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Expectations and needs of people with illicit substance use disorders in general practice: a qualitative study in Belgium

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Abstract

Background People who use illicit drugs cumulate medical and psychosocial vulnerabilities, justifying a rounded health approach. Both caregivers and patients can form barriers to accessing care, leading to inadequate care. This study aimed to identify the needs and expectations of such patients in general practice.

Methods Qualitative research was conducted using semi-structured interviews with 23 people with illicit substance use disorder in Brussels in 2020. Multicentric recruitment was conducted to obtain a heterogeneous mix of sociodemographic profiles and care trajectories. Thematic analysis was performed using RQDA package software.

Results Participants highlighted several vulnerabilities. These include the presence of significant self-stigmatization and guilt, sometimes to the extent of self-dehumanization, even after years of care, and overdoses masking suicide attempts and early memory disorders. Multiple substance use, smoking in almost all participants, and misuse of benzodiazepines were also noted. The majority of participants expressed the need for an open-minded, non-stigmatizing and empathic GP with a holistic approach that could guide them throughout their life course. The competencies of the GPs in the field of addiction seemed secondary to the participants. Knowledge and good collaboration with the mental health network were assets.

Conclusion Participants expressed the need for GPs with good interpersonal skills, including a non-stigmatizing attitude. The care coordinator role of the GP was highlighted as a key element, as it was a holistic approach focusing on global health (including the social determinants of health) and not only on substance use disorders.

Keywords Substance use disorders, General practice, Stigma, Patient satisfaction, Patient-centered care, Multidisciplinary care

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Introduction

Since 2013, we have noted a significant increase in the use of multiple psychoactive substances among 15–to 64-year-old in Belgium and worldwide [1, 2]. People with substance use disorder (SUD) have more psychiatric and somatic comorbidities than the general population and require more attention in care [1, 3–5]. In Belgium, people who use illicit drugs (PWUID) are managed at different levels of care [5–7]. Belgian general practitioners (GP) are allowed to initiate medication for opioid use disorder (MOUD) which may play a central role in the diagnosis and treatment [5–8]. These patients can access to them in different ways : via GPs working alone, in private monodisciplinary or multidisciplinary associations, in integrated primary care health centers with needs-based per capita allocation or in SUD centers mostly supported by regional subsidies or public healthcare insurance [6].

In our context, despite direct access to GP in primary care, for which there is increasing evidence that is the best care setting [9–11], most PWUID are treated in SUD centers, which are saturated [12]. This discrepancy can be explained by certain barriers identified at the local and international levels. On the part of GPs, reticence, discomfort in treating this population which perceived as medically, relationally and ethically challenging, especially if patients use illicit substances [7, 13]. On the part of PWUID, they are commonly stigmatized by the healthcare system [13–15]. They can face negative attitudes and inappropriate treatment in primary care with consequent limitation of access to care and breaks in care [7, 16, 17]. This can be facilitated by a lack of confidence in GP due to mental health disorders, substance use and traumatic life experiences in patients [4, 16]. In Belgium, a century of national legislation repressing drug use within the framework of global prohibition, structural stigmas, and a lack of adequately trained GP contribute to this situation [7, 18].

There is little literature from the SUD people's perspective on GP or primary care [16, 19]. In this study, we aimed to conduct a research on people with illicit substance use disorders to gather their perspectives, needs and expectations regarding general practice care. The focus on this population was guided by the fact that they appear to be the most stigmatized and facing the most barriers to accessing primary care [7, 15, 20]. We chose to limit the scope of the investigation to GP practices due to their specific roles as prescribers, care coordinators, proponents of a holistic approach [9, 11].

Table 1 Interview matrix synthesis

Main themes	Sub-themes
1. Life course	✓ Social and family environment ✓ Context of consumption ✓ Consequences of consumption ✓ Mental and physical health status
2. Participant's healthcare pathway	✓ Context of health care use ✓ Relation with healthcare system ✓ Needs, satisfaction and expectations in primary care
3. Specific profiles	✓ Specific questions related to women, migrants, IDU

Objectives

The primary objective of this study was to identify the needs and expectations of PWUID regarding GP care. The secondary objective was to identify the specific needs in general practice according to the patient's profile.

