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Letter to the editor

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Why There Has Been an Excess of Overdoses in Norway Since 1990?

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Former family doctor, now nursing home doctor

TO THE EDITOR: The present study of trend curves and absolute numbers of “drug-related deaths” (DRD) in European countries in the period 1985-2006 shows that the simplest and cheapest treatment modality, the “French method”, also seems to be the best, in four ways – the complicated Norwegian system seems to be the worst, besides being by far the most expensive!

- 1) Immediate lowering of DRD after its introduction in 1995 (methadone); from 1996 mainly buprenorphine (Subutex), after a few years covering more than 2/3 of the population of heroin addicts [4].
- 2) Lasting effect – in spite of very little control over buprenorphine administration (in contrast to methadone).
- 3) French DRD/million inhabitants is about 1/3 of the EU DRD since 1998 and about 1/13 of the Norwegian DRD (besides being many times cheaper). The French DRD data were consistently understated until 2004, but have been upgraded and are now comparable with the other EU countries, and Norway.
- 4) Logically, this lowering is proportionally related to reduced heroin usage, as opioid-related deaths constitute about 75% of DRD in EU countries [2]. This is also of immense socioeconomic and international importance.

1. Comparison of EU reports (including Norway) on DRD

I have made charts of the trends of “drug-related deaths” (DRD) in EU countries and Norway in the period 1985-2006 based on single DRD numbers from EMCDDA (European Monitoring Centre for Drugs and Drug Addiction, Lisbon) [3].

Among the EU countries I have omitted DRD from France, for reasons I will explain later, and Romania too, as the DRD does not cover the whole country. I have related DRD to the actual populations of the reporting countries each year. I got my population statistics from Eurostat, EU: (<http://epp.eurostat.ec.europa.eu/portal/page/eurostat/home/>).

EMCDDA has a diagram in the last annual report showing differences between countries that emerge from the most recent DRD [2], where DRD is related to each ‘million inhabitants between 15 and 64 yrs’. For simplicity I use the numerator ‘million inhabitants’, as this too is a stable parameter. Marking off treatment changes on the trend charts helps to explain the abrupt deviations that sometimes appear on them. This procedure gives a unique opportunity to analyze two opposite systems, the rigid Norwegian one, and the very simple “French method”, with all the other EU countries in between.

I am aware that the DRD numbers are not exact, but I have used the given DRD as a basis for constructive thinking. These results turned out to be highly significant and persuasive, which leads one to trust the tendencies, rather than the exact numbers I present. I also mean that countries other than Norway can optimize their treatment by looking to France. There has been an obstacle to direct comparisons between French DRD and DRD for other EU countries, as the figures for French DRD were too low over a long period, up till 2004.. Until the change that began in 2004, the figures were reported by the police in the same way each year (personal information from EMCDDA), so they have had to be revised to show the trends. For 2005 and 2006 the updated method of DRD reporting shows 4.8/mill.inhab, about 1/3

more than in previous years.

Summing up: In France there is a markedly positive trend after the introduction of substitution treatment in 1995, the first year with methadone, thereafter mainly with buprenorphine, leading to a 2/3 fall in DRD.

Figure 1 compares DRD/mill.inhabitants in Norway to EU (minus France and Romania) and France within in the period 1985-2006. The vertical line in 1994 shows the last year before France started its substitution offensive. The line in 1997 shows the last year before Norway started its specific treatment system, LAR.

It is known that France registered too few DRD until 2004 (EU), but the calculations were always done in the same way, so the trend should be right. For 2005 and 2006 the mode of registration changed. The vertical line in 1997 is the last year before the start of “LAR”. Before 1998 the average yearly extra deaths amounted to 54/yr, whereas in 1998-2006 this figure rose to 197/yr.

plenty of enthusiasm and good intentions, made us build institutions that would allow heroin addicts to become drug-free. But after discharge many die from overdoses, and only a few others become drug-free. A turnaround is possible: many could be helped to become drug-free, as long as they show real motivation, and after having been stabilized on buprenorphine/methadone.

