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Barriers and facilitators to opioid deprescribing among Advanced Nurse Practitioners: A qualitative interview study

Claire McCann | Claire Odile McCauley | Deirdre Harkin

Ulster University, Derry City, UK

Correspondence
Claire McCann, Ulster University, Belfast, UK.
Email: mccann-c91@ulster.ac.uk

Abstract

Aim: To explore the experiences primary care Advanced Nurse Practitioners have had in relation to deprescribing opioids in chronic non-malignant pain.

Design: A qualitative interview study.

Methods: Primary care Advanced Nurse Practitioners were recruited from across the Northern Ireland GP Federations. Data collection for this study took place between April and June 2022. In total, 10 semi-structured online interviews were conducted. Interviews were audio and visually recorded, transcribed verbatim and interpreted using a thematic analysis framework. The COREQ criteria were used to guide the reporting of this study.

Results: The Advanced Nurse Practitioners experienced several challenges associated with opioid deprescribing and the implementation of current chronic pain guidelines. The main barriers identified were difficulties engaging patients in deprescribing discussions, a lack of availability of supportive therapies and poor access to secondary care services. The barriers identified directly impacted on their ability to deliver best practice which resulted in a sense of professional powerlessness.

Conclusion: The experiences of the Advanced Nurse Practitioners demonstrate that opioid deprescribing in patients with chronic pain is challenging, and implementation of current chronic pain guidelines is difficult.

Impact: This study contributes to existing literature on the topic of reducing opioid prescribing and as far as the authors are aware, is the first study to examine the experiences of primary care advanced nurse practitioners in this context. These findings will be of interest to other primary care practitioners, and prescribers involved in the management of chronic non-malignant pain.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
chronic pain, deprescribing, nurse, opioid, primary care, qualitative research

1 | INTRODUCTION

Chronic pain is defined as pain that is present or recurring for longer than 3 months (International Classification of Disease [ICD], 2021). The worldwide prevalence of chronic pain is estimated to be around 30% (Cohen et al., 2021). Prevalence in the United Kingdom is difficult to quantify but is estimated to be between 30% and 50% (The National Institute for Health and Care Excellence [NICE], 2021). In the United Kingdom, chronic pain accounts for 22% of all consultations in general practice (Faculty of Pain Medicine, 2021).

The USA's opioid crisis (Centres for Disease Control and Prevention [CDC], 2022) escalated concerns about the safety and efficacy of long-term opioid use. For several years now, there has been much controversy surrounding the use of opioid therapy to treat non-cancer pain, largely due to their lack of effectiveness and significant risk of harm (NICE, 2021; Taylor et al., 2019). Over the last decade, deaths from drug misuse and drug dependence have increased across the whole of the United Kingdom. Furthermore, the rate of strong opioid prescribing is higher in Northern Ireland than anywhere else in the United Kingdom (Northern Ireland Audit Office [NIAO], 2020). With this context, it is a concern that the United Kingdom have seen significant increases in prescription opioids over the last decade (Curtis et al., 2019; Jani et al., 2020; Mordecai et al., 2018). Moreover, Ashaye et al. (2018) estimate the annual cost of opioid prescribing in the United Kingdom primary care to be in the region of £100 million.

2 | BACKGROUND

Chronic pain can have a detrimental effect on quality of life and is linked to feelings of anxiety, depression and suicide (Rose, 2018). Chronic pain is complex and is often described as a biopsychosocial phenomenon (Gruß et al., 2019). In April 2021, The National Institute for Health and Care Excellence (NICE) issued new guidelines relating to the management of chronic pain. The guidance is expected to have a significant impact on prescribers in primary care as it recommends that health professionals review patients with chronic pain already on opioid therapy and support them to reduce and gradually stop the medication. National and international studies have examined barriers and facilitators to opioid tapering in chronic non-malignant pain (Busse et al., 2020; Gill et al., 2022; Hamilton et al., 2021; Kennedy et al., 2018), but none have specifically explored the experiences of Advanced Nurse Practitioners (ANPs). ANPs are nurses, educated to master's level, who have enhanced nursing knowledge and decision-making skills. They provide care for patients with a range of acute and chronic conditions that commonly present in primary care. Their expanded scope of practice includes clinical assessment, diagnosis, referral and prescribing (Department of Health Social Services and Public Safety, 2016). Advanced Nurse Practitioners have a key role to play in the management of chronic non-malignant pain. Therefore, it would seem relevant to explore their views and experiences of deprescribing opioids in line with current guidelines. This study aimed to fill this gap in research by exploring the experiences primary care ANPs have had in relation to deprescribing opioids in patients with chronic non-malignant pain. The findings of this research are expected to be of relevance to prescribers in similar settings in other countries.

3 | THE STUDY

3.1 | Aim

To explore the experiences primary care ANPs have had in relation to deprescribing opioids in chronic non-malignant pain.