Material and method

A qualitative study using semi-structured interviews was conducted with illicit SUD people. The method allowed the identification of personal and complex needs due to their particular life trajectories, along with addressing sensitive and intimate topics with nuances. By conducting semi-structured interviews, we hoped to create an environment of trust for this vulnerable population.

Setting

We opted to limit recruitment to the Brussels area with its own particularities in terms of population, drug use, and care availability. The population is very heterogeneous according to the cultural and socio-economic status [21], consumption is particularly widespread [2] and SUD centers availability is much denser, but more fragmented, than in the rest of the country.

Data management

Sampling

we aimed for diverse but considered population sampling. We used the literature to identify different patient profiles with specific health needs, such as female gender, patients from immigrant and ethnic minority backgrounds and people who inject drugs (PWID) [22–27]. Sociodemographic diversification variables were also considered (age, origin, socio-economic level, different substance use, etc.). As inclusion criteria, the person had to : be over 18 years old, have an active or former use of illicit substances, and have or had medical follow-up. A history of only a legal substance use disorder was an exclusion criteria.

Interview matrix

A guide for patient interviews was constructed using the available literature and discussions with medical and psychosocial experts. It comprises three sections synthetized in Table 1 (See complete interview matrix in Appendix A).

For the "sociodemographic data" section to be filled in by the participants, we drew inspiration from the

Treatment Demand Indicator (TDI) and EVALUMET tool (See Appendix A). The TDI is an European epidemiological indicator used by health centers in Belgium to monitor SUD treatment [28]. EVALUMET is a tool developed by a network of Belgian GPs in the field of addiction medicine to collect PWUID data [29]. This template was previously used in Belgian studies and was consistent with our research. The interview guide was pretested with a PWUID to ensure its suitability before starting the study. The guide was flexible and allowed possible adaptations as the interviews progressed.

Data collection

Recruitment was carried out via over twenty residential, outpatient and mobile structures. These institutions were either explicitly active in the addiction field or active with vulnerable groups (e.g. homeless people, migrants, sex workers). It was also performed in first-line GP practices to understand the choice of this follow-up by patients. The GPs were part of a network specialized in addiction or were suggested by institutions. Methods used for recruitment included mail and phone calls to the directors and health professionals. We then tried to recruit participants via posters in waiting rooms, mails to patients, active recruitment in waiting rooms and discussion with caregivers to fulfil our criteria. The interviews were conducted face-to-face by a junior researcher and a senior researcher presented as such. The junior researcher interviewed the majority of patients to limit confirmation bias. To reach the groups most marginalized and potentially excluded by the healthcare system, apart from recruitment via mobile teams, we used the "snow ball" method by asking all the participants if they knew of any other people experiencing similar situation.

Data analysis

The data were fully audio-recorded, transcribed and anonymized by the two researchers. A thematic analysis underlaid by interpretative phenomenological analysis [30, 31] was conducted. This method focuses on the analysis of participants' lived experiences and seemed to be the most appropriate for understanding the needs of individuals. All verbatim were coded and categorized into themes in an iterative process between the field, interview guide, field notes and analysis. This work aimed to get as close as possible to the "core content" of the experiences of the participants. Both the researchers participated in the analysis. Coding, choice of themes and sub-themes were regularly discussed between researchers to reach a consensus on a codebook. Qualitative data were analyzed using the qualitative analysis software RQDA (version 0.1.5 rev 31). Sociodemographic data were analyzed using Microsoft Excel.

Results

Twenty-three interviews were conducted in 9 different facilities and one at the participant's home at her request. The structures included a crisis shelter dedicated to addiction, two integrated care centers, a low-threshold substance use treatment service, a non-profit organization working with sex workers, a solo GP's practice, a psychiatric addiction unit and two needle-exchange services. The interviews took place from February 6 2020 to December 18 2020. The average interview duration was 59 min (31–93 min).

