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Views, facilitators, barriers and strategies associated with detoxification in patients with opioid use disorder: A qualitative study on primary care general practitioners.

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Introduction

Opioid Use Disorder (OUD) affects 16 million people worldwide and 2.1 million Americans (1). A diagnosis of Opioid Use Disorder is made when an individual checks at least 2 of the 11 criteria, established by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), for a duration of one year. Detoxification aims at controlling withdrawal symptoms in a safe environment and fostering long-term treatment and recovery. Detoxification used to be the most widely used therapeutic practice. It is now reduced to a minor practice for treating people with opioid use disorder (PWOD). Nowadays, standard care for OUD is based on harm reduction policy and relies on Opioid Maintenance Treatment (OMT). It is established that nearly 30 years of OMT therapy have led to increased patient retention and fewer opioid overdoses, infectious disease transmission and criminal activities. However, developed countries are facing an increase in opioid abuse, a generalisation of overdoses due to synthetic opioids (two-thirds of deaths by overdose in the United States; 80% of deaths in Canada (2,3)) and higher healthcare costs (4). Providing adequate care is also challenging because of the lack of OMT prescribers (5). Hence, opioid detoxification still has some advantages over OMT (6,7).

General practitioners (GPs) are the main prescribers of OMT in France, in the United Kingdom and in Australia (8,9). In the United States, only 3.6% of family medicine practitioners are Buprenorphine waivered, but they make up the largest proportion of opioid prescribers (10). In the United States, Buprenorphine and Methadone are prescribed in federally approved clinics (Opioid Treatment Program) (11). Buprenorphine can also be prescribed by practitioners with a Drug Enforcement Agency waiver in outpatient settings (12). Psychosocial support is generally overshadowed by OMT and usually not provided (13). Detoxification strategies depend on the assessment of the patient's needs, comorbidities, drug uses and level of social support. Detoxification can take place in inpatient or outpatient

settings after informed consent. Detoxification is supported by non-pharmacological and pharmacological treatment (14). Barriers to detoxification include the emotional burden on GPs, inadequate resources, and lack of trust between patient and provider (15). Detoxification is facilitated by age range (30-40), easier access to health support services and trained nursing staff support.

Although such strategies are known, they are rarely implemented. In this context, characterised by a restricted use of detoxification in favour of widespread use of OMT, we conducted this study to assess the GP's relation to detoxification strategies. The primary objective is to collect the views of GPs on opioid detoxification in PWOD. The secondary objective is to identify the facilitators, barriers and strategies associated with detoxification. This study will help to reassess the utility of detoxification, its achievability and its shortcomings.

Methods

Background

Medical prescriptions for PWOD occur in interactional settings involving the use of negotiation strategies, social representation and the knowledge and experience of patients and GPs (16). These behavioural determinants have an influence on the prescription made by GP. Collecting opinions, views and representations about specific treatment strategies can be useful to understand how GPs support OUD in their practice decisions to understand the facilitators of and barriers to OMT and detoxification prescription. Semi-structured interviews (SSI) are known to efficiently isolate these behavioural determinants. SSI provide relevant and structured information on topics set out in an interview guide. They are especially useful when exploring care provider views or describing processes. SSI in-person are known to provide a secure environment which enables individuals to produce rich and varied contents

(17). In-person interviews allow for joint analysis of non-verbal communication (18), reducing the likelihood of judgment or face saving (19).

Setting

We conducted a qualitative study based on SSI in-person aiming at understanding the place of detoxification in primary care. Based on a previously published systematic literature review on this topic, we drafted an interview guide presenting themes of interest associated with OUD prescription strategies/uses and views the of GPs in primary care settings (20). The interview guide focuses on four themes: experience with opioid detoxification, strategies for opioid detoxification, healthcare difficulties regarding detoxification and suggestions to improve the care of PWOD. A discourse analysis was applied to the collected discourse content to identify the use of detoxification in primary care practice, along with views about detoxification and its associated barriers and facilitators.

Study population

From August to October 2019, 31 GPs were contacted by phone, using the directory of GPs of Lorraine. To include the widest range of profiles, these GPs were randomly selected according to their type of medical practice and geographical area in the Lorraine region (France). As our study focuses on primary care, we excluded practitioners who exclusively practiced in addictology. Before the interviews, we provided each GP with a short presentation of the study and its objectives.

