they stopped because the prescription ran out. N=24 (formed 4 focus groups); time of focus groups: average = 98 (range 88-107) minutes
Setting	Back and Pain Center (Department of Anaesthesiology, University of Michigan) and fibromyalgia Patient Education Workshop (University of Michigan)
Study design	Mixed methods study (including qualitative focus group data)
Methods and analysis	Focus groups of at least 5 participants; time between 1 and 2 hours. All participants completed a 20-minute online Qualtrics survey 1 week before ethe focus group. Focus groups were conducted in person by 2 trained interviewers. The number in each group ranged from 5 to 6. A semi-structured focus group protocol was developed and refined and used broad open-ended questions with follow up probes. Questions included both individual responses and more extended group discussion. Focus groups were recorded and transcribed verbatim. Analysed using an inductive thematic analysis. Transcripts read and discussed by 2 researchers to assess overall themes in the data immediately following each focus group. These initial discussions were used to formulate a list of codes to apply across transcripts. Codes were eliminated, added, and modified based on the content of focus groups. Emergent themes were compared across individuals, within groups, and across focus groups.

Study	Goesling 2019[142]
Findings	**Information on impact on mood after cessation**
	Some participants reported that opioids had improved their mood and worried about depression and worsening mood after cessation. Participants described the opioids as immediate 'relief from depression' and sometimes had taken more medication to experience relief from depression.
	Support in cessation/tapering
	Most patients stopped taking opioids without the recommendation or guidance of a physician. Some stated that their physician had discouraged them quitting or even wanted to increase their dosage. For those that had been advised to stop, several had quit in preparation for a surgery or due to another medical condition or because they were ineffective. Several participants described being coached or supported through quitting. "Well, he told me to contact him on email if I had any problems so he could slow down the taper or if I was fine maybe he could get me off it quicker, but I was always in contract with him". Some of the participants who received guidance had received the information from a pain specialist rather than the prescribing physician.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the potential influence of the researchers on the findings not being discussed). No concerns over applicability.

Study	Gruss 2019[151]
Aim	To explore patients' experiences using long-term opioid treatment of chronic pain in an integrated delivery system.
Population	Participants from the PPACT study (a pragmatic clinical trial evaluating the effectiveness of a behavioural intervention in real-world health-care settings), who were randomized to the usual care group at the Kaiser Permanente (KP) integrated healthcare delivery system in the US, in which primary, specialty and hospital care and pharmacy and laboratory services are provided to health plan members. Patients had been prescribed opioids for pain and took opioids while closely monitored by their healthcare providers at a time of increasing pressures on providers to reduce opioid doses among patients who had often been on stable opioid doses for extended periods without identified safety concerns. Patients were eligible in the PPACT study if they were a KPNW health plan member for at least 180 days, had received long-term opioid treatment in the six months prior to recruitment (defined by at least two dispensing's of long-acting opioids

Study	Gruss 2019[151]
	or at least a cumulative 90-day supply of short-acting opioids during any 4-month period within the 6 months prior to recruitment; and were diagnosed with a pain-related condition prior to recruitment. Also, patients had to report a pain interference of 4 or higher for the general activity item of the PEG scale, a validated 3-item pain intensity and pain-related interference composite measure assessing pain intensity, as well as pain's interference with enjoyment of life and general activity. Reporting pain interference above this threshold suggested that opioid treatment was not fully successful in managing participating patients' pain. N=97; male/female: 21/76; mean age (SD): 61.3 (12.1) years; >60% of patients had been diagnosed with more than two conditions known to cause chronic pain; back/or neck pain (59.7%), fibromyalgia and/ or widespread muscle pain (57.7%) and limb or extremity pain, joint pain and arthritic disorders (54.6%). Participants were at various stages in their use of long-term opioids at the time of the interview (i.e., still prescribed, dosage decreased, completely tapered).
Setting	Kaiser Permanente Northwest location (KPNW) healthcare system site
Study design	Qualitative interview study
Methods and analysis	In-depth semi-structured interviews lasted between 20 and 60 minutes. Interviews were conducted with a member of the PPACT study team (AF) who had 20 years of experience in qualitative research. The interview guide contained seven questions that broadly prompted patients to share their experiences about receiving primary and pain care services at KPNW related to their chronic pain conditions. The interviews were recorded with participants' permission. A framework method was followed for the analysis focusing on participants' narratives about their opioid-related care experiences that emerged throughout the interviews. All data were first transcribed, then coded and analysed according to the five stages of this method. As part of the first stage the research team (IG, AF, CM) familiarised themselves with the data by reading transcripts and developed a coding dictionary. To develop a thematic framework, the three researchers independently coded transcripts, met to discuss codes and definitions and revised the thematic framework based on their discussions. The thematic framework was then applied by one researcher to all transcripts with the help of the qualitative software NVivo 12. The researcher then selected the two codes that were relevant for answering the research question (individual factors: 1) personal experience of and relationship to chronic pain, psychosocial effects of pain and pain care) then created a matrix by summarising the data for each of the two codes and cases (each transcript was considered a case). Finally, researchers met to review the content of the matrix and made connections across codes and cases resulting in three themes.
	Emotional support
	Patients with chronic pain described significant emotional distress as a result of their opioid use, which at times was severe enough to prompt seeking mental health counselling. For some, emotional suffering resulted from the social stigma associated with opioid use, while for others it was patient worry that stricter prescription regulations might limit their access

Study	Gruss 2019[151]
	to prescription opioids. Being on long-term opioid treatment was also an emotional burden on patients who did not want to rely on medication for their well-being
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the potential influence of the researchers on the findings not being discussed). Serious concerns over applicability due to the study being conducted in the USA, reportedly at a time of increasing pressures on providers to reduce opioid doses and on patients who were receiving care from an integrated delivery system as KPNW health plan members, who may not share the same views to people in primary care in the UK, and due to recruitment of participants whose pain interference score suggested that opioid treatment was not fully successful in managing their pain who may hence hold different views to patients whose opioid treatment has been successful.

Study	Guillaumie 2015[152]
Aim	To describe pharmacists' perceptions with respect to their practices related to patients having an antidepressant drug treatment; identify challenges they encountered regarding their practices with those patients and explore potential avenues for improvement of their practice regarding ATD drug treatment
Population	A convenience sample of community pharmacists from five regions of Quebec were recruited. Regions were selected to provide a comprehensive picture of community pharmacists that included metropolitan, urban and rural areas. Community pharmacists with different characteristics that potentially affect pharmacy practice (e.g., sex, age, employment status and worksite setting) were included. N=43; male/female: 20/22; n=27 were employees and n=15 were pharmacy owners; n=28 had over 15 years of experience in community pharmacy practice.
Setting	Pharmacies in the province of Quebec.
Study design	Exploratory descriptive qualitative study using focus-groups
Methods and analysis	Six focus groups were conducted by the same member of the research team using a semi-structured topic guide that was based on the literature about pharmacy practice with patients with mental illness, and on interviews with four community pharmacists and four academic experts in pharmacy practice or mental health. Another research team member also attended the groups as an observer. The guide mainly covered three topics: 1) recent changes in the role of the community pharmacist-in general and towards patients that have an ADT; 2) pharmacy practices considering new prescriptions of antidepressants and 3) practices relating to refills of antidepressants. Focus groups took place in hotel meeting rooms or restaurants. The audiotaped group sessions lasted 120 minutes. At the end participants were asked to complete a short questionnaire on their sociodemographic and employment characteristics.

Study	Guillaumie 2015[152]
	Field notes were taken during and after each group to provide insights for the conduct of subsequent groups for data analysis. Based on these field notes and observations, the two researchers who had attended all focus groups extensively debriefed after each group on their preliminary analysis of the emerging ideas and potential codes. Complete verbatim transcriptions were made for each group. A research team member checked randomly selected extracts of transcriptions for accuracy against the audiotapes. Thematic analysis of transcriptions was done using qualitative data analysis software. The codebook was developed iteratively following a validation process inspired by the continuous thematic analysis process. A mixed approach- inductive and deductive was used to develop codes. Codes were derived from the literature, the expert interviews, the semi-structured topic guide and they also emerged from the corpus. Credibility increased with the intercoder reliability. Three research team members trained in social and cultural anthropology developed a first version of the codes-book. They independently coded transcripts from the first focus group. After, the coding of the three coders was compared and they debriefed. This process was repeated for subsequent groups until consensus on the codebook and coding of the transcripts was reached. One of the coders used the final version of the codebook to code the three remaining focus groups, possibly adding new codes and consulting with other team members whenever necessary. Besides coding, part of the analysis took place during the drafting of annotations and memos. Findings from the final analysis were presented in a regional pharmacists' meeting to 20 other pharmacists who had not participated in focus groups to obtain the feedback. When questioned directly concerning the relevance of the findings, the participating pharmacists indicated that the findings reflected their practices and challenges very accurately.
Findings	**At initiation: Information on the benefits of ATDs/ Reassurance and emphasis on positives**
	Pharmacists reported that many patients hesitate about taking an ADT as they often fear becoming dependent on antidepressants, having to take them for their entire life or gaining weight. They also reported that patients are often embarrassed to come to the pharmacist with a prescription for antidepressants. In this situation, most pharmacists report they try at the first meeting to persuade patients to take or at least try the medication. To facilitate this, they give information about the treatment, emphasising the benefits and the fact that potential ADT side effects are quickly overcome. Pharmacists make an effort to reassure patients and assuage their guilt feelings. Some pharmacists demystify the use of antidepressants by describing in general terms **how the medication works** while stressing the psychological causes of depressions. Pharmacists also said they try to inspire hope by focusing on the **positive aspects of treatment (e.g., the first benefits in four weeks) and being somewhat reticent about mentioning right from the beginning the long-term negative aspects patients may experience with medication (e.g., long duration, weight gain, decrease of libido).**
	First weeks of treatment: Information on side-effects & time lag before benefits
	During the first meetings, the pharmacists prepare the patients to deal with side-effects. They describe the steps of the first weeks, mainly the gradual increase in dosage, the possible occurrence of side-effects and the time lag before experiencing beneficial aspects. Pharmacists seemed to be aware that patients find it difficult to cope with side-effects and then persevere with ADT without having experienced some degree of benefit. From the start pharmacists invite patients to pay

Study	Guillaumie 2015[152]
	attention to side-effects, not to worry if they occur, not to stop the treatment but to contact their pharmacists or their doctor. Pharmacists particularly reported they tell patients that 'side effects will often occur before the therapeutic effects. And that they have to persevere because unfortunately we start with the inconveniences'; they reported that 'support in the first few weeks is important because the person is expecting a positive outcome and sometimes there are possibly side effects that will occur at the start
	Support: Advice & strategies for adherence
	Pharmacists stated that non-adherence, especially non-persistence was a frequent problem among their clientele with an ATD treatment and that one of their important goals was to have the patient stick to the medication. As one pharmacist particularly reported, they 'have a very important support role at the start of therapy' and then they 'have to keep encouraging the client'. Actions taken by pharmacists following the identification of an adherence problem were usually in the form of a brief consultation at the counter and by the provision of advice and strategies to improve medication-taking behaviour.
	Various stages of treatment: Patient information leaflets
	Pharmacists indicated that patient education tools, such as information leaflets could be useful in their efforts to support patients at the various stages of their treatment. A lot of information needs to be provided to patients, yet a consultation is usually only a few minutes long. Important information concerning the treatment is often not communicated to patients or often not remembered by them and the pharmacists often judged the information leaflets available in addition to the drug information sheet to be incomplete.
Limitations and applicability of evidence	Overall CASP rating: No concerns (with concerns over the potential influence of the researcher on the findings not being discussed being counterbalanced by the very rigorous data analysis process that included intercoder reliability and credibility checks with fellow pharmacists). No concerns over applicability.