The next step in the official form of treatment is through the administration of substitution drugs – methadone (prescribed to 60%) and buprenorphine (40%) – in a geographically decentralized system, with 14 different quite independent treatment regions, organized by three partners working in cooperation (called LAR - “Drug assisted Rehabilitation”):

- 1) A specialist body that governs the treatment
- 2) A social welfare office
- 3) A family doctor

It may take months or even years to proceed from an application to admittance for treatment. The age limit has been

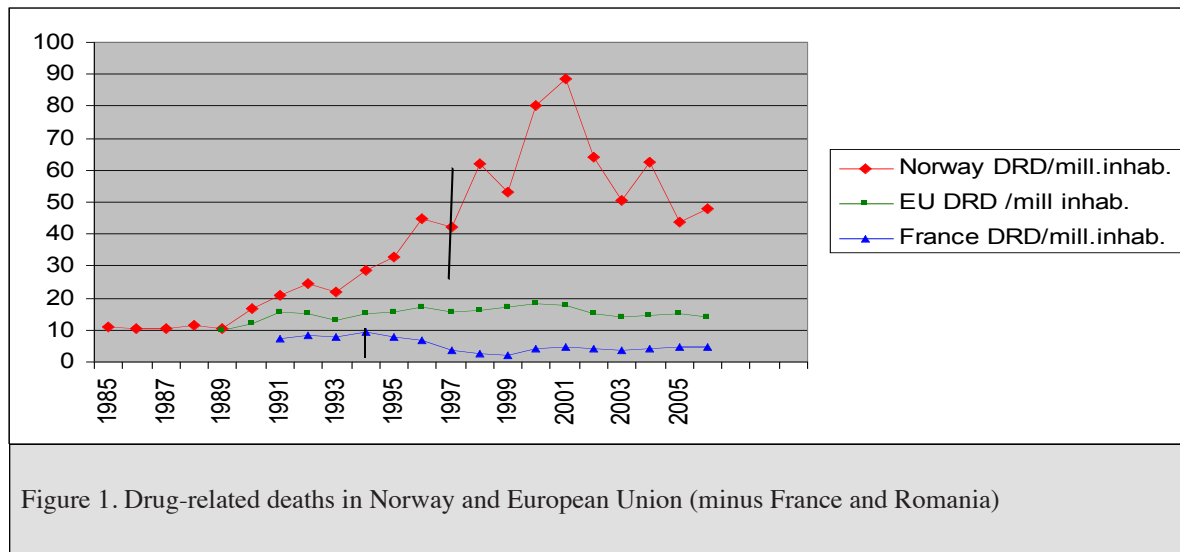


Figure 1. Drug-related deaths in Norway and European Union (minus France and Romania)

I have deduced that in the period 1990-2006 Norway had a DRD excess of 2,200 compared to “EU mortality” and 2,800 compared to France. The average age of death is about 35 yrs [2].

2. From beliefs to science

For various different reasons Norway in 1998 tried out, and later held on to its own way of treating heroin addicts, “which is somewhat out of tune with the general European trend towards harm reduction and diversity”, according to Professor Helge Waal in an article summing the situation up [5]. For too long we have let beliefs rather than science guide us. We have the prerequisites for a very good level of treatment, but only after a few adjustments have been made. Currently, buprenorphine/methadone is being used more as a reward than an instrument. Our traditions, together with

25 yrs, though there is now a plan to lower that limit. There is a rigid control of medication (for both drugs) and urine tests.