Profiles of participants

Our sample covered a variety of participant profiles based on different diversification criteria as shown in Tables 2

Table 2 Participants' characteristics

Variable SD		N=23
Gender	Male	15
	Female	8
Age (years)	18-24	2
	25-34	5
	35-44	8
	45-54	6
	> 55	2
Origin	Belgium	7
	BE with European origin	3
	BE with Non European origin	6
	Europe	2
	Africa	3
	Asia	2
Couple	Couple- living together	3
	Couple -living separately	5
	Single	15
Children	Child custody	3
	Loss of child custody	6
	None	14
Social security	Yes	20
	Urgent medical card	2
	Not in order	1
Professional activity <30d	Disability	11
	Unemployment	5
	Student	1
	Occasional job	1
	Regular job	1
	None	3
	Other	1
Educational degree	Elementary	4
	Low. secondary education	3
	High. secondary education (general, vocational)	11
	High school (college, university)	4
Housing < 30 days	Independant housing	9
	Shared housing	8
	Homeless, squat	5
	Supervised appartment	1

Table 3 Substance use and treatment

Variables		N=23
Substance daily use <30 d	Tobacco	22
	Cocaïne, crack	11
	Alcohol	6
	Opiates	5
	Cannabis	4
	Sedatives	1
SU Treatment demand	Opiates	17
	Cocaine	16
	Alcohol	4
	Sedatives	2
	Hallucinogens	1
	Other psychostimulants	1
	Cannabis	1
Drug injection history	Yes	8
	No	15
Medical Follow-up	Yes, regularly	20
	Yes, occasionally	2
	None	1
Treatment	Opioids	17
	Benzodiazepine(s)	14
	Antidepressor	11
	Antipsychotic(s)	9
	Gabapentinoïd	1

and 3 (data were collected from "sociodemographic data questionnaire").

Semi-structured interviews

To limit external bias as much as possible, we ensured that the interviews were conducted under good conditions in terms of time, mental availability and safety. This allowed us to collect interesting data and reach the internal saturation for each interview. External saturation of the main research objective was reached after 15 interviews. Other interviews were conducted to validate this saturation and to respond to the secondary research objective.

The results have been structured into 4 themes : firstly the individual's life course and consumption; secondly their care course, patient needs and expectations of General Practice.

and lastly profiles with specific health needs.

Life and consumption pathways

Life context/triggering factors for consumption

All participants reported challenging life events in their narratives which influenced their consumption, especially domestic violence, unease, feelings of rejection during their youth. Most of them reported mental health disorders occur personally and within their families. See Table 1A Appendix B.

Risk-taking and medico-psychosocial consequences of drug use

Risk-taking All participants mentioned risky behavior at the medico-psychosocial level. At the medical level, risk-taking was noted above all during the exchange of substance and equipment in non-sterile conditions (injection and inhalation) and single or multiple overdoses (OD). Many risks had been posed in terms of sexual and reproductive health. Psychosocial risks such as substance trafficking, theft and sex work have been also reported.

Consequences Half of the participants complained about memory disorders (retrograde, anterograde or both) which they linked to their drug use. Many mentioned suicide attempts with heroin and/or other drugs. Some of these episodes were misdiagnosed as OD. Hepatitis C has been reported in PWUID (including via sexual routes). Few sexually transmitted diseases including HIV have also been contracted. There was significant overuse of psychotropic drugs, mainly benzodiazepines. Cardiovascular problems and bacterial surinfections including gangrene, have been reported in PWUID. Massive weight loss during intensive use was also common. Several other local damages have been also described. In terms of psychosocial consequences, family tension and social isolation were the main findings.