Fifteen GPs (13 males and 2 females) agreed to participate. The reasons for refusal were lack of availability (11) or lack of interest (6). Professional experience in primary care ranged between 2 and 41 years of practice. Ten GPs practiced in urban areas, two in semi-rural areas and three in rural areas. These practitioners currently support between six and 300 PWOD (75 individuals on average). Three GPs practiced alone, six in a group practice, six in a microstructure (outpatient care facility dedicated to addictology with a GP, a psychologist and

a social worker) and four practiced in a multidisciplinary health centre (MSP, its French acronym). The selected GPs had undergone training in addictology: seven were formally trained, six had attended continuous medical training seminars. Among their additional occupations, four taught at university, two worked in addictology care departments, one coordinated a multidisciplinary health centre, one worked in a hospital and one was an advisor to the French College of Physicians (Ordre des Médecins) (table 1 and table 2) (21).

Conduct of interviews

Fifteen interviews were conducted between December 2019 and March 2020. Each interview started with a reminder of the topic. The objectives of the study and the confidentiality agreement were presented, acknowledged and consented to. Next, the professional characteristics of the practitioner were collected: *year and geographical area of creation of private practice, any training undertaken in addictology, number of PWOD among their patients, type of medical practice and additional activities practiced*. When the themes of the interview guide were not addressed, the interviewer nudged the practitioner toward these themes. Time slots dedicated to interviews were about 45 minutes, allowing discussions on all topics without any rush. The interviews were conducted at the Department of General Medicine of the Faculty of Medicine and at the interviewed practitioner's office. The interviews were led by a doctoral student in the presence of a third-party observer with expertise in qualitative research. The observer focused on the non-verbal aspects of the practitioner's discourse.

Collection and use of data

The interviews were fully recorded after the signature of the consent. We also reported on a note pad the main themes discussed by participants (to assess saturation of data). The recordings were transferred to a computer and then transcribed using word processing software (transcription of pauses in speech, reactions, hesitations and language errors). We

anonymised participants using a letter of the alphabet set in the chronological order in which the interviews were conducted (A, B, C, etc.).

Analysis:

A triple-blind thematic analysis was conducted on the 15 transcribed interviews by three authors (first, fourth and last author). The main themes were selected after consensual agreement. An interdisciplinary approach was applied, since the three authors together combine competencies in the medical and psychological fields. As such, each author's point of view was considered. After reaching a consensus on the main themes, we reiterated the process to determine the sub-themes. We then carried out an in-depth analysis of the discourse of the GPs and linked each sentence to its relevant sub-theme. We assessed the length of time allotted to the discourse of the GPs and counted the number of laughs or relevant words (pertaining to themes or sub-themes). Finally, the prominent elements of the discourse were presented according to the main themes highlighted and their relevant sub-themes.

Results

The discourse of the GPs reflects their clinical experience, convictions and opinions. The selected topics were i) GPs' views on detoxification (omnipresence of OMT, a time for re-evaluation, eligible candidates), ii) facilitators (motivation, trust and psychosocial support), iii) barriers (non-eligible candidates, psychiatric comorbidity, personality of drug users, specificities of people abusing opioid pain medication, lack of availability, management of withdrawal syndrome, specialised healthcare facilities hard access, decline of practitioner-patient relationship), and iv) strategies associated with detoxification (freeing up time, new organisation centred around the PWOD, more spaced-apart follow-up, physical activity, role of former PWOD, practitioner support from the Order of Physicians).

Discursive analysis

More than three quarters of the allotted time (77.8%, 8h11min) belonged to the GPs. The time allotted to periods of silence and self-reflection came to 2min57s, which indicates well-conducted interviews. The presence laughter from the GPs (142 events) reflects the quality of the interview and the relaxed atmosphere (potentially reducing social desirability bias). Saturation of data was reached from the twelfth interview onward. We confirmed data saturation with three additional interviews. Thematic analyses isolated three topics of note: facilitators, barriers and strategies associated with detoxification.

Detoxification is achieved through OMT tapering

The omnipresence of OMT

Practitioners discussed OMT more than detoxification (13.72% against 12.12% of all speech) although the subject of the study had been reiterated at the start of each interview. This omnipresence of OMT can be explained by the fact that detoxification had faded away to be replaced by OMT due to “*very negative experiences*” (D), especially given that detoxification no longer seems to be addressed during initial training.

