Supplementary File B

Supplementary Table 1. Thematic analysis with sample participant quotes

Theme **Subthemes**	Sample participant quotes
Theme 1: The 'too hard basket': Challenges of deprescribing	
Subtheme 1: Medication-related challenges	"The concern is, you become tolerant to the analgesic effect, but you don't become as tolerant to the risks of respiratory depression and the risk of the other side effects." (P3, SI) "In some situations, the opioids do make people feel better in more ways than just relieving pain and I think that they are susceptible to maintaining that drug." (P13, FG) "The problems in terms of the consequences of opioid use, you know there are things like risk of death by misadventure, which is the commonest way to die from prescription opioids, risk of intentional overdose, risk of all the other issues that come with opioids. For elderly people the risk of falls, hip fractures, cognitive decline, endocrine problems, osteoporosis, hypogonadism." (P10, SI) "I do often talk about non-pharmacological measures so, topical agents, well I suppose they are pharmacological, but heat packs and cold packs and exercise and hydrotherapy. But I think I feel a bit limited using that." (P6, SI)
Subtheme 2: Patient-related challenges	"The people most likely to end up with problems are people with previous mental health issues, people who are also taking benzodiazepines, people who have had chronic pain in the past." (P4, SI) "This problem can occur across every demographic." (P14, FG) "The number of people who do profess the fact that they are aware of a degree of dependence and they would like to do something about it, and I think they are the ones we can target." (P1, SI) "Yes, it is stigmatising, and I don't think the current system is good enough to help address that stigma." (P15, FG) "There's a fair number of people – life's not very happy, they are a little bit depressed, they are a little bit not happy with themselves a little this that and the other and they have a sore knee or a sore neck and that's the reality of clinical practice as you know." (P5, SI) "It's also based on their experiences, so if they have had adverse effects or if they already have a predisposition to wanting to minimise tablets then they are more open to it." (P9, SI)

	"So perhaps there is a behavioural thing, it seems easier to pop a pill than to try a heat pack or what not." (P6, SI) "We have to be careful that we don't demonise opioids, it's a bit of a fine line between engaging the community and educating them but not sort of demonising." (P16, FG)
Subtheme 3: Prescriber-related challenges	"In my experience, it's really hard to take something away from people without giving them something in return. So, if you are saying I am taking away your candy and not give you anything, people aren't going to react very well to that." (P4, SI) "When looking at the deprescribing opioids you want to know that you are not worsening the patient centred outcomes like their quality of life or their functionality." (P6, SI) "I think that's really difficult unless that patient comes and says, 'I don't take this anymore' or 'I don't want to take this anymore'." (P17, FG) "I think across the specialities we find that most people would not interfere when they are lobbed in hospital." (P1, SI) "You know that's hard work for the GP and for the patient and unless it's all done properly, then everyone is doomed to failure" (P1, SI) "I guess I would probably like most of my general practice colleagues, if someone is stable on a low potency opioid like pandeine forte or something, and is ok on that, I am not going to rock the boat and probably most of us would take that pragmatic approach." (P5, SI) "Tapering dose is something that I would be happy to do with a patient if they wanted to." (P5, SI) "Deprescribing is part of our jobs...it's almost like, no it is patient advocacy to be talking about deprescribing." (P6, SI)
Subtheme 4: Health System-related challenges	"(Hospital) is not the right time to try and institute a deprescribing program – I mean you might think so from the outside…but we would generally continue their dose of medication throughout their stay and we would generally discharge them on the same dose they came in on." (P1, SI) "I hope we can do our bit from a hospital perspective by not spending people out with vast amounts of opioids so the poor GP doesn't have that to contend with – and hopefully if they get enough resources, they might be able to have some success." (P1, SI) "It's under resourced. There is a very long waiting list for pain clinics and it's a problem." (P2, SI) "It becomes difficult as well like if you have a GP that isn't bulk billing, then the patient has to go back there and it costs them every time they see them, and that will make it less likely for the patient to go and see them." (P8, SI)