3.2 | Objectives

- To investigate the views of primary care ANPs regarding the use of guidelines in managing chronic non-malignant pain.
- To explore barriers and facilitators experienced by primary care ANPs to deprescribing opioids in patients with chronic non-malignant pain.

3.3 | Design

The aim of this research was to describe and explore the views and experiences of primary care ANPs. Therefore, a qualitative methodology was selected, and a qualitative interview study conducted. Qualitative description was the selected approach for this research. Qualitative description is associated with the accurate description of a phenomenon, from the emic position of the participants. It is a flexible and inductive approach which allows the researcher to analyse, interpret and reflect on the data to accurately represent the responses of the interviewees (Bradshaw et al., 2017).

A total of 10 semi-structured online interviews were carried out. The interviews were audio and visually recorded, transcribed verbatim and interpreted using Braun & Clarke's thematic analysis framework (2022). This method of thematic analysis fits well with qualitative description as it allows the researcher to construct codes and themes that authentically describe the research findings.

3.4 | Study setting and recruitment

The ANPs were recruited via the Northern Ireland GP Federations, and all were practicing in GP surgeries across Northern Ireland. Convenience sampling was undertaken to ensure only eligible, qualified primary care ANPs with the relevant knowledge and experience of deprescribing opioids in patients with chronic non-malignant pain, were selected. The inclusion and/or exclusion criteria can be viewed in Table 1. On receipt of an expression of

TABLE 1 Inclusion and/or exclusion criteria.

Inclusion criteria	Exclusion criteria
Must be over 18 years of age	Trainee ANPs
Must be proficient in the English language	Practice nurses with a prescribing qualification who have not completed the Advanced Nurse Practitioner programme.
Must be currently working as a qualified ANP in primary care.	No experience of deprescribing or prescribing opioids.
Must be an employee of the Northern Ireland GP Federations	Qualified ANPs who are not employed by the GP Federations.
Must have experience of deprescribing and prescribing opioids	Primary care ANPs who are currently on sick leave or who are participating in a 'return to practice' programme.

TABLE 2 Interview guide.

1.	Tell me about your experience of prescribing opioids for patients with chronic non-malignant pain?
Probe	How do you feel about prescribing opioids in patients with chronic malignant pain?
2.	What do you perceive to be the most commonly prescribed opioid in your clinical area?
Probe	For example, co-codamol, tramadol, tramacet, and patches (butrans, butec).
3.	How do you feel about incorporating opioid deprescribing in chronic non-malignant pain into your practice?
Probe	How confident and competent do you feel in this area? How easy or difficult do you find it? How important do you think it is?
4.	Can you tell me about any guidance you use in relation to managing chronic pain, and explain how it has informed your practice?
Probe	Are you aware of the updated NICE guidelines relating to the management of chronic pain? How easy or difficult do you think it is to implement these recommendations into your practice? Are there any other guidelines or resources you use to guide your deprescribing practice?
5.	What facilitators influence your deprescribing practice in patients with chronic non-malignant pain?
Probe	What would prompt you or drive you to initiate a deprescribing discussion with a patient? What factors positively influence your deprescribing decisions? What helps your deprescribing practice—factors relating to you as a clinician, the patient and the environment?
6.	What barriers influence your deprescribing practice in patients with chronic non-malignant pain?
Probe	What factors prevent you from initiating deprescribing discussions in this group of patients? What factors negatively influence your deprescribing decisions? What hinders your deprescribing practice—factors relating to you as a clinician, the patient and the environment?
7.	What support would be helpful to guide your practice of deprescribing opioids in chronic non-malignant pain?
8.	What role do you feel the primary care ANP could play in reducing opioid prescribing in chronic non-malignant pain?

interest to participate in this study, a participant information sheet and consent form was sent by return email, directly to the potential participant. The participant information sheet provided a full account of all features of the research and explicitly detailed the respondent's involvement, explaining how and where the data would be obtained, handled and stored. Interested participants were asked to contact the researcher directly within 2 weeks. A total of 10 participants were recruited.

3.5 | Data collection

Data collection for this project was via semi-structured interviews conducted by the first author who was a trainee ANP undertaking the research as part of their master's in Advanced Nursing Practice. Interviews continued until data saturation was achieved and no new themes were interpreted. No participants withdrew from the study. A reflective diary was also kept encouraging reflexivity and promote rigour in the project (Braun & Clarke, 2022).

An interview guide was developed based on the research aims and objectives of the study and informed by the literature search. The participants were asked approximately eight open-ended questions, and probes were used to clarify and explore responses. The interview guide is presented in Table 2. Due to the COVID-19 pandemic and unpredictable changes in guidelines regarding face-to-face meetings, the interviews were conducted via an online videocall platform. All interviews were audio-visually recorded and saved to the secure University Office 365 cloud storage.