Attempts to detoxify are almost always “*destined to fail*” (M), so the topic is nearly always considered by the practitioner through OMT tapering, especially the less experienced among them. It can even be a shortcut used by patients when they come to “*request detoxification*”:

“*Most of the time, people come already with the idea of a request for a substitution*” (C).

When discussing indications for detoxification, some practitioners started to wonder whether they should not encourage some of their patients to taper. The reminder of detoxification enabled some practitioners to consider it for their patients:

“*It’s true that I should try*” (A).

A time for re-evaluating care

All practitioners agree that care almost mandatorily involves OMT, which helps PWOD to enter the healthcare system. One practitioner adds:

“Before substitution, we didn’t see them., and substitution brought drug users into the health system; and that also helps deal with STDs (Sexually Transmitted Diseases), vaccines, blood pressure, alcohol” (F).

According to practitioners, OMT is a step towards detoxification, to take the time to concentrate on their problems other than their drug use, and to attenuate the deterioration of their condition.

Eligible candidates for detoxification

Practitioners mention patients that meet nearly all the conditions to be able to stop OMT, i.e., socio-economic re-integration, a good state of health, removal from an abusive environment, absence of pregnancy, of abuse of OMT, of polydrug use, of risk of transfer of dependency, low dose of OMT:

“Some need to be encouraged to do it, they’re capable of living without their OMT” (I).

However, these patients are reluctant to undergo tapering because of a fear of a relapse or habituation. In these cases, practitioners suggest supporting the PWOD.

Facilitators of detoxification

Sufficient motivation

Motivation is a significant facilitator when implementing detoxification, one practitioner (G) mentioned increasing motivation through motivational interviews.

Motivation criteria include constraints relating to OMT in stable patients, professional consequences, the fear of losing a driving licence, the desire to be freed of any dependency or even fear of death:

“You need incredible strength, incredible motivation.” (J).

The contract, a relationship of trust

In order to successfully complete detoxification, it is essential to first establish a “contract” between the practitioner and the patient. Beyond the terms which need to be agreed upon (“agree” was mentioned 119 times), it is more of a partnership and a relationship of trust that must be created to ensure a successful detoxification:

“I set limits and I keep to them. That means that we are more respected by patients and that we respect them more with conversations based on truth.” (J).

Everything may only be done with the patient’s agreement. The aim is to:

“Assist people with their decision, to head towards cessation” (I).

Seeking psycho-social support and the patient’s stability

The key word seems to be stability; PWOD must be reintegrated in social, familial, medical and professional terms (“work” was mentioned 83 times). The living conditions of PWOD must be ensured in order to consider detoxification. In sum, the patient must have “already built and mulled over something” (O). Social workers and psychologists appear to be of precious help to GPs (“social” mentioned 110 times and “psychological” 122 times).

“Cause addictology often involves medicological psychological and social care - I need help, so there’s a psychologist, a social worker” (K).

Detoxification for people abusing opioid pain medication (PAOPM), generally more integrated, appeared easier:

“These are profiles of people with more assets to stop” (I).

Barriers to detoxification

Non-eligible candidates for detoxification

The low level of motivation appears to be a barrier to implementing detoxification. GPs must ensure that they reject any “*labile*” request caused by “*extrinsic factors*” such as “*an upcoming divorce, separations, legal affairs*” (O). Requests for detoxification are difficult without a close supportive circle.

“*Abuse of opioid maintenance treatment*” (O) and polydrug use is an argument used to refuse detoxification, with one practitioner explaining:

“I never decrease a dose if the treatment isn’t being taken properly. Similarly, use of multiple drugs seems to systematically lead towards failure” (G).

The risk of transfer of dependency was an additional obstacle to the proposal of detoxification. Almost half the practitioners fear the transfer of dependency (particularly towards alcohol) during OMT tapering in the case of polydrug use:

“I have seen people brutally fall into, into alcoholism.” (J).

It appears to be more difficult to consider detoxification when the opioid use has been too long or extensive and when a lot of harm has been done. The practitioners believe that people who use drugs (PWOUD) are always at risk of a relapse and, as such, detoxification is almost impossible:

“When addiction has been present for too long, it has taken so much space, that it’s not reasonable to push them to stop” (I).

A long history of consumption was an argument contraindicating detoxification:

“We tell ourselves that if there weren’t all of these priors, all of that history, all of that habit with the substance, it would in fact be easier to propose detoxification and not put in place a treatment that will take several years” (E).