	"There is often some shared responsibility in a group general practice which of course is appropriate and that's how it operates, and it gives people choice and flexibility but also sometimes things get lost." (P5, SI)
	"I am perhaps seeing them on a once off basis and have to make a decision about whether or not to give a prescription which they are regularly getting from their doctor anyway." (P5, SI)
	"I have had some challenging management processes over the years where they have been discharged from surgery and "oh go and get another prescription from the GP when you run out". That's very unhelpful." (P5, SI)
	"Access to those multidisciplinary pain clinics was pretty difficult, they had long wait lists and I mean the one in my region, it's just excellent but the problem is getting people in there. I think what they might be tending to do is write a referral which is OK, but there are only a limited number of appointments and chronic pain is a chronic condition, so I'm not sure how that works in the real world." (P10, SI)

Theme 2: Even if I want to, I don't know how: Opioid Deprescribing Guidelines

Subtheme 1: Guideline characteristics	"If I was doing it all again that's where I could have done better and if I had had some more structured plans of how to go about it in practice." (P10, SI)
	"I am a great believer in guidelines, I think they are an incredibly valuable resource." (P5, SI)
	"Well I think you should probably consider it in all patients because the great majority of patients will not be deriving any benefit from the medicine and the potential harms are outweighing the possible benefits…if someone is on long term opioids for chronic non-malignant pain, then you should be thinking about decreasing and hopefully stopping the medicine." (P10, SI)
	"A deprescribing guide would be helpful for in hospital and for GPs – If it could cover both areas that would make perfect sense – because that way there could be a consistent approach – like that way we know here in hospital what the GP is being told and likewise." (P3, SI)
	"I am a better person to be doing it with than others because I have available to be other options as we go along including if it turns out that they are dependent, moving them over to a dependency pathway. I do have the other referral options more easily available to me." (P5, SI)
	"GPs are on the front line in being able to do it but it's not an easy thing." (P11, SI)
Subtheme 2: Guideline content	"I think it's really helpful to provide community prescribers with risk predication tools and trigger points of when to refer and when to start to deprescribe. And then offer them a really solid deprescribing strategy – and in my mind part of that should be having a treatment agreement, one prescriber and controlled dispensing if necessary and then what to do if that doesn't work." (P4, SI)

	"The key is to establish the expectations upfront when you're prescribing. Say 'yes, OK here we are going to be prescribing an opioid, but this is the expectation. We are going to try and if it's going to work, we can look at reducing…It helps the patient understand where things are going on that trajectory and makes the conversation about deprescribing much easier." (P18, FG) "You have to treat these patients individually, I think a pathway as such for pain management doesn't work, I think the pathway is saying all patients are following the same trajectory in their dose reduction and that sort of thing, that's when problems are going to arise and that's when people are not going to be happy with the service they are receiving and people might have pain unnecessarily." (P8, SI) "You've really got to have a conversation with the patient about it. Because if you go too fast and they get into withdrawal they don't want to come back and aren't going to agree to it. But If you say to them, we are going to do this really slowly and get their confidence and they keep coming back and I think we just keep enabling them to get through it." (P11, SI) "The most important thing from my perspective is thinking about deprescribing from the point of initiation. So, having an exit plan. Part of that is having a deprescribing strategy at the point of initiating opioids, not when you realise that they aren't working." (P4, SI) "I'll always give people options, I think that's really important, so they don't feel trapped or hemmed in and often people feel very angry towards the health professionals for getting them on such a high dose of opioids or they feel angry and themselves, angry at the pain." (P4, SI) "What you're really aiming at improving their functionality and quality of life, switching the focus from looking at pain levels to overall health. You have to measure pain, you certainly don't want the pain to escalate but I think you are painting yourself into a corner if that's what you are focusing on because while you might get some decreased pain by putting in all those supports, it is going to be modest. What you're really looking at is improving quality of life and capacity and that needs to be part of your evaluation of how deprescribing is progressing." (P10, SI)
Subtheme 3: Guideline dissemination and implementation	"I think the concept of it is good, but a lot of thought is going to have to go in for how you implement that. I think it's going to fail if you try that on its own." (P8, SI) "I definitely recommend you check healthpathways out for this project, but it's what GPs use to understand what they should do with a condition and who they should refer to and that's a good resource." (P4, SI) "I think this is a tricky area, it's difficult, the evidence base has evolved, context has certainly evolved...I think it's also useful if they are available, and I am not sure if they are, but through the various healthpathways websites." (P10, SI) "A good outcome is having the patient still engaged but having managed to reduce their opioids." (P11, SI)

*P = Participant, SI = Semi-structured interview, FG = Focus group