3.6 | Pilot interview

A pilot interview was conducted with a qualified ANP who met the inclusion criteria, but the data were not used to inform the findings. The purpose of the pilot interview was to ensure rigour of the data collection method and allow the researcher to test the interview questions and technique (Moule, 2018). Following the pilot interview, a debrief took place with the second researcher to review and hone the interview guide, ensuring the questions were relevant to the aims and objectives of the study.

3.7 | Data analysis

Braun and Clarke's Thematic Analysis (2022) was used to analyse the data collected in this research study. The interviews were transcribed verbatim by the first researcher who was fully engaged in the data, taking notes and rereading interview transcripts. All 10 interview transcripts were analysed, and a combination of semantic and latent codes applied (Braun & Clarke, 2022). The process was repeated to ensure all relevant data were captured and codes were not missed. Codes and themes were reviewed by the second researcher. The themes and subthemes were constructed and organized to appropriately answer the research question. The themes are presented and illustrated with anonymized participant quotes. The themes will be discussed in relation to the study aims and objectives, and in comparison, to relevant literature.

3.8 | Ethical considerations

Ethical approval for this research was obtained on the 10 November 2021 from the University Institute of Nursing Ethics Filter Committee (Project Number: FCNUR-21-087). All information was handled in compliance with the General Data Protection Regulations (2018). Written informed consent was obtained at the outset before interviews were conducted and was an ongoing consideration throughout the study. Every effort was made to maintain confidentiality. Care was taken not to use names during the interview recording and no names appeared on the interview transcript. Each participant was assigned a code and pseudonyms were applied to the participant quotes.

In accordance with the University Code of Practice for Professional Integrity, in the Conduct of Research (2020), Participants were aware that they could withdraw from the study at any stage before or during the interview. Participants were monitored by the researcher for any signs of distress or fatigue during the interviews. Useful links to support services were included in the participant information sheet.

3.9 | Rigour and reflexivity

The COREQ criteria were used to guide the reporting of this study (Tong et al., 2007). Credibility has been established by peer debriefing with an experienced second researcher who independently verified the data, which helped to moderate personal bias.

4 | FINDINGS

4.1 | Characteristics of participants

The 10 study participants were all female primary care ANPs, educated to master's level and employed by GP federations across Northern Ireland. All were working in GP practices and had experience of prescribing and deprescribing opioids. This is demonstrated in the four themes generated from the data: (1) ANP attitudes to reducing opioid use in chronic pain, (2) ANP experiences of opioid deprescribing discussions, (3) lack of resources leads to professional powerlessness and (4) interprofessional support in opioid deprescribing. Subthemes were constructed to further explore the findings of theme 2. These were 4.3.1 it is a negotiation and 4.3.2 engaging patients in self-management strategies. These themes and subthemes have been used to address the aims and objectives of the study, illustrate the barriers experienced by the ANPs and highlight potential strategies for facilitating successful opioid deprescribing. Additional quotes from the data, which further support the validity of the findings, can be viewed in Table 3.

4.2 | 'Theme 1': ANP attitudes to reducing opioid use in chronic pain

Several participants were apprehensive about initiating or continuing to prescribe opioids for chronic pain. They discussed the lack of evidence to support the use of opioids as an appropriate treatment for chronic non-malignant pain and recognized the importance of deprescribing. Some ANPs also commented on the lack of efficacy of opioid use in this context, and expressed a reluctance to prescribe medication that is unlikely to be beneficial and indeed, may be harmful. Concerns around potential misuse, dependency and addiction were also raised. One of the participants pragmatically pointed out that opioid deprescribing essentially embodies good prescribing, by weaning excessively high doses and discontinuing medications that are not working.

> 'I do think it is important absolutely. I do think it's important because I do think we have an over abuse of medication within the system you know, and they have become dependent on medication they don't necessarily need. I think if we need to learn anything I think that it's probably best not to prescribe them to begin with' (Amanda)

> 'I think it's a really, really important thing. I think it's really important to try now and not initiate them, especially if there's no evidence base behind them

TABLE 3 Themes, subthemes and quotes.