> *"I am a mother and now my son can't even recognize his own mother. [...] So I don't even mind coming with a client (for sex work) to my house. And my son is here. So I think my son is being rude. But it's normal, everything he says, he's already put up with a lot, eh?". Interview 18, Female, 45–54 y., Congolese.*

Precariousness with job loss, loss of housing (including homelessness), debt mediation, and food insecurity have also been reported. Numerous relationship separations appeared consequent to drug use (15 of the 23 participants were not in a relationship) and child custody loss featured in two-thirds of the parents. Drug use may also have led to incarceration, dropping out of school or from religious practices. In addition, many self and social

stigmas were described by the participants, brought notably by the physical consequences of drug use.

> *"What is sad is that it's very remote from society, [...] You have to see how people look at you as if you're the orangutan straight out of the Antwerp zoo." Interview 13, Male, 25–34 years, Belgo-polish.*

Self-esteem and self-image were variable but for some could remain much altered even after years of care leading to compare themselves to a parasite or a plant. For those with positive self-esteem, this seemed to be influenced by abstinence, professional activity or psychotherapeutic work. Important guilt, which may have led to a break in contact with the country of origin was also reported.

Care pathways

Request for care

The most common reason for seeking health care was the desire to be abstinent followed by requests for treatment. It could also be part of the legally imposed conditions after jail. Fears about health, linked to the physical consequences of their drug use (especially in the lungs) or their housing conditions, were present among participants and could lead to procrastination in carrying out screening tests.

Satisfaction with general practice

The participants had mixed feelings regarding the general practice.

Positive elements Availability and listening were the most important qualities highlighted by the participants. The GP's non-judgemental openness regarding their consumption was essential. Medication assistance was considered as an added value. The GP's role as an advisor was also appreciated. Some of them felt or were feeling psychologically supported. Trust between patient and the GP was also mentioned on several occasions.

> *"Because when you're here, you're not judged, you can really… Because at the end of the day when you come here, you come for yourself. So if you relapse, you have to blame yourself and it's not the doctors who are going to be sad about the fact that you relapsed because you're just here to learn to evolve." Interview 19, Female, 18–24 years, Belgian.*

> *"He always takes the time to take care of his patient even if it lasts ¾ of an hour, he doesn't care and afterwards he finds the right medicine, he helps you [...]. He is free and very open-minded and even for intimate topics." Interview 11, Male, 35–44 y., Belgian, PWID.*

Some participants also mentioned the doctor's kindness and empathy (which was sometimes perceived as sympathy).

> *"It just hurts him to see how low I've sunk. So uh… Sometimes he blames himself. It's like, he blames himself, he tells me 'how he didn't realize that I…'." Interview 18, Female, 45–54 y., Congolese.*

GP flexibility, awareness of the consequences of drug use and affordability of the consultation were also notable factors. Good collaboration with specialized networks was an important skill mentioned by several participants.

Negative elements Lack of availability or attentiveness on the part of the GP recurred among many participants. They were deterred by expeditious and procedural medical contacts.

> *"So I think I had to make calls because there were times when I was crying in the doctor's office to get the medicine and it was like saying 'But help me, I need you' and I felt like actually it's like he didn't understand the distress I was in [...]. I had the impression that GPs are not fit for the purpose. [...] I sometimes went to the same doctor 2 or 3 times and still had no reaction." Interview 23, Female, 35–44 y., Belgo-Indian.*

The lack of drug prevention and harm reduction strategies on the part of their GP was also noted. Feelings of judgement and categorization by doctors or the health care system (sometimes unconsciously) were also described, sensed as a lack of empathy or a denigrating attitude.

> *"He, my GP, when it comes to consumption, to "stop", he becomes another person, as if he were judging us, we'll say. He doesn't remain himself, he changes. And for him, when you take drugs, "oh". I don't know how he thinks but I can see his reaction. He told me: "Stop it all". At the center they said, "Could you cut down on the Diazepam?" Interview 7, Male, 45–54 y., Belgo-Moroccan.*

A few participants highlighted a deficiency in adopting a holistic approach.