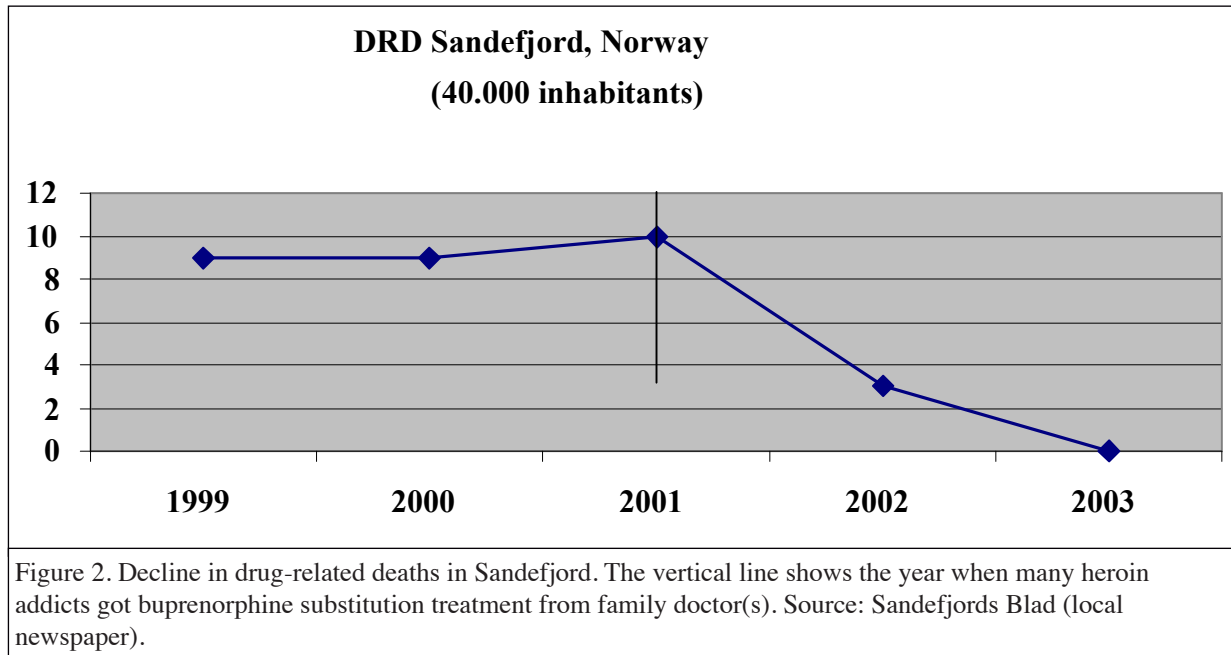
There are about 10,000 heroin addicts (nearly all injectors) including 5,000 get treatment in LAR. The EU countries as a whole also have about 50% coverage [2].

3. The “French Method”

Since 1996, family doctors in France, without any special training, have been the backbone in the treatment of heroin addicts. Buprenorphine (Subutex) is the drug of choice, given to 80%, and methadone to 20%, with more than 2/3 coverage [4].

The consultations and drugs are free.

There is little control of intake of urine and Subutex, in contrast to methadone. Subutex is usually prescribed for one month, to be taken home for one week at a time [2].



4. My own experience

For 16 years I was a family doctor, often dealing with heroin addicts in our town. Sandefjord has 40,000 inhabitants and has a big narcotics problem. Like some other Norwegian doctors I searched for the “treatment of choice”. I saw that the complicated Norwegian system did not function and still fails to function. During the last years I came to test out “the French method”, which was too simple and good to be true, as buprenorphine is a quite safe drug, even when not being controlled, even when injected. Buprenorphine only not helped our patients, but also replaced heroin on the streets. This was the experience in Finland, too [1].

To explain the effectiveness of the treatment: I was nearly alone as a doctor prescribing substitution treatment independently of the LAR in Sandefjord, where LAR at that time covered less than 20% of the need.

I prescribed buprenorphine to about 2/3 of the heroin addicts (to about 60 patients).

The saying in the town was that only one of the remaining 1/3 heavily addicts preferred illegal buprenorphine to heroin.

The DRD declined dramatically (Figure 2).

Exhausted heroin addicts who otherwise would have ended their lives by taking overdoses grasped the new hope when they were offered drugs unconditionally. I saw how these patients went through a ‘metamorphosis’, behaving more normally as soon as their brain receptors were stabilized. This also opened the way to help by volunteers. Encouraging results are ‘contagious’. A family doctor colleague, Dagfinn Haarr, made an interesting comparison between those treated

according to the “LAR” system and those treated according to the “French method”. With the second, he found a decrease of 60% (with DRD falling from 1.3% to 0.5%). Those dropping out of treatment had 5.1%) (article in the Norwegian doctors’ magazine, June 2007).

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Conflict of Interest

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