Study	Henry 2019[163]
Aim	To gain insight into patient experiences with opioid tapering by conducting focus groups and individual interviews with patients suffering from chronic neck and/or back pain.
Population	Patients ≥ 35 years of age with chronic neck or back pain who were either taking long-term opioids (defined as ≥ 1 dose per day for ≥ 3 months) or had taken long-term opioids and had tapered down or off within the past year, identified through an electronic health record screening algorithm.

Study	**Henry 2019[163]**
	N=21; male/female:10/11; mean age: 58 years; n=14 had recently completed an opioid taper (with 4 no longer taking opioids), n=4 were in the process of tapering and n=3 had discussed tapering but had not made changes Of the n=7 patients who completed interviews, n=4 had completed tapering, n=2 were currently tapering and n=1 had been recommended to tapper.
Setting	13 primary care clinics within the University of California, Davis
Study design	Focus group and qualitative interview study
Methods and analysis	Focus groups were conducted by the same investigator (while another investigator was taking notes), using a guide with topics derived from the Health Belief Model. Major topics included perceived barriers and benefits to tapering, strategies for communicating with clinician's, strategies for managing pain and opioids and sources of support. The most compelling storytellers (i.e., patients who investigators judged were best at engaging and opening other patients to the possibility of tapering) were identified based on group dynamics, audio recordings and transcripts. These patients were invited for 30-minute interviews. Individualised interview guides were used to prompt interviewees to recount and elaborate on the stories they told during their focus group. Interview transcripts were iteratively reviewed by four investigators to identify themes in patients' accounts of their tapering experiences. Investigators met every 2 weeks for 6 months to discuss and compare their interpretations of findings and to resolve differences among investigators. They summarised the key themes and concepts that emerged from the data and used them to develop a conceptual model of patients' tapering experiences.
Findings	**Information about tapering**
	Patients' ideas about what tapering meant influenced attitudes about tapering and discussions with clinicians. Those who understood tapering meant a gradual or partial reduction in opioid medication were generally more receptive to tapering than those who understood it to mean stopping completely. Those who used the terms 'taper' and 'detox' interchangeably tended to associate tapering with withdrawal symptoms. Fear emerged as a powerful emotion affecting both patients' willingness to taper and their overall tapering experience. Most patients' fear involved the possibility of worse pain and withdrawal owing to decreased opioids. One patient was so afraid of withdrawal that she would only attempt tapering in an inpatient facility. For most the prospect of tapering evoked fears involving a mix of pain, withdrawal and loss of function.
	The tapering process & monitoring opioid supply
	Patients repeatedly emphasised that tapering requires planning and sustained effort, that 'it's a process' and involves going through a lot of different changes', that requires patients to adjust and recalibrate in response to changes in their perceived need for opioids, their pain, social relationships and emotional state. The most salient effort during tapering was figuring out how to manage activities necessary to get through the day (e.g., working, running errands, helping family). Tapering often

Study	Henry 2019[163]
	required patients to expend more effort adjusting their habits and opioid consumption to maintain functionality. Nearly all patients noted that managing opioids became more difficult as tapering progressed. In addition to timing opioid consumption around daily activities and contacting clinics for refills, patients expended more energy monitoring their day-to-day opioid supply with several comparing this with having a second job. However, patients reported that discussions with clinicians tended to focus on opioid dosing and medically prescribed pain treatments and discussions of patients' everyday experiences with tapering, their social relationships and their emotional state were rare.
	Honesty/Transparency & mutual decision making
	Patients whose clinicians unilaterally tapered or stopped prescribing opioids expressed a profound sense of loss and betrayal. Patients who described positive relationships with their clinicians and who identified them as a source of support during tapering talked about effective patient-clinician communication around tapering. First, they expressed the importance of mutual honesty-clinicians being honest with patients and patients being honest with clinicians and with themselves. Mutual honesty was described as a prerequisite for successful opioid tapering. Patients reporting negative interactions with clinicians felt clinicians were not entirely honest about their reasons for tapering (e.g., were motivated by institutional anti-opioid pressures rather than patients' best interests)
	Tailored guidance about tapering/ patient centred approach
	Patients who described positive relationships with clinicians described clinicians who took the time to learn about their needs, built mutual trust and devise individualised tapering plans. Several patients noted that simple, open-ended questions such as 'how are the pain medicines working for you?' and 'what problems are you having?' facilitated productive information exchange and signalled that clinicians were not using a one-size-fits-all approach. Patients who reported positive experiences received anticipatory guidance about tapering and described clinicians willing to adjust tapering plans based on patients' experience or in response to changes in patients' emotional state and health status. Patients reporting negative interactions with clinicians felt clinicians did not listen to patients or individualize tapering plans or were inflexible once tapering started. Several patients reported experiences with clinicians who they perceived as focused on tapering opioids rather than treating pain.
	Strategies for pain management and withdrawal during tapering
	Many patients reported minimal or no advice from clinicians about how to manage the pain, withdrawal and decreased opioid supply associated with tapering, and so devised strategies of their own to solve these problems. A few patients considered seeking alternative opioid sources during tapering when their pain and withdrawal was severe which occasionally had negative outcomes. One patient suffering from withdrawal during tapering accepted unknowingly counterfeit hydrocodone pills from an acquaintance resulting in hospitalisation for overdose. Another patient admitted that when his supply of opioids gets low, he imagines either buying heroin or injuring himself to obtain additional opioids. Some patient-initiated strategies indicated possible substance use disorder or 'aberrant' opioid related behaviours. Patients

Study	Henry 2019[163]
	generally reported discussing only a small fraction of strategies with clinicians, although discussion was required for strategies that involved prescription or referrals.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to the potential influence of the researcher not being discussed and minor possibility of selection bias in patients interviewed (selected by the researchers: 10/21 of those who participated in focus groups were invited for individual interviews based on group dynamics and data review)). No concerns over applicability.

Study	Kinnaird 2019[206]
Aim	To investigate the views and experiences of people who use codeine in order to describe the 'risk environment' capable of producing and reducing harm.
Population	Adults from the UK who had used codeine in the last 12 months other than as directed or as indicated. n=16; 13 women, 3 men; mean age 32.7 years (SD 10.1); mean period of codeine use was 9.1 years (SD 7.6). All participants began using codeine to treat physical pain.
Setting	UK: participants recruited from an online survey and one residential rehabilitation service
Study design	Qualitative interview study
Methods and analysis	This was a qualitative study that used data from semi-structured interviews with participants living in the UK who reported use of codeine in the last 12 months. Inclusion criteria was any individual aged 18 years or over who used codeine other than as directed or as indicated, whether wilful or unintentional, and whether it resulted in harm or not. Participants were recruited among respondents to an online survey (n=14) and through a residential rehabilitation service (n=2). Interviews took place either in the residential rehabilitation service, at a location chosen by the participant or over the phone. Interviews lasted from 35 mins to one hour and 35 mins. Participants were compensated for their time with a £20 gift voucher. Interviews were conducted using a topic guide, covering demographic information, initial use of codeine, patterns of codeine use, difficulties managing codeine use, sourcing of codeine, use of other drugs or medicines and views on codeine availability and regulation. New topics brought up by the participants were pursued during the interviews with follow-up questions. Interviews were audio-recorded and then transcribed verbatim by a professional service, with any participant identifying information removed from the transcripts. Data analyses were completed by three researchers and coded using the qualitative software NVivo. A coding framework was developed deductively from the topic guide and from codes that

Study	Kinnaird 2019[206]
	emerged inductively from the data. Coded data were analysed using Framework. In the first stage, the coded data were reviewed to describe aspects of each factor that influenced codeine use in the risk environment. Since similar factors were identified as being important to the production and reduction of harm among the participants, the analyses were merged and then grouped into more inductive categories.
Findings	**Information on potential risks (addictive potential)**
	Many participants explained that they had not fully understood the potential risks when they first started taking codeine, including its addictive potential. Reflecting on their initial codeine use, many expressed frustrations with their GP and suggested that they wished they had been given more information. Most participants expressed negative GP experiences that led to disengagement and over-reliance on poor information sources. For some of the participants, disengagement from medical professionals, and the placing of responsibility on the patient to self-manage their dependence, created situations where participants reported that they instead used the internet to find out more information about codeine, pain treatments and advice on how to manage the use of codeine.
	Barriers to effectively communicating risks
	Participants identified several potential barriers facing health professionals in effectively communicating risks. Specifically, participants felt that the typical 10 min GP appointment was not enough to fully discuss available options for pain therapy. Of note was that participants who had greater awareness of the risks of codeine, typically from searching for information on the internet, were often more motivated to avoid these risks. However, when participants voiced concerns to their GP, they felt ignored and detached from decisions about their health and care. Such encounters with health professionals enhanced the feeling of not being listened to and contributed towards disengagement from health services, distrust in medical opinions and isolation. In this environment, fewer factors acted to protect against unsupervised, long-term codeine use. Consequently, the lack of effective communication between prescribers and patients, and a resulting poor education of patients on codeine risk, appeared to facilitate the development of codeine dependence for some participants.
	Relationships with pharmacists and GPs; Role of the pharmacist
	An important outcome of accessing multiple pharmacies in the local area was that participants never established a strong relationship with a single pharmacist, contrasting this to those who described a better relationship with their GP. Even where participants only accessed one pharmacist, they often perceived this relationship as less important to them and therefore less effective in regulating use and providing risk education, support and interventions than their GP. This appeared to also be related to the short amount of time participants spent interacting with pharmacists when buying codeine. However, participants also emphasised that pharmacists were far easier and quicker to access than scheduling an appointment with their GP, providing a disincentive to wait and consult with their GP about their codeine use. For participants with a positive and trusting relationship with their GP, a reluctance to be dishonest in their communication with the GP appeared to reduce