Moreover, “*when there is a pregnancy*” (L), detoxification is contraindicated.

Psychiatric comorbidity

Psychiatric comorbidity was considered a significant obstacle. GPs are faced with difficult access to a psychiatrist, lack of communication and an insufficient care offer:

“It’s the psychiatric patient or the almost borderline patient. They are indeed more difficult in family medicine and they need support from a psychiatrist” (O); “We contact the CMP (Mental health centre) but we don’t hear anything back” (L).

Care for psychiatric comorbidities is crucial in order to implement detoxification.

The personality of drug users

“The anarchic personality of drug users” (M) can make *“sticking”* to care more complicated. The PWOU have more difficulties adapting to constraints in healthcare facilities (waiting times for example). Intimidations, threats make providing care difficult. Some GPs feel as though they are *“held hostage”* and dispossessed of their role as carer, becoming mere executors.

“Often they are there when it’s not their appointment because they missed it” (M); “To keep waiting seems to them intolerable” (C).

During the first consultation, most PWOU themselves decide on their medical care:

“In their mind, it’s stopping taking illicit drugs, but the real request is substitution.” (H).

Through a fear of losing the practitioner’s trust and *“a feeling of guilt” (F)*, the patient often struggles to *“acknowledge”* their relapse.

Specificities of PAOPM

Half of the practitioners distinguished between use of heroin and that of opioid pain medication (OPM) and said they had less knowledge of OPM abuse. The profile of PAOPM is different to that of heroin users. Unlike PWOU, PAOPM are already integrated into the healthcare system (chronic pain) and are being closely monitored. These people are seen as better integrated in socio-economic and professional terms:

“They aren’t really drug users” (O); “They are more like patients with chronic pain.” (L); “These people don’t have the same life course, they’re better integrated” (I).

Care for PAOPM is described as quite specific: the patient becomes aware of their dependence only belatedly, often due to iterative suggestions from the practitioner who *“himself realises (the dependency) much later than he should” (L).*

Various clues should point the practitioner towards abuse: *“exhaustion of medical remedies”*; *“change in dosage” (L)*, increases in treatment dosage *“not justified” (L)* and medication requests for any disorders:

“Having a request for benzodiazepines to sleep, to relax” (L).

Multidisciplinary care to *“reclaim one’s own body, pain, history and experiences”* appears to be a must.

GPs mention that Tramadol is the most misused OPM.

Lack of availability

Lack of availability was one of the major obstacles to detoxification (*“Time”* mentioned 337 times). One practitioner mentioned hasty recourse to OMT due to lack of time:

“We often don’t have the time to start anything other than support on prescription.” (O).

Detoxification requires closer monitoring and needs more time.

Insufficient effectiveness of treatments for withdrawal syndrome

Withdrawal syndrome is a shared *“phobia”* between the patient and the GP:

“I see patients who, when we talk about detoxification, are already experiencing detoxification symptoms.” (I).

Treatment of withdrawal syndrome using *“Clonidine”* is mentioned by the older practitioners (F, G, K). The other medications mentioned are pain medications such as Phloroglucinol, *“Paracetamol”*, sometimes *“benzodiazepines”*, *“antidiarrheals”* or

“neuroleptics”. Naltrexone was mentioned by one practitioner (C): although patients *“stop it quite quickly”*, its prescription is supposed to ensure that *“they return afterwards”* and to ensure continuity of care. These medications are prescribed without any conviction of their true effectiveness in treating withdrawal syndrome:

“It was more for a placebo effect” (B).

Specialised structures that are hard to access

The practitioner’s lack of availability, management of withdrawal syndrome and the PWOUD staying in touch with *“people who continually offer drugs or ways to find them”* (C) all lead practitioners to suggest care in specialised healthcare facilities.

When the practitioner had insufficient knowledge of the addiction healthcare circuit, he/she would not directly contact the health facility to implement detoxification, considering that *“it was not of his/her areas of expertise”*. (D).

The organisation of specialised healthcare facilities makes implementing detoxification difficult, due to an insufficient care offer or *“constraints in terms of transport”* (A):

“As a general practitioner, we’re quite alone really...” (B).

The absence of partnerships with specialised healthcare facilities makes any follow-up challenging.