> *"The fact that they are more attached to the medical issues than to the social life of the person I find. [...] No, perhaps what matters to them is more the*

medical aspect and therefore what I simply need as medication. [...] They don't dig deeper, they don't get to the heart of the matter, it's still a very medically discussion." Interview 20, Female, 35–44 y., Belgian.

Some said that they missed transparency with their doctor because of a lack of trust or an open-minded attitude, because they were afraid of being held back from reducing their MOUD or because they were afraid of disappointing their caregiver. This fear could stem from the feeling of disillusionment that the doctor might transmit to the patient following several relapses. Some participants reported feeling over-medicated by the physician. GP may lack knowledge about specialized networks and therefore may not be able to refer them appropriately. Communication difficulties were also mentioned, particularly due to the use of medical jargon causing feelings of ignorance or uncompetence.

Specificities related to the place of care

Few elements emerged concerning the specificities of one type of GP support compared to another. According to the participants, the doctor working alone or in a group partnership seemed on the one hand to know his patient better but on the other hand sometimes, lacked knowledge in the field or interest in patterns of substance use. The SUD centers where places participants highlighted more openness, empathy and appropriate skills. However, being surrounded by PWUID there could be problematic as they felt better known and understood by psychosocial workers than by doctors. Only one woman mentioned a desire to be followed up in a structure for women in the past.

Patient needs and expectations of general practice

Patient needs mirrored where they were on their life course, substance use pattern and care trajectory. We found that of the 70 needs and expectations regarding general practice mentioned, only 31 were related to skills in the field of addictology. The need for "soft" or more empathic skills seemed to be prominent along with wider general medical know-how not necessarily specific to this field.

Soft skills

Participants expected the most for listening, empathy and availability from the GPs. Some participants mentioned a need for a trustful environment without judgment or categorizing attitudes. They also needed flexibility.

"Well, being able to speak frankly, frankly. Sometimes I don't dare. I tell him I've relapsed but I'm not going to tell him how much." Interview 4, Male, >55y., Belgo-Italian, PWID.

Knowledge

They wanted the physician to have knowledge of addictology (substances, harm reduction, withdrawal and treatment). They also asked GPs to better anticipate the risk of shifting one addiction to another.

"It would be to give less medication, less benzos. Because then you get addicted to benzos and it's another drug. Doctors prescribe too easily benzodiazepines. Everyone has Rivotril on the street, boxes of Bromazepam, boxes of... We need to cut down and really give it to those who need it. Because I've never had any problems getting benzodiazepines. [...] Besides, I take them too. Interview 6, Male, 35–44 y., Belgo-Italian.

Know-how

Half of the participants wanted more proactivity from GP in terms of substance use (screening, prevention and early intervention). Participants also expected better knowledge of mental health networks and good collaboration. They wanted the GP to advise them and provide more psychosocial support. A few also asked for a more patient-centered care approach.

"Essentially, it means, "You, dear patient, tell me... 'What do you need? How?" [...] Yes, so from the bottom to top. Interview 5, Male, 45–54 y., Belgian, PWID.

A few expected to be more attentive to the patient's perspective about MOUD.

"I was a bit disturbed by the fact that, but then it seems true for all the doctors apparently, basically, insisting on taking it for longer and often, the doctors too, they advise taking more. I'm still confused about this but... But I'm more on the doctor's side now than I was before, but it's true that I know a lot of people... often the doctors tell them to take larger doses and to do it over the long term, and they are obliged by themselves to lie in order to reduce the dose and to do things more quickly. Interview 1, Female, 35–44 y. Belgo-Moroccan.

Some requested a more biopsychosocial approach to addiction.

"...in which context was I earning my money, whether I was risking my life or putting myself in danger. They could have asked me [...]. They could have asked me [...]. They could also have asked me what was the way I was using. They never asked me

that, but I had been referred to a specialized center and they spoke clearly about material (means of consumption) but the doctor did not. So I think the doctor could have this role, especially in a place where addiction is treated. Interview 20, Female, 35-44y., Belgian.