Study	Kinnaird 2019[206]
	the risk of dependence occurring. However, this appeared in some cases to be undermined by the convenience of over-the-counter availability.
	Supervision from GPs
	The majority of participants who received prescription codeine did so through a repeat prescription. Individuals robustly reported being able to order their repeat prescription with few restrictions on amounts and frequency, which for some resulted in increasing codeine intake. Within the risk environment, prolonged access to codeine with minimal supervision from a health professional can facilitate use of codeine other than as indicated during the initial consultation, influencing transition to subsequent dependence. It was striking that participants using codeine from a medical prescription reported being prescribed codeine as a first resort for pain, even when participants were otherwise motivated to try other types of pain treatments. For some primary care patients in the study, these issues were perceived as a general systematic problem reflecting a lack of treatment resources. They felt like they had been prescribed codeine in order to quickly get rid of them, rather than their GP taking the time to deal with the underlying problem or being referred to specialist services. This did lead to frustration and, in some cases, disengagement from GPs, for example, to seek treatment privately. Where participants engaged with their GP regarding their codeine use, either due to GP instigated follow-up consultations concerning their use of codeine or to the participant asking for an appointment, their GP was able to help via effective interventions such as tapering codeine and replacing compound products with pure codeine formulations. This suggests that in an environment where GPs have resources to support the patient, they reduce the likelihood of harm occurring.
Limitations and applicability of evidence	Overall CASP rating: Moderate concerns (due to the majority of participants having contacted the researchers if they wanted to take part, possibly making them more motivated to give stronger or more negative views; relationship between researcher and participants unclear).No concerns about applicability.

Study	Leydon 2007[229]
Aim	To explore patient experiences of and beliefs about their long-standing SSRI use and understand the barriers and facilitators to discontinuation.
Population	People taking selective serotonin reuptake inhibitors (SSRIs). N=17; M:F 7:10; age range 28 to 64 years. Length of time taking their current SSRI ranged from 1 to 11 years (mean 4 years). Seven described this as their first and only episode of depression. Of the rest, six talked in terms of previous distinct episodes, while four described their depression as ‘ongoing’ or ‘long term’. Stratification: Currently taking/stopping; Antidepressants (SSRIs)

Study	Leydon 2007[229]
Setting	One group general practice in Southampton, UK.
Study design	Face-to-face semi-structured qualitative interviews with thematic analysis
Methods and analysis	Patients were recruited from one group practice within Southampton City Primary Care Trust (PCT). All participants receiving prescriptions for an SSRI for 12 months or more were identified from computer records by a clerical member of the practice staff. Only those patients deemed well enough by their GP were contacted by a letter from their GP about the study. A single research conducted the semi-structured qualitative interviews. Interviews lasted for an average of 1 hour. Participants were invited to tell their 'story' of SSRI use and in this way many of the issues of interest were raised spontaneously by patients. Interviews were audiotaped and transcribed verbatim. Thematic analysis was carried out both by hand and with the use of a word processor. Analysis began once data collection commenced and followed an iterative process derived from the 'constant comparative method'. Independent coding of a sample of transcripts was carried out by two of the authors. This was followed by a series of 'data sessions' between all authors to derive a consensus-coding framework.
Findings	**Uncertainty about consequences of stopping**
	Participants described uncertainty about the potential for bad consequences when stopping, as well as uncertainty about the process itself, which could invoke fear. In addition to anticipated problems, actual problems encountered during past attempts to stop instilled trepidation about future attempts to stop.
	GP support
	GPs were seen as playing an important role in helping patients to reach a decision to stop. Those who described themselves as 'well monitored' referred to the benefit of sharing decisions about treatment. One participant spoke explicitly about their fears of the consequences of stopping without the support of an expert. One participant, who was one of the longest users of SSRIs and the most severely depressed of the interviewees, described wanting to try discontinuing but reported feeling that there had been a lack of opportunities to discuss doing so.
	Advice on tapering
	Seven of the 17 participants reported receiving advice on tapering their dose to minimise discontinuation symptoms. One participant reported that she gained a sense of security because her GP had informed her that she could always return to a higher dose if tapering her dose proved too difficult. In this way, she was merely 'testing the waters', rather than making an irreversible decision.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to participants only recruited from one group practice within one primary care trust)

Study	Leydon 2007[229]
	No concerns about applicability.

Study	Matthias 2013[244]
Aim	To understand how physicians and patients with chronic musculoskeletal pain communicated about issues related to opioids.
Population	Primary care providers (PCPs) in a Veteran Affairs (VA) facility and their patients who 1) had a diagnosis of chronic musculoskeletal pain, 2) had at least moderately severe pain (≥4), assessed by a 0 (no pain) to 10 (worst pain imaginable) scale; 3) were a patient of a participating PCP; and 4) had an appointment scheduled with their PCP during the study's duration. Physicians: n=5; male/female: 2/3 Patients: n=30; male/female: 26/4; mean age (range): 57 (27-70); 17 had low back pain; 13 had arthritis; 20 were taking prescribed opioid medication for pain
Setting	Primary care clinics at a VA medical centre
Study design	Qualitative interview study
Methods and analysis	Data collection occurred for 7 months (August 2010-March 2011). Primary care clinic visits were audio-recorded and in-depth patient interviews were conducted immediately after. A digital audio recorder was placed in the exam room by the research assistant (RA), who was waiting outside the room during the consultation. After each appointment the RA interviewed patients about their relationship with their PCP, their pain and pain treatment. Recordings were professionally transcribed. Using emergent thematic analysis, four study team members met weekly over eight months to analyse data. Analysts independently listed broad thematic categories emerging from the data and met to discuss and modify these categories. After agreeing on an initial set of themes, analysts iteratively applied these themes to transcripts. Through this process, themes were combined, added or eliminated. Once coding was stable and consistent, transcripts were divided evenly among analysts, with every fourth clinic/interview transcript coded and checked by all analysts to ensure stability and consistency in coding, facilitated by NVivo software.
Findings	**Information on opioids: appropriateness & risk of addiction**
	Issues related to opioid misuse or addiction were commonly raised among patient-physician interactions. When a patient with back pain raised the possibility of addiction, his physician provided education about the risks of escalating doses of opioids, uncontrolled use, and opioid-related euphoria ('high'), and reassurance that opioids could be an appropriate treatment: Sometimes patients preferred to face the uncertainties presented by opioid treatment by avoiding the medications

Study	Matthias 2013[244]
	altogether. Fear of addiction was the reason they wanted to avoid opioids as a treatment option. For example, a patient recalled in the interview that he refused an opioid because of addiction concerns while another asserted 'trying to stay off narcotics' as they did not want to get addicted.
	Support/Alternative pain management options (for those with history of substance use disorder).
	A patient with history of SUD was particularly concerned about becoming addicted to opioids and found hydrocodone was ineffective, mentioning that 'nothing helps.' Conversations between patients and PCPs were driven by the uncertainty surrounding SUD history and the potential of opioid misuse. Concerns with substance abuse in the past shaped the way the patient thought about opioids.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to the role of the researcher not being discussed and lack of detail over part of the data collection methods (the interview contents)) No concerns over applicability.

Study	Nolan 2005[278]
Aim	To explore what factors, lead patients to consider they have a satisfactory relationship with their prescribing clinician and what kind of information they find reassuring and helpful. To examine how medication regimens are monitored and what kind of follow-up patients appreciate, and to identify pointers for establishing effective therapeutic relationships between patients and prescribing clinicians.
Population	Patients who had experienced a first episode of depression in the past 18 months to recruitment were recruited from four GP practices in the West Midlands, UK, two of which were located in urban settings and two in rural settings. To be eligible, participants should have been treated in primary care, should have been prescribed antidepressant medication, should have no other significant diagnosed physical or mental health problem. N=60; male/female: 23/37; mean age (range): 42 (24 to 67) years.
Setting	Primary care: four GP practices in the West Midlands, UK
Study design	Qualitative interview study
Methods and analysis	Semi-structured interviews were conducted at the participants' home or their GP practice. All interviews were undertaken by one of the authors (FB) to ensure consistency, they were audio recorded, transcribed and analysed. Transcripts were analysed by both authors independently, who then conferred to discuss and agree themes to prevent bias in the analysis arising from its being undertaken by the interviewer.