The decline in the practitioner-patient relationship

The *“routine”* which is established between the practitioner and the patient under OMT leads to a decline in their relationship. Overall care for the patient’s health ends up being lost. *“Therapeutic inertia”* (F) can therefore appear both from the patient’s standpoint and from that of the practitioner:

“It’s like a ritual.” (J).

Consequently, although the conditions to implement detoxification are met, neither the patient nor the practitioner are able to consider it.

Strategies envisioned for the care of PWOD

Freeing up time and adapting to the patient

As regards the lack of availability, several solutions were suggested by practitioners: having consultation slots for PWOD, completely separated the work as a GP from that as an addictologist.

Furthermore, a microstructure (a private outpatient practice consisting of a social worker, a psychologist and a GP) can help the GP to *“free up some time on his/her schedule”* (E), time that he/she may use for longer consultations. In addition, the advantage of facilities such as microstructures or Multidisciplinary Health Centres (MSP) is that they concentrate various health providers in one place and improve multidisciplinary care:

“It’s close to their home that makes it compatible with their schedule; that allows for care by a team which reinforces support” (L).

The practitioner could then also delegate some of the follow-up consultations to *“an independent nurse”* *“during an outpatient detoxification”* (I).

New organisation of care centred around PWOD

A coordinated healthcare circuit could be deployed for PWOD in order to adopt a global strategy and ensure better coordination. One of the priorities in Professional Territorial Health Communities (French acronym CPTS, groups of professionals centred around common health guidelines) could be the creation of *“communication tools”* (O) to *“avoid each primary care team needing to start all over again on their own”* (G).

One practitioner had the idea of Therapeutic Patient Education (TPE) interviews carried out by nurses from Independent Health Initiative Teams (ASALEE, its French acronym):

“In the context of TPE, if requested by the patient, if the ASALEE nurse is trained, it could possibly be a field of intervention.” (G).

Another solution would be to increase the mental health offer by involving advanced practice nurses in mental health and psychologists whose services would be reimbursed.

Mental healthcare facilities could facilitate communication by creating “*a dedicated number*” (L).

Geographical inaccessibility to care could be solved through teleconsultations, to prepare for detoxification or to initiate Methadone:

“Might do a teleconsultation to prepare a hospital admission” (D).

However, creating an overly strict framework which would push PWOUD away should be avoided:

“I think that overly intense monitoring can also repel them. Therapeutic education, it might not suit everyone.” (C).

In this case, developing a new circuit in this configuration, in agreement with the patient, would be necessary.

More spaced-apart follow-up

The decline in the practitioner-patient relationship could be offset by more spaced-apart consultations for patients under stabilised OMT after approval from the National Health Insurance’s medical department:

“If I saw them every three months, I think I’d be more invested.” (F).

Physical activity as a treatment

A third of the practitioners considered the resumption of a physical activity as “*vital*” for care. The aim would be to “*reconcile with the body*” (G), to “*work on self-esteem*” (D) and to “*not think about drugs*” by occupying their time:

“It helps them to get moving again, to find a balance again, to have confidence in physical exercises” (M).

Role of peers (former PWOD)

The role of former PWOD was mentioned during detoxification and in primary prevention (raising awareness among youths):

“A withdrawn patient could tell the other patient about stages, difficulties they encountered, and therefore support him” (D).

Practitioner support from the Order of Physicians

Lastly, better identification and support of struggling practitioners by the Order of Practitioners could help them to *“escape the spiral”* (O) of inappropriate prescriptions of OMT.

Discussion

Detoxification is still in use but is rarely implemented. Detoxification is perceived through OMT tapering, or inpatient detoxification coordinated by a GP. Facilitators of detoxification include familial, social, professional, psychosomatic and financial stability; sufficient and long-lasting motivation; and trust in their practitioner (22). Medical contraindications (barriers) to detoxification include abuse of OMT, polydrug use, pregnancy, or long/extensive drug use. Several difficulties are mentioned: lack of availability, difficult management of withdrawal syndrome, challenging access to specialised healthcare facilities, the PWUD's personality, psychiatric comorbidity, lack of coordination and insufficient knowledge. Recognising OPM abuse is more difficult for the practitioner and the patient. Faced with these difficulties, practitioners have considered various solutions: better coordination of healthcare providers, creation of a healthcare circuit dedicated to PWOD, multidisciplinary care, spaced-apart follow-up, better support for practitioners under pressure from PWOD, and recourse to appropriate physical exercise (23). The role played by former

PWOUD in caring has been highlighted, particularly in the field of prevention. These suggestions converge with the conclusions of the qualitative study conducted by Kennedy et al. based on a focus group carried out by the University of Colorado (15).