Theme 1: ANP attitudes to reducing opioid use in chronic pain.
I mean obviously the whole idea, deprescribing, it's part of good prescribing, isn't it? You're backing off on doses that are too high and you're stopping medications that are no longer needed. That's the whole point of it isn't it? (Emily)
There's a sort of fallacy that there's a pill for every ill and you know that there isn't. And you know that there's no quick fixes and you know and at the end of the day we're here to promote best practice. Ehm, yes, it's so much easier just to press a button and give more of the same but actually, you're not doing your job properly if you do that. (Gillian)
Deprescribing medicines is about taking in the biopsychosocial problems that that patient presents to you…. It's not about prescribing more medicines that'll make them more unwell. It's about deprescribing. I do totally believe that…. and finding other alternatives to find a way to manage their symptoms. (Erin)
I do tend to deprescribe…. I will question, do they need 30/500? (Maggie)
It's not something you do light heartedly (Emily)
I think opioids for me would probably be the biggest ehm, my biggest prescribing headache (Maggie)
I tend to stay away from you know, really strong opioids. (Emily)
And there's always that fear factor as well isn't there. That you're going to start something as well that you can't fix. (Emily)
I did not like initiating opioids. (Lisa)
Theme 2: ANP experiences of opioid deprescribing discussions.
Subtheme 2.1: it's a negotiation.
I'm always looking at quantities…. I'm always looking for lesser dose…. always looking to stop or step down. I'm negotiating with the patients more. (Emma)
Deprescribing for some of the patients who have again been on the medication but maybe they've underlying other chronic health conditions or ehm mental health issues, conditions and I think for some of those patients it's quite difficult to get them off the opioid medication because they're quite fixed that this is what they have to have. And, and sometimes it's a bit of a negotiation (Kate)
A lot of them really want the drug, they've been on it a long time and they're not even sure if it's working or not, but they don't want to be without it. (Kerry)
I will have that discussion but, especially people who have been on it for a long time you sometimes feel like you're banging your head on a brick wall. You know because people feel that they can't function without it. (Gillian)
And say to them you know, you can damage your kidneys, and ehm, you know for long term use…. so, you're trying to sell it that way and say well you know you really need to reduce these down (Maggie)
I've always had them, or I always get them! Or they've moved from one GP to another, and I got them in my old surgery and why can't I have them now? And, yeah. I'm going to my MP! (Emma)
Subtheme 2.2: Engaging patients in self-management strategies.
I would say minimum of them are very receptive. A very small percentage of them. I don't know whether that's because we're coming from a deprived area, and really, they just want, they just want something that's going to help their pain and they want to go out that door with a prescription in their hand. (Amanda)
Sometimes you refer people to places and they don't actually go in the end. (Amanda)
You know sometimes you might talk to them about, I don't know, physio…. and you can just hear them saying yes, yes and you know that it's falling on deaf ears.' (Gillian)
Patients' willingness…., I guess like I just said, you some of them you know you're fighting a losing battle before you start (Gillian)
They expect the physio to actually fix them […] and they don't want the tools to fix themselves. (*Gina*)
I do try and keep it (prescribing opioids) as a last option. Just about re-educating and maybe refocusing them and try and get them to think about their lifestyle and take control of their condition rather than just popping a pill every time. (Maggie)
And then, you're trying always to convince somebody to look at alternatives. If it's low back pain or things like that always look at alternatives rather than just pain killers (Emma)
And the most appropriate thing is exercise and mobility and weight loss and lifestyle changes, all the things we don't have time to talk about. And all the things we should start with. (*Kerry*)
You have to get them to agree with you, to make the appointment for physio. (*Emma*)
Theme 3: Lack of access to resources leads to professional powerlessness.
Quite a number of them I think waiting for surgery and because of that length, that gap of wait, their pain is not being effectively managed.
And if you don't give them something then they are going to go and buy things on the internet so, what's the safer option? (Maggie)
And maybe they've gone through all of the houses of being seen by the chronic pain clinic and tried all the alternative methods, and really, it's like you're, they're in a holding bay' (Kate)
I can understand we don't want to be prescribing as many opioids but if there's no alternative, there's no acupuncture and there's a waiting list for a pain management course, you know (Maggie)
You know because obviously to get in with the physiotherapist or to get acupuncture or something done like that is going to take time. And you always have that well, what am I going to do in the meantime? (*Amanda*)
It's so busy, sometimes it's easier just to give the pain relief than have the harder longer conversation of maybe giving the better thing for them, that would be better for them. (*Lisa*)
There's not a lot I can do because I don't have the skills or the back up or even the resources that can back up how you manage chronic pain. (*Gillian*)
Theme 4: Interprofessional support in opioid deprescribing.
Working well within the team, working well with the pharmacist and the physio for the non-opioid treatments you know?… Team effort, definitely a team effort (*Emma*)
The pharmacist is invaluable…. my biggest reliever when it comes to managing opioids and things like that. So, I really value her opinion. (Maggie)
The pharmacist, the pharmacist that is a really good resource you know? (Emma)

> […] with the high prescribing in Northern Ireland it's going to be a very difficult thing to turn around, but I suppose we have to start somewhere' (Lisa)

> 'If all the research demonstrates that actually it's no benefit to the patient then obviously it's really important, because we're almost promoting an addiction aren't we if we're continuing to do it (prescribe opioids) even though we know it's of no benefit' (Gillian)

Overall, the ANPs displayed positive attitudes towards opioid deprescribing, and their responses showed that they are motivated to participate in opioid reduction strategies. They recognized the harms of opioid therapy in this context and their comments convey a reluctance to initiate or continue to prescribe opioids. Their rationale for this is fear of causing harm to their patients, and moreover, it conflicts with their professional judgement. They also demonstrated knowledge about the potential for tolerance and dependency and showed an awareness of public health concerns.