Study	Nolan 2005[278]
Findings	**Relationship with practitioner & continuity of care**
	So important was the relationship developed during the initial consultation that to see the same GP on subsequent visits became a critical part of respondents' ongoing treatment. Continuity of care meant not having to repeat the same details over and over again, feeling that one was not a nuisance and being treated as a 'friend'. Respondents were fearful that having developed a special relationship with the GP they would have to see different doctors on follow-up visits. As one said, 'You cannot be reassured by someone you don't know'. Some were inclined to question the sincerity of the GP whom they had first visited and felt that 'GPs make promises they can't keep'. Failure to keep promises undermined relationships with health care professionals and set back progress. It was considered by many to be especially helpful when members of the team were aware that they were being seen by another member of the team.
	General information on ATDs
	a) Rationale for medication: Initially, 27 of the 60 respondents felt resistant to the suggestion of medication. Many expressed concern at the speed with which GPs offered medication, usually as the sole treatment approach. The mention of medication evoked strong negative feelings in some respondents and threatened their commitment to doing whatever was needed to recover.
	b) Risk of addiction & side effects: Respondents had fears of becoming addicted to medication or that it would seriously reduce their alertness. Many had negative views of medication that were grounded in the experiences of friends or relatives who had taken older types of medication and who had stayed on them for years. Concerns about ATDs included fear of becoming addicted (n=10), that taking medication means you are helpless (n=5) or stigmatises you as someone who is depressed (n=5), that it results in one losing control over their life (n=4) and fear that medication will affect one's personality (n=1)
	Advice on length of medication (prior to treatment commencing)
	Participants were asked to recall what advice they had been given prior to commencing treatment. Only four could remember being advised not to stop taking their medication although the need to continue for 3-6 months after remission od depressive symptoms is now considered to be a cornerstone of effective treatment. **Fourteen patients reported they were not given any verbal information at all, whilst two stated that something had been said to them about their medication but could not remember what that was.**
	Patient information leaflets
	Fifty-four respondents stated that they found Patient Information Leaflets (PIL) enclosed with their medication useful and that it was much less stressful reading quietly at home than trying to absorb what was being said to them in a surgery. A small

Study	Nolan 2005[278]
	number of people admitted that the PIL caused anxiety about side effects of medication and felt that the content could be more encouraging.
	Encouragement and support with self-monitoring
	Some participants had been told that they themselves were the best people to observe the effects of medication and were encouraged to keep themselves under review. Respondents found being invited to monitor their own progress and difficulties very helpful in building their self-esteem and putting them in control of their own recovery. Specific questions by GPs such as whether they had noticed any changes, whether they had lost any weight, experienced panic attacks or had problems with early morning waking or getting off to sleep at night helped respondents understand their illness better and monitor for themselves their response to medication and their progress towards recovery.
	Health professionals' interest in their well-being
	Respondents valued having their treatment monitored because it meant the GP was interested in how they were progressing. Being asked how they were doing made them think about their life in general and to what extent they were improving. For some, being asked how they were feeling by the GP was difficult as they did not know what to respond. Also, respondents appreciated being asked how they were doing when they saw other members of the primary care team such as community psychiatric nurses (CPN) and practice nurses.
Limitations and applicability of evidence	Overall CASP rating: Moderate concerns (due to concerns over the lack of sufficient detail on the data collection method and the data analysis). No concerns over applicability

Study	O'Mullan 2014[287]
Aim	To explore women's experiences of coping with the sexual side effects of antidepressant medication
Population	Women in a heterosexual relationship who had been taking SSRIs for longer than 3 months n=10; all women Inclusion criteria: under 45 years old; currently in a heterosexual relationship; had been taking SSRIs for longer than 3 months at the time of the study; self-described as experiencing sexual difficulties that were believed to be attributable to SSRIs; experiencing sexual difficulties that were causing problems or distress to her and/or her partner. Stratification: Currently taking/stopping; Antidepressants (SSRIs)
Setting	Australia

Study	**O'Mullan 2014[287]**
Study design	Qualitative study using semi-structured interviews
Methods and analysis	Participants for this study were recruited via a mental health website (depressionnet.com), social media sites and snowball techniques. Data were collected through two semi-structured interviews comprised of questions that related to heterosexual women's experiences of coping with the sexual side effects of SSRI medication. The interview schedule comprised of eight open-ended questions, which were informed by the literature review and professional experience of the first author. First interviews were face-to-face and lasted between 1 hour and 1 hour 45 minutes in length. Follow up interviews were between 45 minutes and 1 hour 15 minutes. During this second interview, the lead researcher and each woman reviewed the transcript and discussed emergent themes. Data analysis involved: reading and re-reading the transcript, initial noting, developing emerging themes, moving to the next case and looking for patterns across cases. Once data analysis was completed for all cases, the next stage involved analysing for recurrent themes across all ten cases; this resulted in four super-ordinate themes.
Findings	**Information about side effects *(substrata: Before taking)***
	A search for reasons behind the sexual side effects frequently underpinned the coping experience of most women in this study, with women commonly commenting on how GPs had neglected to inform them about the side effects when the medication was prescribed. Consequently, these women particularly struggled with sexual side effects at an early stage in their journey, and frequently questioned 10 whether they had psychological problems and/or whether their experiences were normal. The primary motivation for searching for information stemmed from a desire to protect current relationships. Having answers about the sexual side effects had positive implications for both their relationship, as well as their identity as a sexual person. *The majority of women felt having more information at an earlier stage, would have assisted them in coping.*
	Validation from GP
	For the women, having their sexual concerns validated played an important part in helping them to cope. They felt the difficulties were serious enough to consider seeking professional help but their experiences of not having concerns validated by GPs had an impact on how they understood and hence coped with difficulties initially. Furthermore, women reported that GPs appeared unwilling to accept their sexual side effects as a legitimate problem. This led them to seek validation and support through online discussions forums.
Limitations and applicability of evidence	Overall CASP rating: Moderate concerns (due to some methodological details being unclear) Moderate concerns over applicability due to the study population (n=10) being very narrow and homogenous and hence of possibly limited relevance to the overall review population.

Study	**Parr 2006[316]**
Aim	To gain more detailed understanding of perceptions relating to starting, continuing and stopping BZD use.
Population	GPs and users of BZDs that had at some time been prescribed daily BZDs for 3 months or more, were recruited. GPs: n=28; male/female: 20/8; mean time in general practice: 14 years (range: 6 months to 35 years with only one in practice for less than 12 months). Users of BZDs: n=23; male/female:9/14; mean age (range): 50 (25-79) years; mean duration of use: 11 years (range: 6 months to 28 years); 30% were prescribed BZDs for more than one mental health condition including panic disorder, depression, anxiety and post-traumatic stress disorder; six were currently prescribed BZDs for panic attacks, nerves, sleeping problems, anxiety, obsessive compulsive behaviour or because they were addicted to them; For those who had ceased, mean length of time since cessation was 8 years (<1 year to 25 years)
Setting	Tropical holiday and regional centre of Cairns, Australia and surrounding rural districts.
Study design	Qualitative interview study
Methods and analysis	Semi-structured face to face interviews were conducted with GPs and users in the tropical holiday and regional centre of Cairns, Australia and surrounding rural districts. GPs were interviewed in their surgeries using a 15-30 min semi-structured interview adapted from smoking cessation in general practice project (Young et al 2000). Interviewed commenced by asking GPs about their experience with BZD prescriptions, exploring factors that influenced their decision to prescribe and their approach to cessation. Interviews with users were conducted in their homes or another mutually agreed site, using a 30-60 min semi-structured interview, exploring initial reason for BZD use, reasons for continued use and beneficial and harmful effects of using BZDs. If they had attempted to cease, they were asked the reasons for doing so, how they went about it and what helped or hindered the process. All interviews were conducted by the first author and included questions such as ‘What do you usually do to help people who are dependent on benzodiazepines to stop taking them?’ for GPs and ‘What information were you given about benzodiazepines’ for users. Interviews were audio taped, with notes being taken concurrently and audiotapes were later transcribed verbatim by the first author. The primary research team (the first three authors) independently reviewed the first three GP and user interviews and developed a preliminary list of domains and categories, referring these at a face-to-face meeting. The first author applied these domains and categories to remaining interviews. The fourth author audited all interviews to verify that the ascription to domains and categories adequately reflected the information in the transcripts. The research team agreed on domain amalgamations. Assessments of representativeness of categories involved assigning a rating of ‘general’ if raised by all participants, ‘typical’ if raised by more than half of them or

Study	Parr 2006[316]
	'variant' if raised by 15-50% of participants. Further corroboration of categorization was achieved through verification of the results by three GPs and four users who were asked for feedback on whether they reflected their thoughts and experiences or those of other potential informants.
Findings	**Short-term length of prescription**
	GPs considered benzodiazepines to be useful in assisting with acute stressful situations as long as patients were informed that they would only be prescribed on a short-term basis.
	Education about BZDs
	a) **Addiction potential & withdrawal symptoms**: GPs typically reported providing patient education when they prescribed BZDs, including advice that they were addictive; were only to be used short term; and withdrawal symptoms may occur when the drug was stopped. Users who had positive interactions with health professionals while using BZDs reported their GP was providing them with advice that BZDs could be addictive.
	b) Information on use/administration and need for medication: Users who had positive interactions with health professionals while using BZDs also reported their GP was providing them with a rationale for the treatment; and information on when to take the tablets. Although participants acknowledged that GPs provided some information on the use of BZDs, they typically perceived the information as inadequate or limited. There was also a perception that the medications were too easily prescribed; those scripts were often written without seeing the GP; and that cessation of use was never discussed.
	c) Information from pharmacists: Users' comments on their interactions with pharmacists were variant, with pharmacists more likely to advise not to drink alcohol while using medication or not to use certain medications while on BZDs due to drug interaction. Some pharmacists provided information leaflets on BZDs while others questioned why the participant was taking it. Pharmacists were often seen as either not providing any information on the medications or inadequate information.
	Support with cessation
	a) Tailored support: GPs acknowledged that cessation of benzodiazepine use was a long-term process and that tailoring reduction regimes to patients' coping ability was important. Individually tailored dose reduction schedules were reported as a useful strategy for cessation by patients.
	b) Consequences of ongoing BZD use & benefits of stopping: A minority of GPs mentioned reinforcing benefits of ceasing; describing problems that could arise from ongoing use; associating patients' current ill health with use; or raising the possibility that patients were already addicted to them. They reported conducting a thorough assessment

Study	Parr 2006[316]
	of BZD use and health; explained the benefits of stopping use. The typical reasons identified by GPs for patients successfully completing a dose reduction regime included perceived benefits in ceasing
	c) **Alternate treatment approaches (medical & non-medical**): They prescribed alternate medication if appropriate (particularly antidepressants. Patients were also encouraged to use non-drug therapies such as coping strategies, relaxation and counselling GPs also provided monitoring and ongoing support.
	d) **Additional health professional support:** obtaining additional support from other health professionals (pharmacists; local mental health services, community pharmacists; local mental health services, community counselling services) was a factor identified by some GPs for patients successfully completing a dose reduction regime. A perception that their doctor was unsupportive (e.g., had not given them sufficient assistance; continued to write prescriptions; never questioned whether they were still needed) was identified by users as a reason contributing to an inability to cease use. For cessation, apart from GPs users reported they sought assistance from other health professionals and agencies such as a chemist.
	e) **Social support:** One of the variant (i.e., less frequently identified) reasons identified by users as contributing to an inability to cease use was the absence of an appropriate support network (feelings of isolation and being on one's own; cost of long-distance telephone calls to a specialist tranquiliser recovery service; lack of contact with individuals who had ceased use). Social factors such as family support or pressure, partner control of medication and a stable home or social environment were among the typical reasons identified by GPs for patients successfully completing a dose reduction regime. Family and friends were also regarded as a significant source of support with ceasing BZDs by users.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to the potential influence of the researcher not being discussed and themes occasionally illustrated by single quotes). No concerns over applicability.