Profiles with specific health needs

We could not identify profiles expressing specific needs in general practice except for two migrants from the Middle East who seemed to seek a more paternalistic relationship with their GP whom they saw as the person with knowledge. Specific health needs were identified as follows:

Female gender

Certain gender-related specificities such as sex work, gender-based violence (e.g., incest, intra-partner violence and sexual violence) and difficulties related to parenthood, such as loss of child custody, were identified. There were also specificities related to reproductive health, such as disturbances in the menstrual cycle, whether or not linked to drug use or substance use during pregnancy (stopped as soon as the pregnancy was announced). Some felt that they were not allowed to express their desires for pregnancy.

People from immigrant and ethnic minority backgrounds

This specific group raised the problem of psychological health needs related to identity disorders and suffering linked to difficult life experiences in the host country (e.g., feeling of permanent insecurity, precariousness, racism and disillusionment). Some were already using drugs in their country of origin, perhaps sometimes to self-medicate in the face of an undiagnosed mental health disorder. Others started drug use in Belgium to cope with their illegal situation or (not necessarily consciously) promote social integration. Shame and guilt towards their family of origin were reported, with one participant even saying that "he didn't have longer a face".

People who inject drugs (PWID)

Specific physical damage caused by injection such as hepatitis C, cardiovascular disorders and bacterial superinfections were identified.

Discussion

The needs and expectations of patients with illicit SUD in general practice have been little explored in the literature and this study highlights interesting elements to enable better support for this target group. Despite difficult recruitment due to the SARS-Cov-2 crisis and challenges in motivating and mobilizing this population, we were able to obtain a panel of people with a variety of sociodemographic characteristics and life and care experiences.

The wide variety of personal life trajectories and principles of intersectionality in health dictate that this population remains complex individuals not reducible to one or two dimensions. Their needs and expectations result from the combination of their life courses and personal characteristics (e.g., biological sex, gender, sexual orientation, ethnicity, migration experience and drug use patterns) [32]. Therefore, we could highlight common expectations and needs shared by people in vulnerable situations.

What patients expect and need from GPs

The most prominently needs were interpersonal skills and soft skills that are not specific to addiction. Indeed, PWUD are first of all people with multiple vulnerabilities who need a human and person-centered approach. The participants expressed needs that correspond to the definition of empathy used by Derksen et al. [33]: "*empathy as the competence of a physician to understand the patient's situation, perspective, and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way*". Indeed, it can increase patient satisfaction, reduce stress and anxiety, and lead to better clinical outcomes [33]. Furthermore, the participants emphasized the importance of not being stigmatized or categorized by doctors. This is key element knowing that stigmatization can limit the access and the quality of care but also limit empowerment, optimism about treatment and recovery by the patients [14, 34, 35]. They also noted the importance of being acquainted with and collaborating with a network of other health professionals inside or outside the practice. This need for a multidisciplinary approach is in line with the literature and proven to be effective [7, 9, 36]. GP was also expected to be able to carry out prevention, screening, early intervention and harm reduction in relation to drug use, but also with other health issues, in a holistic approach. Indeed, our sample highlighted health problems well documented in the literature [1, 37] for which GPs may play a key role [11]. Only four participants spontaneously indicated their expectations for GP to initiate consultation by inquiring about their needs. This raises the question of the legitimacy and consideration that these people give to their own health, which is presumably influenced by strong self-stigma. These different elements and attributes are consistent with the limited literature found on this subject [19, 38].

Relevant results

To understand and meet needs and expectations, we highlighted several elements in our study that should also

be considered and actively sought to improve care for this vulnerable population.