Some practitioners underline the need for lifelong OMT as the only solution when the patient's history of consumption is too long and extensive, especially when PWOUD misuse their OMT (24,25). Practitioners consider that detoxification is achieved through OMT tapering, whereas the possibility of detoxification is often abandoned due to the maintenance of long-term substitutions. Some practitioners confirm that they no longer discuss detoxification, even after several years of medico-psycho-social stabilisation in the patient. To avoid this situation, detoxification support must be reinforced by professionals from the medical, social, psychological and psychiatric fields. In addition to such providers, there must also be post-detoxification monitoring follow-up, as suggested by some of the practitioners in our study, and the provision of housing facilities.

The patient's motivation, coming back systematically, is, for most of the practitioners, a condition for successful detoxification. The patient's motivation must be properly assessed: over 85% of patients in a study claim that they want to taper their OMT, yet only 10% of patients actually take steps towards detoxification (26). The components improving the patient's motivation include belief in possible abstinence, pressure from a friend or relative, shame and social rejection, financial reasons, travel restrictions relating to OMT, and a personal detoxification attempt (27).

Psychiatric pathologies are underdiagnosed among PWOUD (28). Furthermore, resorting to a psychiatrist as mentioned by the GPs appears to be ineffective (29). Fear of

withdrawal syndrome is a major obstacle to detoxification for the patient (30). This fear is also found among practitioners, who feel out of their depth. Various treatments were discussed by practitioners, who report an almost complete absence of effectiveness. However, Clonidine reduces the symptoms of withdrawal syndrome. None of the practitioners report any of the potentially serious side effects of the treatment prescribed for detoxification, which include severe low blood pressure for Clonidine (31).

The proposals made for care are numerous. The practitioners state that more time is needed to understand the patient in all of his/her dimensions. Spreading out consultations could offset the GP's time constraints and their insufficient remuneration for long consultations (32), and could improve the organisation of care.

Such planning would restore the practitioner to his/her role as a healthcare provider instead of an executor of the patient's demands. This would avoid the need for an immediacy of response outside of any urgency; this immediacy is detrimental to the implementation of detoxification. To complete the care provided to patients during detoxification, practitioners suggest an organisation including microstructures, healthcare networks and MSPs. Through the multi-disciplinary support they offer (GP, psychologists, social workers), microstructures improve OMT patient satisfaction and make the monitoring of patients easier. These microstructures were created by an association in the Alsace region; practitioners, preferably trained in addictology and accustomed to multi-disciplinary care, were called on to set up microstructures which, due to the multidisciplinary nature of their providers, reduce recourse to hospitals or specialised structures (33). Furthermore, MSPs would enable more comprehensive, quicker and more coordinated care for patients (34). As regards specific addictology healthcare circuits, these would reduce isolated practices for some GPs. Knowledge of addictology circuits appears weak; in 2009 only 5.3% of practitioners were part

of a network providing care for addictions (35). Practitioners have reservations regarding an overly rigid care framework which could lead patients to be lost to follow-up. The concept of “flexibility” enables practitioners to take account of the patient’s specificities to facilitate his or her reception and support. Detoxification remains the objective to achieve for practitioners (36), even when OMT must be used to get there. This OMT aims to provide stability and to overcome medico-psycho-social difficulties. A survey on the medico-social circumstances of patients under OMT over a period of more than 10 years provides contrasting conclusions as regards the results on the social situation of these patients. Indebtedness is observed among 32% of patients, and recourse to social actors is not systematic (37).

The normalisation of Tramadol prescriptions in France is an emerging issue: Tramadol is the most consumed OPM in France, and the opioid most often involved in unintentional overdoses (38). Although French authorities are seeing an increase in prescriptions and deaths by overdose of OPM, the situation in France is less alarming than in the United States (overdose, abuse of analgesic opioids, falling into illicit drug use and more recently into synthetic opioids) (39).

Limits of the study

It should be underlined that this study presents a selection bias relating to the sample of practitioners, with an overrepresentation of men, who practice in urban areas and are more experienced than the overall population of GPs in France. Participants in this study care for more dependent patients than the national average (40), have mostly undergone addictology training, and are involved in teaching in this field.