Study	Paterson 2016[319]
Aim	To explore the use of the "Model of medicine-taking" to identify the varying influences on patients' decisions about their use of prescribed long-term opioids
Population	A purposive sample of people taking long-term opioids for chronic non-cancer related pain was drawn from two pain clinics in Melbourne, Australia. The study run alongside a clinical trial which was investigating the use of electro acupuncture and education to reduce opioid medication by people with chronic non-cancer pain. To draw a maximum variation sample of people taking opioids for chronic non-cancer pain, the researchers sampled from three groups: 1) patients taking part in the

Study	Paterson 2016[319]
	trial, 2) patients who had been approached but declined to take part in the trial, and 3) patients who had not been approached for the trial. n=20, male/female: 10/10; age range: 29-77; length of use: 3 years or less: n=9 over 10 years: n=6; 3-10 years: n=5; participants were made up of 13 from group 1), one from group 2), and six from group 3); people had been initially prescribed opioids by their GP, a rheumatologist, in the pain clinic or in acute hospital care.
Setting	Sample drawn from pain clinics in Melbourne, Australia
Study design	Qualitative study
Methods and analysis	Semi-structured interviews, of 30–80 minutes duration were performed in people's homes or, if they preferred, at some convenient location. The interview began with an open question asking for some background to their current situation and then used prompts and questions to understand their experiences up to the present day. This included enquiry into their illness and disability, their life-world context, and details of opioid use and other treatments. The interviews were audio-recorded and transcribed verbatim, and all names replaced by pseudonyms. A constant comparative approach was used, in which data analysis went side-by-side with data collection, thus enabling later Interviews to explore emerging themes. The data were analysed at two levels: first at an inductive descriptive level and then at a more conceptual level. Three researchers developed an inductive coding framework of descriptive themes, resolving differences by discussion and by attending to reflexivity and their own differing perspectives. This coding frame was then systematically applied to all the data in all the interviews. During this process, analytic memos were written and discussed and negative (or deviant) cases were attended to. Matrices were used to look for relationships between themes and patient characteristics. The content of the descriptive analysis was then compared and contrasted to the data and conceptual themes that make up the model developed by Pound et al. The final analysis used these conceptual themes plus a new theme that the model did not encompass.
Findings	**General information on opioids: Information on side effects, opioid safety and effectiveness, length of treatment**
	Several participants refused to take opioids for many months because of concerns about addiction and adverse events. Knowledge about opioids had generally been acquired slowly over time, from pharmacists, patient package inserts and leaflets, the internet and television programmes and sometimes from doctors, especially doctors at the pain clinic. None of the participants recalled being much explanation about side effects or planned length of treatment when they were first prescribed opioids. Participants reported having asked about the side effects and receiving limited information or expressing frustration looking into side effects. When opioids were started in hospital they were rarely discussed until discharge, when pharmacists sometimes gave information. The move to stronger opioids was the spur for some people to search for information on the internet but others appeared to learn slowly and through experience.

Study	Paterson 2016[319]
	Information on addiction, tolerance, dependence & withdrawal symptoms
	Participants expressed worries about tolerance, dependency and problems with the regulation and supply of opioids with many expressing concerns that getting started on opioids would be an ever-increasing requirement. Several people had only learned of potential dependence and addiction through watching television programmes about celebrities addicted to opiates or by stopping their own strong opioids suddenly and suffering a severe reaction. There were examples of doctors providing useful explanations and knowledge, however several people had experienced frightening withdrawal symptoms and expressed their worries about the dangers of physical dependence in terms of negative views about being addicted. There was no indication that patients differentiated between physical dependence (and associated withdrawal reactions) and addiction (compulsive use despite negative consequences). As reported in the paper, it appeared from the data that many patients would benefit from understanding the difference between dependence and addiction, both in terms of avoiding dangerous withdrawal symptoms and in reducing their poor self-esteem that arose from perceiving themselves as 'addicts'
	Withdrawal symptoms & (in)appropriateness of stopping
	Participants evaluated their medicines in terms of the balance between adverse effects and medication anxieties conversely, and the benefit of a degree of pain relief on the other. It appeared that people often evaluate symptomatic treatment by stopping it for a period of time and observing the result. This common approach was inappropriate for opioids because of unpleasant and potentially dangerous withdrawal symptoms. However, many people appeared to be unaware of this danger. One participant in particular reported she stopped all her opioids to prove to herself that she needed the medication and the amount that she was taking, which resulted in her collapsing unconscious and being admitted to hospital as an emergency, which made her realise she did need medication
	Information on the need/ necessity for medication
	Peoples' attitudes to their medication were affected by the degree to which they accepted that better explanations, interventions and 'cures' were not possible, and that continuing medication was necessary. One participant in particular reported she stopped all her opioids to prove to herself that she needed the medication and the amount that she was taking, which resulted in her collapsing unconscious and being admitted to hospital as an emergency, which made her realise she did need medication.
	Definitive/ Alternative options
	Some people continued to find their medication unacceptable even after many years, with one in particular reporting experiencing side effects and stating a wish for surgery and not living like this for the rest of their life.
	Peer support

Study	Paterson 2016[319]
	Attending the pain management clinic, where people were among others with similar problems, helped some participants and their families to overcome many of the negative feelings and experiences reported to often arise due the stigma associated with taking opioids.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the recruitment strategy with the majority of the sample consisting of people recruited in a clinical trial and as the paper reported being biased towards people interested in nonmedication pain management options). Very minor concerns over applicability due to the aforementioned concerns potentially limiting the relevance of the findings to people interested in non-medication alternative options to pain management.

Study	Pérodeau 2016[325]
Aim	1) To model chronic BZD use among community-dwelling mature adults based on their subjective experiences of engaging in and maintaining BZDs use. 2) To take into account their individual and contextual circumstance as well as broader social processes and macro-structures which trigger and/or maintain long-term BZD use. 3) To add parallel viewpoints of physicians and pharmacists among the French-speaking population in the Ottawa Valley (Ontario, Canada)
Population	Long-term (at least 4 months) mature (50 years or older) BZD users were recruited via verbal presentations, posters placed on bulletin boards at health service providers, local community centres and residential homes for seniors plus ads in newspapers. Antidepressant users or people using neuroleptics were excluded as the focus was on BZD use for health issues associated with anxiety and/or insomnia symptoms. Sample was representative of cognitively well-functioning mature individuals. Health professionals were recruited from a list of names of pharmacists and general practitioners provided by the regional health and social services agency. A snowballing strategy was used based on initial interviews was used for recruitment. BZD users: n=23; male/female: 9/14; mean age (range): 64 (50-85) years; mean BZD use (range): 14 years (8 months to 36 years) Primary care physicians: n=9; mean age (range): 50 (40-68) years; mean number of years of practice (range): 21 (9-37) years. Pharmacists: n=11, mean age (range): 39 (26-52) years, mean number of years of practice (range): 14 (1-26) years.

Study	Pérodeau 2016[325]
Setting	Health service providers, community centres, residential homes for seniors, regional health and social services, Ontario, Canada
Study design	Qualitative study
Methods and analysis	In-depth interviews took place at BZD users' homes and the workplace of health professionals. Themes covered with users included: beliefs and attitudes about psychotropic drugs, especially with regard to long-term use, sources of information on the drug and their possible influence on the users' attitude or behaviour; Subjects covered with health professionals addressed their beliefs and attitudes regarding BZD prescription to mature adults, their prescribing practices, sources of information concerning BZDs. Interviews were audio recorded and transcribed verbatim. Two questionnaires were administered after the interviews to obtain descriptive data on the sample of users: a basic sociodemographic questionnaire and a measure of psychotropic drug use focusing on user patterns. The medicine cabinet of users was also inspected visually to record the total number of drugs used and prescription rationale. Both measures aimed at obtaining additional health and socio-demographic portraits of the users as well as ensuring that the inclusion criteria were met. First horizontal analysis of the data collected in each group of participants interviewed was carried out to pinpoint emerging similarities and recurring themes, followed by dual open coding by the research co-ordinator and research assistant on 16/43 interviews. Related concepts were grouped together in one common conceptual category. Following agreement between the two coders on the domains emerging from the data, categories for each domain were inductively defined, which were amended throughout data collection and data analysis until data saturation was reached. In-depth analysis of qualitative data was then done based on the principles of the axial coding process in line with grounded theory. Analysis of descriptive profile data, measurement of use of psychotropic drugs and other substances was carried out using SPSS.
Findings	**Information on timeframe for use & short-term prescriptions**
	Some doctors claimed that they set a clear time limit within a relatively short time frame, especially for new prescription of BZDs: 'when you start it, you must have a plan to stop it'. Most practitioners believe that it is extremely difficult to break the habit of BZD use once it has become a lifestyle. Doctors blame their predecessors who prescribed the medication without setting a time limit for its use. These views are shared by their fellow pharmacists, who also tend to believe that prescriptions are renewed too readily. One experienced pharmacist condemns prescribing the medication on long-term basis saying BZDs should be used wisely on a short-term basis. Many health professionals believe that BZD use is appropriate in a short-term basis and in specific circumstances such as life crisis or following a psychiatric diagnosis, but most concur that chronic use is a life-habit, devoid of intrinsic medical goals other than a quick solution and deplore the ensuing dependency on and increased tolerance for the drug, which results in higher dosage to obtain the same effect.