We have noted challenging life events leading to substance use in line with the literature but which are not always well explored by GPs. Our sample revealed many mental health troubles as well as people on strong psychiatric medication without any diagnosis (or possibly not understood by them). A proportion of participants also appeared to be or have been self-medicated with psychotropic substances and did not seem to have had any follow-up. The literature highlights 50–75% of psychiatric comorbidities, many of which are underdiagnosed making the individual more susceptible to double stigma and inadequate care [4, 39].

With regard to risks related to consumption, some of the participants had already suffered from one or more OD regardless the substance administration way, whereas the literature reports more risks related to injection [27]. This could be explained by the intentional nature of some OD reported by the participants, which could be more investigated in emergency rooms.

Apart from these substance-related risks, the participants also took many biopsychosocial risks worthy of more attention. In the sexual sphere, very few participants reported having suffered STIs. However, the participants interviewed had risk factors as injection, chemsex, sex work, migration, jail, homelessness [1, 40, 41] and regularly reported having sex without condom. Few seemed to have been tested recently, and if so, mainly by blood, which does not include all STIs screenings.

The medical consequences of drug use make PWUID a very fragile population, to which the GP must be particularly attentive. It is indeed worrying that almost half of the participants had memory issues concerning them. This is potentially linked to the use of alcohol and benzodiazepines in a large proportion, but this was not the case for all. At the psychosocial level, the impact of drug use on self-image and self-esteem was also important. Even if some patients did not seem to be too affected (being even positive), very self-deprecating comments were made showing significant self-stigma. For some patients, low self-esteem was already a trigger for use, leading to a vicious circle. In addition, despite the psychotherapeutic work done by several participants, feelings of guilt and responsibility related to drug use persisted in an important proportion. We might assume that the image reflected by society and also by health professionals is at least partly responsible for this observation [7, 14, 34, 42]. Self-stigma and guilt might be explained by various negative stereotypes taken on by the participants even going as far as a phenomenon of meta-dehumanization reported by some comparing themselves to a plant, for instance. These phenomena have been documented particularly in people with severe alcohol use disorder [43]. This self-stigmatization may explain why some participants had low expectations of GP care imaging that all depended on their own willpower, a notion found in the study by Crapanzano et al. [35]

Turning to the positive and negative elements highlighted in speaking about care management. In view of the complexity of SUD people's conditions along with their fears about their health, it is questioning to note the rapid nature and brevity of medical consultations reported by participants. Several considered that the GP who spends time in consultation is a competent doctor, which allows us to argue that financial support from health insurance should be provided for this type of complex consultation [17, 19, 44]. Even if the importance of medication was mentioned by some, a few participants pointed out the excessive emphasis placed by GP on medication in SUD management to the detriment of other concerns. We could observed overmedication with long-term benzodiazepines in our sample, provided by GPs or black market. This is consistent with the literature in Belgium [45]. It also seems upon the participants that the doctor's objective was not always the same as the patient's objective. The latter might have wanted to come off MOUD as quickly as possible to break the addiction pattern while the GP's aim was to offer the patient maintenance treatment to support his recovery. The routine consultations did not always lead the doctor to propose a reduction in the MOUD desired by the patient. At the same time, some participants reported that after several relapses, they had a better understanding of the doctor's vision. This is a process that they probably have to go through to accept it. However, this mismatch between the patient's and the GP's agendas deserves discussion when MOUD is introduced and afterwards in order to create real partnerships with shared decision-making and affording the patient complete confidence and transparency [46]. These elements highlight the importance of addressing the Ideas, Concerns and Expectations (ICE) of each which has been demonstrated to lead to fewer prescriptions [47].

To conclude, 22 out of 23 patients were still smokers at the time of our interviews, which is in line with the study by Shulte et al. [48], which reported a smoking rate of 77–93% among SUD people. With the objectives of limiting illicit consumption and socially reintegrating people, GPs may underestimate the damage caused by legal substances or prescribed psychotropics which are not less dangerous [41].