4.3 | 'Theme 2': ANP experiences of opioid deprescribing discussions

The ANPs described the challenges they have encountered in relation to initiating and engaging patients in deprescribing discussions. Lack of engagement from the patient or a failure to respond to opportunities to discuss deprescribing were reported.

> 'People who aren't open to the conversation at all. You know, that shut it down completely or won't respond when you keep sending messages saying you're due a review, you're due a review and just won't, won't engage' (Kerry)

> 'You can be flogging a dead horse if you're trying to talk to somebody and they're just closed down, no focus, don't want to engage with you, then that's a difficult one' (Kate)

The data captured the sense of frustration felt by the ANPs at the lack of engagement from patients. The quotes highlight the difficulties they face when patients are not motivated to participate in discussions about opioid tapering. This presents a significant barrier to implementation of shared decision-making and mutual goal setting.

4.3.1 | It is a negotiation

The ANPs confessed that deprescribing conversations with patients can be difficult. They talked about trying to 'sell' deprescribing to patients and having to 'negotiate' with them to even consider the possibility of tapering. Despite the ANPs presenting valid, evidence-based explanations for opioid tapering they are often met with resistance and opposition from patients.

> 'It's difficult. It's difficult. In most people. And I think the difficulty is the negotiation with the patient. And getting them on board' (Gina)

> 'It's a negotiation with the patient. Whilst you may think of something that might be appropriate, and more appropriate for them, they may come back and tell you a whole lot of stories why they can't have that' (Kate)

> 'Patients seem to know exactly what they want, pain relief wise and you try to take them a step back and try to explain the reasons why you're doing all that but ehm it can be difficult. It can be challenging. Because they'll come and they'll say to you well […] my friend is on this, and it really works for her so can I not have it?' (Amanda)

There was a sense that the ANPs found deprescribing conversations emotionally taxing, particularly with regard to managing patient's expectations for opioids. Some participants identified that patients have very fixed ideas about their opioid medication and do not want to be without it, even if they feel it is not working for them. Other participants recognized that these attitudes may be precipitated by a fear of withdrawal of their medication and anxiety about a subsequent increase in pain. One ANP surmised that many patients do not understand tolerance, therefore are reluctant to step down their opioid medication believing they need more, not less.

4.3.2 | Engaging patients in self-management strategies

Several ANPs encountered indifference from patients when trying to engage them in self-management of their chronic pain. They used phrases such as 'fighting a losing battle' and 'falling on deaf ears' to describe their attempts to promote self-management strategies. One ANP reported cases of patients being referred to multidisciplinary services but failing to attend their appointments.

> 'I said to her what about pain management course or pain management clinic, she goes; that was a complete waste of time, I've been to both, complete waste of time. […] Whenever you say to somebody about the pain management like, they roll their eyes and say, 'that's all your giving me?' basically, 'I want something today' 'I want a quick fix' (Maggie)

> 'I'll try and get them to Versus arthritis or something […] some people will say they'll give it a go, some people will do it a couple of times and then stop and say it didn't work. It's so varied, the response to it. And so, the odd person will get a good response but not that many' (Gina)

> 'We give them exercises of course from patient leaflets, but I know the patients don't, you know, those go in the drawer along with the Chinese menu' (Kerry)

The data suggest that the ANPs felt very few patients were motivated to engage in self-management strategies to manage their chronic pain. Some faced cynical attitudes towards non-pharmacological alternatives and reported a lack of interest from patients to engage in self-management. Furthermore, pain management programmes, which are designed to provide knowledge and skills to actively manage pain, did not appear to be deemed a valuable alternative to medication by certain patients. Generally, there was a sense that patients wanted a quick fix, a pill to take away the pain.

4.4 | 'Theme 3': Lack of access to resources leads to professional powerlessness

Poor access to non-pharmacological services and long waiting lists for secondary care presents a significant challenge for the ANPs. They described their experiences of accessing supportive services and secondary care clinics for management of chronic non-malignant pain. There is a disparity between the availability of multidisciplinary team (MDT) services, such as physiotherapy and psychotherapy within the GP federations across Northern Ireland. Some areas have an MDT service embedded within their practice, but most do not.