Study	Pérodeau 2016[325]
	Support with cessation/ encouragement from health care professionals in cessation attempts
	Weaning off medication is troublesome for some patients, giving rise to feelings of discouragement, especially if undertaken under medical supervision or advice. Ideas of future attempts are sometimes discarded, which contributes to long-term use. Most professionals seemed to have given up trying to wean long-term users off BZDs because of the perceived difficulty in educating these particular patients about the benefits of a drug-free lifestyle. The same is true of many pharmacists who were not proactive.
	Alternative approaches for the elderly
	Health professionals appeared to be influenced by the prevailing perceptions of aging and sometimes made remarks with strong ageist undertones, especially in relation to possible alternatives to prescribing psychotropic medications for older patients. For example, appearing reluctant to send elderly patients to therapy (psychological).
	Information on BZDs (safety & side-effects)
	Media (including communication technologies such as the internet) influence users' perception of long-term BZD use. In their eyes the message conveyed by the media is confusing, with users hearing that the use is too widespread and on the other hand that the drug is not overly dangerous. Patients appear to selectively retain information that confirms their own way of thinking about the issue. Some enquire about a seemingly miracle drug while others seek further information about various side effects. To justify their habit, users appeared to downplay the potential side effects of BZD, for example reporting the drugs are not that powerful and comparing them to narcotics. Users felt immune from side effects and attributed memory loss to normal aging rather than the medication. Some users, although aware of the inherent potency of BZDs, they had a false sense of control related to the fact that it can be taken in limited quantities.
	Need for information & care that is tailored to the needs of elderly patients
	Doctors and pharmacists believe that the transmission of information is not always adapted to the older patient's special needs and is done too quickly to permit sound management of the medication. Some admit their lack of knowledge and expertise in working with older people and fear that this information gap may be detrimental to the quality of their discussions with older patients.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the potential influence of the researcher not being explored). Very minor concerns over applicability due to the sample being limited to older adults whose concerns and information and support needs may slightly differ from those of younger populations taking BZDs.

Study	**Pohjanoksa-Mantyla 2009[328]**
Aim	To assess how and why people use the internet to access antidepressant information and the self-reported impact of information obtained online.
Population	A cross-section of people with depression was recruited via organisations' websites, information boards and newsletters. The inclusion criteria were 1) present or past diagnosis of depression, 2) present or past use of an antidepressant, 3) use of the internet as a source of antidepressant information during the previous 12 months, and 4) aged 18 years or older. Health and information technology professionals were excluded. n=26, all females; mean age (range): 47 (20-69) years; 12 retired or unemployed, 10 students, 7 full or part-time employed; 25 had used the internet for more than 1 year; 16 were members of a patients' organisation or support group.
Setting	Support groups and consumer organisations in Helsinki
Study design	Qualitative study
Methods and analysis	Six focus groups (FGs) were conducted across Helsinki in the premises of support groups and consumer organisations. Previous literature was used to develop an FG guide which was pre-tested using a convenience sample of people with depression (n=6). Based on the FG guide, participants were asked to describe their experiences using antidepressant information from different sources, and then particularly online. All support groups were facilitated by the same moderator and lasted 67 to 107 minutes. FGs were audiotaped and transcribed verbatim. Each transcript was repeatedly read by a researcher, while listening to the audiotapes. A constant comparison approach was used to identify emerging patterns and key themes. Single words, sentences or groups of sentences related to a particular theme were coded by one researcher and verified by another researcher. Any differences of interpretation were resolved through discussion. Once key themes were identified, the transcripts were purposively read to detect any discussion that deviated from these themes.
Findings	**Specific information about antidepressants**
	One of the most common reasons for seeking information online cited by participants was to satisfy an acute information need and to obtain a second opinion (for example regarding the dose of medication, medication alternatives, prices and reimbursement). The need for information particularly occurred **when participants started or changed an antidepressant.** Many participants reported that they were unable to absorb, or did not receive all the information they required during their initial consultation with their physician. Participants also used the internet to prepare to visit their physician. This facilitated an open discussion of treatment options, the ability to ask questions, and the option to suggest an alternative treatment.
	Information on adverse effects, risks and benefits

Study	Pohjanoksa-Mantyla 2009[328]
	Some participants reported being worried or confused by lists of potential adverse drug reactions, but most agreed that this information should be disclosed to patients. Some participants described the likelihood of experiencing an adverse drug reaction as the reason for not taking an antidepressant as prescribed. Online information prompted some participants to request additional information about the risks and benefits of specific antidepressants from their physician.
	Sources of information
	a) **Internet:** Participants used the internet to complement rather than replace information received from health professionals. The internet was often described as the first source of additional information when specific or unexpected information needs arose, especially among students and younger participants. The internet was perceived as valuable when fear of stigmatization and embarrassment limited communication in community pharmacies. Most participants felt confident, relieved and reassured after reading online antidepressant information. The internet was perceived as a key component in the shift towards greater patient access to drug information, which was described as empowering. However, many participants were concerned about information quality and reliability, several doubted their ability to discriminate trustworthy information, and some were frightened by the information they retrieved. Two participants indicated that they would rather communicate face-to-face with a person. Older participants commonly preferred books, physicians, pharmacists and telephone services over the internet.
	b) **Physicians:** Physicians were generally considered the primary source of antidepressant information.
	c) **Telephone services:** Telephone services such as drug information call centres were preferred over the internet if an immediate answer was required.
	d) **Package Information Leaflets (PILs)** supplied with dispensed drugs were typically read very closely. Most participants perceived PILs as a useful source of information, but some reported using the internet to check the meaning of a medical term or to have additional information.
	e) **Email:** Most participants indicated they would communicate with their health professionals by email, although some perceived that their health professionals would be poorly equipped to respond to their questions in this manner.
	f) **Information & support from peers:** The use of the internet was also related to the need to maintain contact with the outside world and share experiences with peers. The internet facilitated contact when fatigue and lethargy prevented people from leaving their homes. Discussion forums and electronic support groups were used by some participants to read about other peoples' experiences taking antidepressants. Most participants recognized that discussion forums could contain inaccurate or non-evidence-based information. Some people were concerned that

Study	Pohjanoksa-Mantyla 2009[328]
	discussion forums could lead other people to misuse antidepressants, although all participants reported being cautious themselves. People particularly appreciated the anonymity afforded by these forms of communication.
	Evidence-based & up-to-date information
	Most participants recognized that discussion forums could contain inaccurate or non-evidence-based information. Some people were concerned that discussion forums could lead other people to misuse antidepressants, although all participants reported being cautious themselves. Some participants read online information targeted to health professionals. The main reasons were to access the most up-to-date and comprehensive sources of information.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the potential impact of the researcher on the findings not being explored). No concerns over applicability.

Study	Slat 2021[398]
Aim	To understand barriers to primary care access and multimodal treatment for chronic pain from the perspective of multiple stakeholders.
Population	Adults with chronic pain, primary care clinicians, and clinic office staff in Michigan. Eligible criteria for patients: adult Michigan residents, self-reported chronic pain, and experienced problems receiving opioid medication. This was amended towards wend of sampling window to only include men due to imbalance of sample. N=25, Including: patients=15, primary care clinicians=7, office staff=3 Patients: male/female: 4/11; Median (range) age: 49 (35-69) years; White=10, Black=4, other/Multiple races: 1; Setting rural/urban: 6/9 Clinicians: male/female: 5/2; Physician/Nurse practitioner/physician's assistant: 4/2/1; Practice setting rural/urban: 4/3 Office staff; all females; office manager/Scheduler: 2/1; Practice setting rural/urban: 1/2
Setting	Clinicians and office staff were recruited by calling 189 Michigan primary care clinics from a healthcare database. Each clinic was audited in a previous study to assess if they were willing to see a new patient requesting opioids for chronic pain, and if they were accepting patients with private insurance and Medicaid. Patients were recruited by an advertisement on an institutional health research recruiting site, or through a posted flyer throughout high traffic areas of a large academic medical centre.
Study design	Qualitative study

Study	Slat 2021[398]
Methods and analysis	Semi-structured phone interviews: 30-minute qualitative interview guides were developed; following the first 5 interviews the team modified guides and three research assistants trained to conduct interviews; interviews coded using inductive and deductive methods for thematic analysis. Interviews conducted until thematic saturation achieved. Interviews were recorded and transcribed. Median interview length 20 minutes (range 11-52).
Findings	**Paucity of multimodal care and coordination between providers**
	Most clinicians and patients discussed the complexity of chronic pain and long-term opioid treatment, issues with pain care delivery and need for better multimodal care in chronic pain treatment. Patients reported that the care between primary care clinician and specialists can be inadequate which impacts treatment plans and subsequently requires them to take on a pharmacist role.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the majority of information not relevant to the review). No concerns over applicability.

Study	Verbeek-Heida 2006[452]
Aim	To provide insights into these processes of decision making from the patients' point of view, in the hope that this might be useful for doctors when they talk with patients about continuing or stopping SSRIs.
Population	People taking selective serotonin reuptake inhibitors (SSRIs). n=16 adults using SSRIs; M:F 7:9; mean age 51 years (range 30-80 years). All were using SSRIs at the time of interview; nine had previously attempted to stop taking SSRIs. Twelve respondents were married. Educational and social backgrounds ranged from low to high. The average duration of SSRI use was 4.5 years (range 6 months to 10 years). Stratification: Currently taking/stopping; Antidepressants (SSRIs)
Setting	Netherlands
Study design	Qualitative study using interviews and thematic analysis
Methods and analysis	Most interviews were conducted at the subject's own home, and all were tape-recorded with permission, and transcribed verbatim. The analysis is based on grounded theory, aiming at the systematic development of theories and hypotheses through the inspection of interview responses. Emerging themes were discussed and refined using the constant comparative method.
Findings	**Uncertainty about effects and dosage of SSRIs (theme stratification: starting)**

Study	Verbeek-Heida 2006[452]
	Many participants described a period of uncertainty about the effects of the SSRIs at the start of taking their medication. For some, when improvement was taking a long time, they started looking for other solutions. After a while, some would have liked to raise the dosage as they were disappointed in the effects of SSRI use, but because of uncertainty about the effects of raising the SSRI dosage on their own, they instead experimented with adding benzodiazepines when they were in stressful situations or when they could not sleep. Besides self-experimenting with benzodiazepines, some looked to improve their condition by adding, when necessary, their own alternatives, such as homeopathic medicines, psychological therapies or, in one case, St John's wort.
	Uncertainty about stopping
	There was widespread uncertainty and fear surrounding continuing or what would happen when medication use stopped, once subjects had gradually become used to SSRI and were feeling better. Participants wanted to know what could happen to them when they stopped taking medications.
	Experience of others
	Faced with uncertainty about stopping and addiction, participants said they tried as much as possible to collect information about the experiences of other users who had stopped using medications.
	Influence of media/non-health professional sources
	Some participants said they had read about addiction and problems surrounding stopping the use of these medications or had heard about these problems in the media. They had not been reassured by professional expertise. In the media, contradictory messages about addiction appear regularly. For some participants, this was a reason to modify the dosage and take less than prescribed.
	Conflicting advice from health professionals
	Some participants mentioned that they had received contradictory advice from the professional world (differences between specialists, and between specialists and general practitioners) about stopping or not, and when stopping is the issue, whether to do this gradually or abruptly. Participants had also read and heard about disagreements between professionals about the acceptable length of treatment with SSRIs. Doctors differed widely in their opinions on this.
	GP advice and support
	Participants identified support from their doctor as a key factor for coping with uncertainty around stopping and deciding whether to stop, continue or modify their treatment.