This observation may be due to the fact that in the Grand Est region (which includes the Lorraine region), there is a higher prevalence of opioid use than in the rest of France, resulting in more consultations with PWOUD.

Conclusion

Detoxification is still in use but is rarely implemented. This lack of implementation is due to insufficient support structures and to PWOUD not being sufficiently well prepared. Facilitators of detoxification include a steady environment, sufficient motivation and trust. This study also shows the difficulties of conducting detoxification in primary care, particularly due to specificities in the approach to PWOUD, the insufficiency of multidisciplinary, multi-professional support structures and the dominant role afforded to OMT. Practitioners have proposals to improve the implementation of detoxification: development of multidisciplinary care and prescription of appropriate physical activity. This study concludes that detoxification is possible in primary care in dedicated outpatient practice coordinated by GPs, a fact that raises questions about the current use of detoxification.

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Figure 1: Word cloud



Word	Times repeated (> 150)	Weighted percentages (%)
detoxification	632	1,25
patients	515	1,02
patient	375	0,74
little	350	0,69
time	337	0,67
people	313	0,62
still	293	0,58
treatment	256	0,51
substitution	236	0,47
know	230	0,46
often	224	0,44
good	192	0,38
care	185	0,37
already	174	0,34
follow	161	0,32
want	158	0,31

Table 1: Description of the sample of practitioners questioned

Identity	Year of establishment	Place of establishment (département)	Training courses	number of patients	Annex activities	Type of structure	Duration of interviews
A	2018	Urban (54)	No addictology training	30-40	Teaching	Group practice, microstructure	58:23
B	2014	Urban (54)	Addictology seminars	Not quantified but a priori a very large number		Group practice	44:20
C	2013	Urban (54)	DIU in addictology psychiatry, HIV and viral hepatitis; Qualification in Addictology	200		Microstructure	38:45
D	1990	Rural (55)	Addictology seminars	10-15		Health centre	46:38
E	2018	Urban (57)	DU in Tobaccology, addictology seminars	70	Experience in rehabilitative care	Group practice, microstructure	36:12
F	1979	Semi-rural (57)	Addictology seminars, teaching (university)	12-15		Group practice	46:52
G	2012	Urban (54)	Expert in Continuous Professional Development	Not specified	Coordinator of an outpatient care structure	Isolated practice	35:58
H	2016	Urban (54)	Not discussed	15	Former coordinator of	Isolated practice	31:47

					a temporary housing structure for the poor		
I	1983	Urban (57)	Qualification in Addictology	200-300		Group practice, microstructure	46:33
J	1982	Urban (54)	Addictology seminars	40		Microstructure	37:24
K	2017	Urban (57)	Qualification in Addictology	70	Part-time in rehabilitative care	Group practice, microstructure	32:43
L	2011	Rural (55)	SASPAS (Outpatient internship in primary care under supervised autonomy) experience, teaching (university)	6-7	Teaching	Health centre	44:02
M	1984	Rural (88)	Qualification in Addictology, DU in Tobaccology, teaching (university)	200	Part-time in an addictology structure, sports practitioner	Health centre, inpatient setting	43:34
N	2000	Urban (88)	Addictology seminars	30		Health centre	44:20
O	1999	Semi-rural (55)	Addictology seminars, teaching (Continuous professional development)	25	Teaching, involvement in the order of practitioners	Isolated practice	43:59

Table 2: Characteristics of participants (n=15)

Gender	
Male	13
Female	2
Year of establishment	
Average (interval)	2002 (1979-2018)
Place of establishment	
Urban (>2,000 inhabitants, >10,000 jobs)	10
Semi-rural (<2,000 inhabitants, >1,500 jobs)	2
Rural (<2,000 inhabitants, <1,500 jobs, non dependent on an urban unit)	3
Number of opioid-dependent patients cared for	
Average (interval)	75 (6-300)
Type of structure	
Isolated	3
Group practice,	6
Multidisciplinary health centre	4
Microstructure	6
Inpatient setting	1
Addictology training	
Specialised training (including DU- University Diploma)	7 (3)
Seminars	6
Other activities	
Teaching	4
Rehabilitative care	2
Coordinator of an outpatient care structure	1
Part-time in an addictology structure,	1
Involvement in the order of practitioners	1