> 'Pain management, CBT, all the things we just talked about so it's just, it is hard. It's ok, it's ok in theory but then when you've got a patient sitting in front of you who's really upset and in a lot of pain, you know, turn round and saying here's a pain management course, oh by the way it doesn't start for another 2 months or 3 months. […] acupuncture as well, just whenever I looked at that, nowhere actually offers acupuncture. There's definitely a lack of resources, lack of those other, other alternatives like acupuncture […] I can't find anywhere that offers acupuncture even though it's mentioned in the NICE guidelines' (Maggie)

> 'You've referred them to the chronic pain clinic and the waiting list is really, really long, you're kind of really stuck. I mean, that is a huge barrier because you can't access the service' (Kate)

> 'An urgent waiting time for a physio is 8 months. A routine, which most of these patients are, is over a year. The pain team is over a year. So, unless they have private insurance it's fairly difficult to access' (Kerry)

While they are trying to observe the recommendations from NICE to reduce opioid prescribing and promote alternative therapies, their efforts are impeded because they cannot access these therapies in a timely manner. Some of the ANPs felt conflicted about suggesting private services to patients, particularly in socially deprived areas.

> 'Quite often I'll talk to patients about physio but, because there's such a long wait, you're almost saying, even if you can afford one private physio ehm, and that's quite hard. Especially if you've got somebody that you know can't' (Gillian)

> 'And then sometimes patients then would ask me, I would never suggest going privately because not everybody could afford that but if they ask me; do you think I should go private then I would then say to them yes, that is (…) because you're going to be waiting a long time. If you feel privately, you can do that, yes go on ahead' (Lisa)

Essentially, the data show that ANPs are motivated to initiate and participate in opioid deprescribing but that it is difficult to implement without a suitable pharmacological or non-pharmacological alternative to offer patients. The findings show that a critical barrier to deprescribing opioids in patients with chronic non-malignant pain is poor access to non-pharmacological treatments and secondary care services. ANPs rely on access to multidisciplinary services to facilitate opioid deprescribing and implementation of the guidance.

Many of the ANPs talked about the lengthy waiting times and the lack of clarity regarding how to manage the patient in the interim. The dilemma they face is; where do we go from here? what do we do now? They acknowledge that this leads to patients staying on their opioid therapy for far longer than they would have before. Moreover, some of the ANPs felt it is unethical to withdraw pain relief without being able to offer something in return. This leads to a feeling of professional powerlessness.

> 'A lot of patients are on a lot of high doses of opioids. And you know, they get to the stage where you know they don't seem to be working, and you're sorta thinking, where do we go from here?' (Emily)

> 'Yeah, and you do feel powerless don't you because […] you can sometimes hear the desperation that people have. You know that they can't cope with things ehm, but we don't have a magic wand' (Gillian)

The ANPs felt it was more difficult to deprescribe in these situations and one ANP expressed concern that tapering opioids without a suitable alternative may lead patients to engage in aberrant drug behaviours to obtain illicit pain relief. This has led to ANPs prescribing opioids even though they know it contradicts current guidelines and conflicts with their own professional judgement.

> 'Sometimes you do have to prescribe opioids, there's no way around it sometimes you know [...] Or maybe if they're waiting for a hip replacement but again, they're waiting for 2 years well, you have to give them something, you can't let them go with nothing' (Maggie)

> 'Whilst it isn't maybe totally appropriate for chronic pain to be prescribing opioids and the NICE guidelines would tell us otherwise the difficulty is that some of those patients have tried everything else and they've nowhere else to go' (Kate)

The responses of the ANPs reflect an ethical dilemma between beneficence (a wish to relieve the patient's pain) and non-maleficence (to cause no harm by prescribing high risk medication). It is this dichotomy between knowing what they should do, in accordance with the guidelines, and what they are able to do, which exacerbates feelings of anxiety and uncertainty regarding their management of patients with long-term pain on opioid therapy.

4.5 | 'Theme 4': Interprofessional support in opioid deprescribing

Many of the ANPs were particularly appreciative of the support from their multi-professional colleagues, particularly the practice-based pharmacists. All the ANPs had access to a general practice pharmacist, with one participant describing the pharmacist as invaluable.

> 'With the pharmacists in the practices they are, they're absolutely brilliant they're such an asset [...] it'll be a lot of input from pain clinics and physios and maybe psychological help as well. So, it's just not one thing it's a holistic, multidisciplinary team thing' (Lisa)

> 'The pharmacist is a useful one to talk to with regards guiding you through, because it's that whole titration down, some medications can be quite tricky' (Kate)

The ANPs value the support of their multidisciplinary team colleagues. The data reflect their understanding that chronic pain is multi-faceted and that successful opioid deprescribing requires an interdisciplinary approach. They recognize the importance of team working in the management of patients with chronic non-malignant pain. Currently, there is disproportionate access to practice-based physiotherapists and psychologists across the province; therefore, many of the ANPs rely on referral to outpatient services. However, it is hoped that the proposed remodelling of primary care service delivery in Northern Ireland will mean more equitable access to these services in the future.