Study	Verbeek-Heida 2006[452]
Limitations and applicability of evidence	Overall CASP rating: Moderate concerns (due to recruitment, with(participants having contacted the researchers if they wanted to take part, thus possibly being more motivated to give stronger or more negative views, the small sample size, and lack of detail or rigour of analysis (i.e., no mention of coding or double/independent analysis or verification))

Study	Voyer, 2004[461]
Aim	To elicit descriptions of dependence from elderly long-term users of BZDs that might reveal potential indicators of dependence other than long-term use (defined as six months or longer).
Population	People from resident houses who had volunteered to participate in an activity programme, were <65, were long-terms users of prescribed psychotropic (Benzodiazepines) drugs; long term use described as minimum of 6 months and maximum of 40 year. N=45; 89% female; mean age (SD): 79 (7.1); n=36 were prescribed only BZDs and 9 received concomitant antidepressants; mean duration of use (SD): 9 (9.1) years; median: 6.5 years of BZD use.
Setting	Two retirement residences for ambulatory seniors in the city of Laval (Quebec, Canada)
Study design	Qualitative interview study
Methods and analysis	Participants' medication containers were inspected. Medications were classified using the Compendium of Pharmaceuticals and Specialties (Canadian Pharmaceutical Association 1998). To estimate the amount of BZD drug used in one week, the number of pills in containers was subtracted from the number counted one week earlier allowing for renewals, and average milligram daily consumption was calculated. All participants were interviewed in person by the first investigator. Interviews were directive and included 20 questions on reasons, duration and effects of BZD drug use and withdrawal experiences, attitudes and reactions from health professionals and relatives. Interviews lasted about 25 minutes and answers were written down by the interviewer and interview notes were reviewed by three investigators. A sub-sample of 11 participants showing heterogenous profiles and drug use patterns-duration of use, health status, polypharmacy were selected for a second interview, to enrich the quality of data. These participants were asked the same questions as previously, but these questions were more open-ended; they lasted approximately 60 minutes, were audio-recorded and then transcribed verbatim. All notes and transcripts were coded and analysed using Atlas-Ti software version 4. During an iterative coding process, participants' comments were abridged and grouped into three major categories:1) reliance on BZDs, 2) descriptions of BZDs and 3) desirability of stopping BZDs. These data were used to understand patterns of BZD use.

Study	Voyer, 2004[461]
Findings	**Information on the impact of BZDS: benefits & side effects**
	Participants expressed concerns about the impact of drug use on their health including citing memory problems and the absence of benefits associated with their BZD use for example citing that they have not been useful in helping them sleep, leading patients to question their usefulness.
	Information on benefits of & support with stopping and withdrawal symptoms
	The majority of participants reported they had previously tried stopping BZDs but were all current users. Those who viewed stopping as desirable expressed concerns with the impact of drug use on their health and the absence of benefits. However, many explained how stopping was not desirable with some expressing fear that symptoms of anxiety would return if the drug were stopped or argued that because of age, the benefits of stopping would not outweigh the disadvantages. Some reported that stopping would not be desirable precisely because they were dependent, with some evoking withdrawal symptoms or questioning 'what good would it do to stop' at their age. Another reason given for the undesirability of stopping was that participants did not want to physically distance themselves completely from BZDs, wishing to keep a supply 'in reserve' in case they experience a problem or a crisis.
Limitations and applicability of evidence	Overall CASP rating: Serious concerns (due to the role of the researcher not being explored, the recruitment strategy with participants selected for a different project, the data analysis being unclear). No concerns over applicability.

Study	Vilhelmsson 2012[456]
Aim	To qualitatively analyse the free text comments appended to consumer reports on antidepressant medication.
Population	People reporting adverse drug reactions to antidepressant medications n=181 consumer reports; 135 from women, 38 from men; The antidepressants most reported for a diagnosis of depression were Sertraline (23.8%), Citalopram (23.8%), Venlafaxine (23.2%), Mirtazapine (10.5%), Paroxetine (7.7%), Escitalopram (6.1%) and Fluoxetine (5.0%) Stratification: Currently taking/stopping; Antidepressants
Setting	Sweden
Study design	Content analysis of free text comments from consumer reports

Study	Vilhelmsson 2012[456]
Methods and analysis	All reports of suspected adverse reactions regarding antidepressant medications submitted from January 2002 to April 2009 to KILEN's internet-based reporting system in Sweden were analysed according to reported narrative experience(s). Content analysis was used to interpret the content of 181 reports with free text comments.
Findings	**Information on adverse reactions**
	Several response narratives identified patients' concerns about a lack of information regarding adverse reactions, and an absence of communication between patient and doctor on this subject. "*When I first started taking it, I received NO [sic] warning of adverse drug reactions.*" – female, aged 37 years (Venlafaxine). Some reports included narratives of giving up on antidepressant treatment because of difficult suspected adverse reactions.
	Lack of follow-up
	In some cases, in the reports patients described not just a lack of communication between doctor and patient, but also that there were no follow-ups of the treatment, and that prescriptions were renewed without a personal contact, for instance, by telephone.
Limitations and applicability of evidence	Overall CASP rating: Serious concerns (due to research aim, design and data collection (retrospective analysis of independently submitted free text feedback from consumers); study not designed to answer review topic, study design dictated by the data/consumer feedback process; results (themes) were reported interspersed with references and insights from other studies, making it unclear what conclusions were based on this study alone). No concerns over applicability

Study	Webster 2019[468]
Aim	To explore the social organization of chronic pain management from the standpoint of primary care physicians; research question: 'How do primary care physicians describe the work they do in caring for patients with complex chronic conditions?'
Population	Clinicians working in urban centres, small cities and remote Northern communities across Ontario Canada, recruited via a scripted email. Primary care physicians: n=19 Primary care nurses: n=8
Setting	Urban centres, small cities and remote Northern communities from across Ontario, Canada.
Study design	Institutional ethnography research approach involving qualitative interviews followed by observational data

Study	Webster 2019[468]
Methods and analysis	Semi-structured interviews ranged from 30 to 90 minutes and were supplemented by approximately 40 hours of observational data of everyday work practices in clinical settings, collected by shadowing primary care physicians' daily work in caring form complex patients The observer took "scratch notes" that were written into more detailed field notes immediately following the observation, and were typed up into more in-depth field notes within a 24-hour period. These observations were complemented by ad hoc interviews the observer conducted in the field, the purpose of which was generally to gain clarification or insight into an observed event. The first several transcripts and field notes were inductively coded by two independent researchers, who then met to compare their codes and achieve consensus on items to be included in a coding framework which was then applied by one researcher to the remaining interviews. Data analysis was an interactive, inductive, and collaborative process that involved identifying emergent themes and theorizing the implications of this for our broader research topic. Nvivo 10 software was used for storage and organization of data.
Findings	**Realistic information on what clinicians can provide**
	Many clinicians described a disjuncture between patients' hopes and expectations for pain management and the reality of what physicians can provide in way of treatment, especially in the current climate in which they are under pressure to restrict opioid prescriptions, the historical mainstay of treatment for patients with chronic pain.
	Help accessing health & financial benefits
	Most care providers were aware of the limitations that poverty posed in terms of the care that patients could access and raised how their work involved obtaining health benefits and other financial benefits for patients.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to no clear statement of findings). Minor concerns over applicability as the sample was limited to clinicians caring for people of lower socio-economic status.

Study	Wilson 2018[487]
Aim	To examine the process involved when adults first initiate the use of opioid medicines to treat pain through enrolment in an outpatient MAT program.
Population	Adults diagnosed with chronic pain receiving medication-assisted treatment (MAT) in an outpatient opioid treatment program, who had previously consented and enrolled in a randomized controlled trial piloting an online self-management program were randomly selected

Study	Wilson 2018[487]
	N=10; male/female: 6/4, mean age (range): 47.6 (23 to 61) years; Primary pain diagnoses reported: neck and back pain (n=3), fibromyalgia (n=3) and arthritis (n=2);n=9 had been receiving pain treatment in the past and n=2 were presently receiving treatment specifically for pain.
Setting	Outpatient MAT facility, Pacific Northwest USA
Study design	Qualitative interview study
Methods and analysis	Data were collected through semi-structured, face-to-face individual interviews taking place from May 2016 through November 2016 at the outpatient MAT facility. All interviews were conducted by a coinvestigator (second author) or trained research assistant (third author) in a secluded room, using an interview guide with open-ended questions to elicit in-depth data from the participants. The guide was revised as themes began to emerge and questions arose through constant comparative analysis. Interviews were approximately 45-90 minutes long and were digitally recorded and transcribed verbatim upon completion. Data analysis was an iterative process beginning with the initial interviews and continuing throughout theory development. Analysis methods used techniques to deconstruct the data in search of predominant categories, concepts and conceptual relationships. The research team incorporated self-reflection throughout the analysis process to avoid biasing analysis. Categories initially identified were supported by data from existing transcripts and or by additional data from subsequent interviews. In some cases, data were discarded due to lack of commonality among the transcripts. Specific grounded theory data analysis steps included beginning coding, open coding, constant comparative analysis, theoretical integration and theory refinement.
Findings	**Pain management education & support**
	Participants commonly described an initial crisis or traumatic pain event, often marked by poorly managed pain and insufficient pain management education and support. Persisting pain (both physical and psychological/emotional) **was an integral piece of participants' experiences of misusing opioids**. Descriptions of pain were frequently accompanied by feeling a sense of shame along with experiencing anxiety and frustration with their unrelenting pain. All participants told stories of physical pain and the negative effects pain has on their quality of life. Living with pain influences participants usual roles (e.g., as parents) and responsibilities, relationships and sense of self were negatively affected. The struggle to cope with physical pain (e.g., injury, withdrawal symptoms) and emotional pain (such as 'feeling judged') and to function in society despite the persisting pain was expressed by all participants. What most often began as a prescription for a medical condition or injury commonly turned into participants increasing the amount and frequency of medications and using opioids for reasons other than prescribed (e.g., stress, anxiety).
	Alternative treatment options