Despite the recent literature supporting primary care as the most appropriate setting for PWUID, especially for MOUD [9–11], the results were ambivalent regarding care facilities in our study and seemed to be person, caregivers and pathway-dependent. The lack of interest in the addiction field in primary care facilities was pointed out

in opposition to the knowledge and non-judgmental attitudes adopted by caregivers including GPs in SUD centers. The participants mentioned also the stigmatizing potential of these structures which forges their identity as a "junkie" and can be a hindrance to reintegrating into society and enhancing their self-image [27].

Profiles with special needs

As mentioned, the study did not reveal any specific needs and expectations in general practice for certain groups or types of people, nor did it reveal any health needs for groups other than the three groups highlighted in the literature. For these vulnerable groups, our results were in line with the literature for gender-based violence, increased sexual risk, parenthood [22, 23] and intimate partner influence for women [23, 49]. For substance use as a coping, a social integration and an acculturation strategy for immigrant population which can be a source of shame and guilt especially if it was in opposition to their home country culture [25], and physical consequences of injection for PWID [26].

Limitations of the study

The fact that we recruited some patients in GP practices to understand their experiences may constitute a selection bias, as well as some were suggested by the GPs themselves. However, we limited this bias as much as possible by recruiting as heterogeneous a group as possible. Unfortunately, we only had one person with break in care despite efforts to reach out to such situations. Therefore, the study did not allow us to fully grasp the underlying causes. This study focused on Brussels with its particular healthcare provision and circumstances. Overall, the themes addressed seem transferable to other populations. Nonetheless, we should remain circumspect of certain nuances that studies in other contexts in Belgium and elsewhere might bring. To better reach the second objective we should also have had a wider sample.

Conclusion

This study, which focused on patients' perspectives, highlighted needs and expectations in general medicine and allowed identification of the different roles expected of the GP according to the various biopsychosocial vulnerabilities of PWUID. The most striking aspect of this study was the simplicity of the needs and expectations expressed by the participants. They were mainly looking for an empathetic GP available to offer rounded advice, rather than merely a specialist in the field of addiction.

A number of key elements need to be considered such as self-stigmatization, even going as far as a phenomenon of self-dehumanization, that still seemed to affect these patients after years of care, many suicide attempts which may be confused with overdose and numerous cognitive disorders. A large proportion of patients seemed to still use many substances despite being involved in care for years.

All GPs, as key first line professionals, must be able, even it could be sometimes challenging, to welcome these patients into their practice, especially as they are appropriate caregivers considering the many risks and biopsychosocial consequences of drug use. In addition to drug use management, they must not neglect their role in prevention and screening related to drug use and other conditions.

In conclusion, these patients with complex life trajectories, are still too often stigmatized by both society and health professionals and consequently discriminated against by the healthcare system, even though they are in great need of humanity and social connection. Such attributes arguably form part of the foundation of GP's role.

Abbreviations

SUD	Substance Use Disorder
PWUID	People Who Use Illicit Drugs
MOUD	Medication for Opioid Use Disorder
GP	General practitioner
TDI	Treatment Demand Indicator
OD	Overdose
HIV	Human Immunodeficiency Virus
ICE	Ideas Concerns and Expectations

Supplementary Information

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Supplementary Material 1

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Author contributions

LR wrote the original draft of the manuscript, she designed the study and participated to the collection, the analysis and the interpretation of the data. NK and CK promoted the study and intellectually contributed to the study process. MA was involved in the conception and design of the study, she was a major contributor in the collection, the analysis and the interpretation of the data as well as the revision of the manuscript. All authors read, commented and approved the final manuscript.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent for participate

The research protocol was approved by the Ethics Committee of ERASME ULB hospital (medical board's approval number: OM 021) on February 4, 2020, ref.: P2020/023. In addition, we insured the research from 01/01/20 to 31/12/20 in

case of damage to participants. All methods were carried out in accordance with relevant guidelines and regulations. Oral and written informed consent was obtained from each participant. In addition, we insured the research from 01/01/20 to 31/12/20 in case of damage to participants.

Competing interests
The authors declare no competing interests.

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