5 | DISCUSSION

The results of this study indicate that opioid deprescribing and implementation of the guideline recommendations is challenging. Significant barriers to opioid reduction were identified such as, difficulties engaging patients in deprescribing discussions, reluctance to participate in self-management strategies, poor access to supportive therapies and lengthy waiting times for secondary care services. These barriers directly impacted on the ANPs ability to deliver best practice which resulted in a sense of professional powerlessness. Four key themes were generated during data analysis, (1) ANP attitudes to reducing opioid use in chronic pain, (2) ANP experiences of deprescribing discussions, (3) lack of access to resources leads to professional powerlessness and (4) interprofessional support in opioid deprescribing.

The themes presented are consistent with other studies which show that the need to reduce opioid prescribing is widely recognized by healthcare practitioners, but complex and difficult to put into practice (Gill et al., 2022; Hamilton et al., 2021; Langford et al., 2020). Our findings demonstrate that the ANPs recognize the lack of efficacy and potential harm of opioid use in chronic pain and see deprescribing as an important aspect of their role (Hawkins et al., 2021).

Concerns around the safety and efficacy of opioid use in chronic pain were well described by the ANPs. These worries were echoed in a recent UK study which explored GPs experiences of prescribing opioids (Gill et al., 2022). They identified tolerance, addiction and a lack of effectiveness at relieving patients' pain resulted in a reluctance to prescribe them. This reticence to prescribe opioids is largely due to an overwhelming desire to do no harm while also feeling an obligation to relieve a patient's pain (Desveaux et al., 2019; Toye et al., 2017). This indicates a requirement for educational information for patients explaining the potential adverse effects and lack of efficacy of opioid medication for chronic pain. Our study adds to current discussion regarding the harms of opioid prescribing.

NICE (2021) recommend that practitioners carry out a person-centred assessment and use shared decision-making to facilitate deprescribing (NICE, 2021). An Australian qualitative study of GPs reported that patient willingness was a key element in successful deprescribing, and that patient motivation and personal goal setting was a facilitator to discontinuing opioid therapy (Hamilton et al., 2021). Comparatively, while the ANPs identified person-centred practices such as goal setting and shared decision-making as facilitators to deprescribing, they found these conversations were often hard to initiate. Our data show that they encountered difficulties engaging patients in discussions around opioid reduction and

found the unwillingness to participate in supportive pain management strategies presented a significant challenge.

This finding is similar to that of Kennedy et al. (2018) who also found that in reality, tapering conversations with patients involving mutual goal setting were not always successful. Furthermore, a cross sectional study of Canadian physicians found that patient resistance was the main barrier to opioid deprescribing and guideline implementation (Busse et al., 2020). Moreover, studies from Australia and America have also reported scepticism from patients about the benefits of non-pharmacological pain management options (Glare et al., 2020; Hawkins et al., 2021; Kennedy et al., 2018). Our data demonstrated limited success in motivating patients to taper their opioids or accept non-pharmacological alternatives.

Shared decision-making is a collaborative process, therefore successful, person-centred outcomes are unlikely to be achieved without the participation of both practitioner and patient. This indicates a need to develop strategies to better educate patients about the harms and lack of effectiveness of opioid therapy in chronic pain and encourage realistic goals to promote engagement in self-management approaches. Furthermore, practitioners would benefit from specific training in the appropriate skills required to successfully drive difficult deprescribing and pain management discussions.

In the UK study by Gill et al. (2022), GPs reported a lack of control generated by issues with patient complexity, patient expectation for medication and a lack of suitable alternatives to offer. This is comparable to the sense of professional powerlessness experienced by the ANPs in our study. Poor access to supportive services, a lack of continuity between prescribers and a lack of training in opioid deprescribing and pain management led the ANP's to feel essentially 'stuck', resulting in their attempts to implement the NICE guidance being obstructed.

These findings build on the results of other studies which have shown that poor access to alternative treatments prevented practitioners from initiating opioid tapering (Langford et al., 2020; White et al., 2019; Kennedy et al., 2018). Non-pharmacological management options for chronic pain recommended in the NICE guidelines are exercise programmes, physical activity, psychological therapy and acupuncture (NICE, 2021). Our data showed that lack of availability of these options and poor access to secondary care clinics is a primary barrier to opioid deprescribing and guideline implementation. A cross sectional survey of Australian GPs also found that a lack of suitable opioid alternatives was the largest barrier to deprescribing (White et al; 2019).

Furthermore, this study reports that the ANPs were reluctant to suggest patients could access these services more quickly if they pay privately for them. This was because they were acutely aware that many of their patients were from low socio-economic backgrounds and were unlikely to be able to afford it. This finding is similar to that of Hamilton et al. (2021) who found access to government-funded non-pharmacological pain management services, and long waiting times for secondary care appointments were a significant obstacle in their GPs ability to deprescribe opioids. Moreover, they highlighted the fact that many people with chronic pain are often unable to work, therefore could not afford to pay for services such as physiotherapy or psychotherapy.