Study	Wilson 2018[487]
	Opioid initiation often involved an event resulting in physical injury that led to initial opioid prescription and developed into an ongoing, physically painful, chronic condition. In many scenarios participants related that opioids were the first line treatment and the only treatment prescribed or suggested. Several stated disbelief about the ease of obtaining the initial prescriptions- often at large doses and for long periods of time- even when it was not for severe pain.
	Information on opioids (long-term effects)
	Opioid initiation included the lack of education about long-term effects of opioid use. Some participants stated they did not question the prescription because they believed the provider was doing their best to treat their medical condition. A patient prescribed morphine specifically reported 'no one ever really told' them 'the whole story as far as how addictive that stuff is…, all the side effects that go along with it.
	Supportive health professionals
	The important positive effect of supportive relationships with opioid treatment clinic staff was emphasised by all participants. Stories were disclosed about relationships that facilitated or enabled the participants' addiction; Participants told stories about non-supportive experiences involving family members, healthcare providers and staff at healthcare facilities. Non-supportive encounters were described as hindering recovery rather than being helpful. They universally reported feeling judged by healthcare providers at some point in their journey to recovery from addiction and pain. They disclosed stories about how their medical complaints were not believed or taken seriously by healthcare providers. They frequently discussed the barriers to adequate medical care they faced and the 'accusatory looks' they received when seeking pain relief, presumably based on their history of opioid abuse and or engagement in MAT.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to potential bias in the data analysis process as some data were discarded due to lack of commonality among transcripts). Minor concerns over applicability as the sample consisted of people previously recruited in an RCT whose views may differ from people not sharing the same characteristics and due to the sample consisting of people who eventually developed opioid use disorder.

Study	Wyse 2019[492]
Aim	To understand how clinicians adhere to recommendations for managing patients prescribed long-term opioid therapy.

Study	Wyse 2019[492]
Population	Physicians and nurse practitioners (n=24) caring for patients prescribed long-term opioid therapy, were recruited from the VA Portland Health Care System. They represented 22 VA Medical Centres across the USA i.e., diverse geographical regions. N=24 (20 physicians, 4 nurse practitioners); male/female: 9/15; mean age (SD): 49.5 (10) years; average number of years since completion of training (SD, range): 17 (10, 2-37) years.
Setting	VA Portland Health Care System
Study design	Secondary data analysis of qualitative interviews study
Methods and analysis	All interviews were conducted by the project investigators, lasted 30-40 min, and were audio-recorded and transcribed verbatim. The semi-structured interview guide used was developed by clinician researchers with expertise in the treatment of chronic pain, long-term opioid therapy, substance use disorders and qualitative research methods. Questions included examined: 1) the methods clinicians utilise to reduce prescriptions opioid misuse and address aberrant opioid-related behaviours; 2) how clinicians responded to misuse; 3) resources and constraints they faced in managing and treating opioid misuse among their patients. A qualitative content analysis approach was used for data analysis. Six interviews were coded jointly by project investigators to establish mutually agreed upon codes and definitions which were then used to build a codebook. The remaining interviews were divided and first coded independently by project investigators and then exchanged for secondary coding (i.e., all interviews were coded by two investigators. Quotes pertaining to conversations between patients and clinicians were then further categorised into sub-themes, which were then further categorised into sub-themes. Quotes that exemplified key sub-themes were selected for inclusion in the manuscript.
Findings	**Rationale for dose changes**
	Health practitioners reported that patients could be angry, aggressive and even violent in reaction to clinicians' changes to their opioid prescriptions. Objections were not just voiced with clinicians; complaints were also frequently shared with patient advocates or hospital administration. Other clinicians described the implications of patient complains to congressional officials, a practice mentioned across multiple interviews. Clinicians found it difficult to be on the receiving end of complaints regarding their perceived lack of concern for patients' pain, when they believed that their actions were ultimately in the patients' best interest. Although clinicians recognised that long-term opioid therapy was associated with heightened risk for patients on a population-level, applying this knowledge to individual patients could feel uncomfortable and it was reported that enacting changes to patients' prescriptions nonetheless felt difficult. Some patients resisted changes (e.g., tapering high doses of opioids) in ways that were emotionally taxing and time-intensive for clinicians
	Setting expectations about opioids

Study	Wyse 2019[492]
	a) **Importance of adherence:** Health practitioners underscored the importance of setting expectations regarding adherence to the treatment plan. For example, establishing ground rules with patients e.g., about early refills, instilling the expectation with patients that prescribing practices would not be flexible.
	b) **Informed consent:** Clinicians appeared to discuss an opioid informed consent document with patients before initiating them on long-term opioid prescriptions. Clarifying possible repercussions through signed informed consent made consequences of aberrant behaviours clear from the start (e.g., aberrant behaviours that could lead to decisions to taper or discontinue)
	Information on the risks of opioids (group education visits)
	Talking with patients about the risks of opioids in person were reported to be very time consuming. Interactions were reported to often be unpleasant with patients being unhappy with dose changes and the relief resulting from group education visits (where nursing and clinicians do one big group education visit to talk with patients about the risks) was noted.
Limitations and applicability of evidence	Overall CASP rating: Very minor concerns (due to the role of the researcher not being explored).No concerns over applicability.

Study	Young 2017[507]
Aim	To determine the acceptability and feasibility of using social media to reduce opioid-related complications among patients with chronic pain; in particular to evaluate the utility of the Harnessing Online Peer Education (HOPE) social media intervention to reduce the risk of addiction and overdose among non-cancer pain patients receiving chronic opioid therapy.
Population	UCLA Health System patients being treated for prescription opioid dependence and co-occurring chronic pain. Staff at UCLA clinics who worked with patients receiving chronic opioid therapy. Patients: n=10; male/female: 6/4; all met DSM-IV criteria for opioid dependence and were receiving treatment with buprenorphine form one of the authors. Staff: n=5
Setting	University of California, Los Angeles (UCLA)
Study design	Qualitative study
Methods and analysis	Semi-structured interviews were conducted using an open-ended interview structure informed by interviews with two clinical staff members that worked with chronic opioid patients. Broad areas of questioning included: patterns of internet/social media use by the individual and their peers, differences in patterns of use between traditional and mobile social media platforms, and

Study	Young 2017[507]
	the potential acceptability of opioid- and pain management–related messages through social media. After gaining insights from the clinical staff, a set of semi-structured interview questions for patients and a modified version for clinical staff that had not participated in development of the interview was used. Questions covered in the semi-structured interviews focused on the nature and relationships of chronic pain suffers to social media, including whether they make or maintain friendships online, how influential they perceived those relationships to be, and whether they felt community settings such as Alcoholics Anonymous (AA) could be helpful for reducing their dependence on opioids. Participants were also asked about the educational information they have access to, other information they would like to have access to in regard to pain management and drug therapy, and how this information could be relayed via social media. During the interviews, the HOPE intervention was described to patients, and they were asked for their thoughts about how it or similar online peer-led communities might benefit them. Finally, participants were asked about the role social support has played in helping improve their pain management and reducing opioid abuse. Participants received a $20 online gift card after completing the interview. Interviews were coded by two researchers to determine topics and themes, who used an open coding method to analyse the data, generating a set of codes that were confirmed by iterative comparison until the two coders reached consistent agreement
Findings	**Online social support**
	Patients valued being able to communicate about their pain and opioid therapy with others online. The ability to share stories, support, and tips for pain management online were all of value to those interviewed. The necessity of regular, accessible and non-judgmental peer support, as reported could be found online, was expressed by all interviewees and was communicated as integral for maintaining recovery and re-abuse prevention. Being able to speak to people online who were on similar medications and able to share tips and experiences was important to all of the interviewees. All clinical care staff reported that an online support community would likely be beneficial to their patients, as they reiterated patient interview responses, saying that they have often tried to refer patients to offline support communities such as AA, but patients were reluctant to go because it was not tailored to their patient demographic and because of the time commitment involved. Three staff members felt that a peer-driven community would be beneficial. Staff members thought that patients would be willing to listen and interact with peer leaders from all age groups. They thought that patients would be able to relate to other opioid users and gather insights from patients who had overcome complications and learned to manage their pain successfully.
	Community-based social support & advocacy
	Patients voiced their need for a support system, regardless of online or in-person, as valuable to bond over shared experiences and get tips on daily pain management. Ambivalence regarding in-person traditional interventions, such as AA, was a commonly expressed by patients. The importance of support seemed more focused on feeling included and not being subject to judgment or misunderstanding. However, some patients were unable to identify with others at community-based settings such as AA. None of those interviewed said that they had maintained a regular attendance at any traditional offline support system, though most participants said they had been to at least one meeting. Because of the philosophy espoused by

Study	Young 2017[507]
	AA and NA of a completely drug-free life, some patients expressed they felt judged and unwelcome for admitting the necessity of pharmaceutics in their lives to maintain quality of life.
	Need for tailored support
	Patients expressed desire for a more tailored form of support that specifically addressed their needs as prescription opioid users as opposed to “street” drug addicts. Patients expressed the need for an educated and supportive environment with empathy for their specific concerns and experiences. The need for a tailored support environment, including people with shared demographic, socioeconomic, environmental, and medication histories, was expressed by patients who had tried online communities as well as those who had only tried offline support groups. Interviewees expressed that a group focused on addressing the needs of non-cancer chronic opioid therapy patients was a unique niche that was not currently addressed. The need to feel less isolated, less invisible, and more heard for their specific needs and struggles were recurrent patterns expressed by patients.
Limitations and applicability of evidence	Overall CASP rating: Minor concerns (due to the role of the researcher not being explored and themes occasionally supported by limited data.) No concerns over applicability.