This leaves prescribers in an impossible predicament if they are advocating opioid reduction, without being able to offer any additional supportive services. Practitioners often find it emotionally challenging when they are faced with patients who are in pain, and they have nothing else to offer them (Desveaux et al., 2019). Furthermore, the findings of this study revealed that it has led to the ANPs prescribing opioids even though they know it contradicts current guidelines and conflicts with their own professional judgement, creating a sense of moral distress. This aligns with the findings of a Canadian study of family physicians who described feeling torn between their awareness of opioid harm, a desire to relieve their patient's pain and an obligation to comply with guidance (Desveaux et al., 2019).

It is interesting to note that although there were slight variances in the findings of the international studies, this was largely due to differences in health care systems. Financial incentives were less likely to be represented in UK studies, due to the free National Health Service (NHS). Perhaps more interesting, is that in spite of different healthcare systems, the results of this research shared more commonalities than differences with the international studies.

Certainly, hospital waiting lists and waiting times for multidisciplinary services have been further impacted by the coronavirus pandemic (Public Health Scotland, 2022). Moreover, although the roll out of primary care multidisciplinary teams has begun (Department of Health, 2018), it will take many years before this service is fully integrated within the GP federations of Northern Ireland. This study findings concur that poor access to non-pharmacological treatments and secondary care services severely impede opioid deprescribing and implementation of the NICE guidance. The vision for the future is to improve patient outcomes by achieving more equitable access to these services.

It was evident from the data that the ANPs value the support of their multidisciplinary colleagues. Some of the participants felt that a lack of specific guidance about tapering doses meant they relied on the practice pharmacist for support. These results are congruent with another qualitative study by Kennedy et al. (2018) who also recognized the value of team working, highlighting the importance of the practice pharmacists as a supportive resource in opioid tapering. There was an acknowledgement that managing chronic pain requires a collaborative approach, and that pain is unlikely to be managed well, by just one individual. An integrated multidisciplinary team is crucial to support opioid deprescribing practices (Hamilton et al., 2021).

Heightened concerns about the safety and efficacy of opioid use in chronic pain is effectively evidenced in the literature (CDC., 2022; NIAO., 2020; NICE., 2021). This study contributes to an understanding of the challenges faced by practitioners involved in the management of chronic pain and opioid deprescribing.

5.1 | Strengths and limitations

This research has a robust qualitative descriptive methodology. Reliability is demonstrated in the verbatim descriptions of the participants experiences, which enabled an in-depth exploration of their opioid deprescribing practices. Furthermore, the engagement of a second researcher to review the interview schedule and verify the data interpretation helped to reduce personal bias and ensure validity of the findings. Potentially, a limitation of this study may be that the study sample was small. The ANP population in Northern Ireland is still relatively small, currently 33 across the 17 Northern Ireland GP federations. However, the fact that this study was conducted with a small group of participants did not appear to limit the applicability of the findings.

In fact, international relevance is demonstrated by the similarities in the findings and conclusions of other United Kingdom and international studies that explored the topic of opioid use in chronic pain management. This is particularly notable in a recent UK study of GPs experiences of prescribing opioids for chronic pain (Gill et al., 2022). This qualitative research is a valuable starting point to understanding opioid deprescribing in other contexts and builds on the current body of literature relating to the barriers and facilitators of opioid tapering. This research may be expanded with a more diverse group of health professionals, or by the inclusion of patient participants, which may uncover a different perspective.

6 | CONCLUSION

The attitudes of the Advanced Nurse Practitioners in this study show that they are motivated to participate in strategies to reduce inappropriate opioid prescribing, in accordance with current guidelines. However, their experiences suggest that opioid deprescribing is challenging, and the recommendations of the NICE guidelines (2021) are difficult to put into practice. Practitioners would benefit from specific training in the appropriate skills required to successfully drive difficult deprescribing and pain management discussions. Furthermore, clear recommendations have come from this study with regard to the multidisciplinary support required by ANPs to facilitate deprescribing practices. Although government initiatives to improve access to multidisciplinary and secondary care services are underway, it is likely to be some time before any discernible benefits are apparent. Finally, to overcome the difficulty engaging patients in opioid tapering, this study illustrates the need for appropriate educational and motivational resources for patients. The development of such resources may be better informed by further research to explore the perspectives of patients with chronic non-malignant pain on long-term or high-dose opioid therapy.

AUTHOR CONTRIBUTION

Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; Claire McCann, Claire McCauley. Involved in drafting the article or revising it critically for important intellectual content; Claire McCann, Claire McCauley, Deirdre Harkin. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; Claire McCann, Claire McCauley, Deirdre Harkin. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Claire McCann, Claire McCauley, Deirdre Harkin.

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No conflict of interest has been declared by the authors.

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DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ORCID

Claire McCann https://orcid.org/0000-0003-0168-4275
Claire Odile McCauley https://orcid.org/0000-0002-2092-349X
Deirdre Harkin https://orcid.org/0000-0003-4627-3189

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