HOW NOT TO TREAT OPIOID ADDICTS: DANGEROUS, RESTRICTIVE TREATMENT IN NORWAY

By Martin Haraldsen

Former GP in Sandefjord (Norway) with 40.000 inhabitants.

I present a case: a Norwegian married couple now in their fifties, to illustrate a typical hyper-restrictive Nordic model for opioid substitution treatment (OST) in Sweden and Norway.

Our two countries top the yearly reports from the European Union (EU) on drug related deaths (DRD). (Norway report without being an EU member.) There is a vast difference in DRD of up to 20 times between liberal "south" and restrictive "north" of well-developed countries. From this there have come some clues to optimal OST.

OST seems to be optimally performed by GPs, but in my opinion, they should be restricted to prescribing buprenorphine, not methadone, as methadone is more problematic, particularly in the early weeks and should be reserved for a more specialist facility and be followed up more closely. Buprenorphine can sometimes have a side-effect of anxiety, so a dose of benzodiazepines should be allowed.

The Norwegian treatment system (LAR) was started in 1998. This is a "Special Unit" which overrules the GPs and the municipal social welfare unit. LAR is very bureaucratic and costly. OST is strictly controlled, often with long-term daily supervised dosing. So many people desperately try detoxification after a period of supervision. Many people who have become dependent on opioids get imprisoned, with no hope of OST on release. As opioid tolerance is lost very quickly, the danger of DRDs is much increased after any breaks in OST.

Thus rigid system means that people have to spend a lot of time in the city, as nearly all have to show up daily, and consequently there is a market for all sorts of drugs and alcohol. This counteracts rehabilitation to work and is a nuisance for society.

The couple I had been working with first received methadone in LAR in 1999 for nine years. Typically the first six months went well, as they calmed down from their strenuous life with prostitution, begging and some stealing. Then unpleasant sedating side-effects caused the intake of amphetamine as well as cannabis, benzodiazepines and alcohol. The last four years on methadone "just disappeared" from the memory with quite high doses of methadone. They got their doses daily under supervision as they had other drugs in their "unclean" urines. They met regularly in a follow-up group, which over-focused on their "unclean" urine tests. They managed to get a good apartment, which is unusual for LAR patients. Addicts usually get stuck with noise and drugs around.

In 2009 this couple left LAR, having managed to taper down and come off their methadone. But they quickly started buying illegal buprenorphine (Subutex) and found it a better drug for them. Hence LAR was out of the question but they were lucky to get a buprenorphine prescription from a psychiatrist in Brussels, as well as benzodiazepines and regular helpful follow-up. By this they were able to function well, like many other travelling Norwegians, quite a distance from home.

Sadly a man who was so irritated by the collection of patients from LAR in the park consuming drugs and alcohol shot this couple and another man, in the city park. The man was shot seriously in the back; the woman of the couple, who was sober and purely visiting old friends was hit in the head and spent 12 days in a coma. Her husband was shot close to the heart. She ended as a wheelchair user, but he is able to take care of her, in cooperation with the social welfare. Fortunately his lung wound did not hinder his monthly trip to Brussels. He has managed to taper down his buprenorphine and plans to come off. She continues on a small dose.

Many of the people who use drugs in the park were previously my patients as I was GP in the town, before they went into LAR. I lost my work in 2006 as I opposed to LAR with all its restrictions. I favored the "The French method" by giving buprenorphine and benzodiazepines when needed. I worked closely with the Salvation Army who supported these patients closely. After only some months with good use of this regime and unsupervised dosing, the overdoses vanished from the town. Heroin was displaced by buprenorphine. Criminality decreased, some people got work and some were even able to become abstinent from opioids.

There are many messages form my story but in summary most people who use opioids need long-term maintenance and this is best done by GPs. Often big "specialist services' are quite punitive in their approach and treat all people the same rather than as individuals. Daily supervision doesn't allow people to move on and making them go into areas on a daily basis where they have been buying heroin for years, which counteracts rehabilitation.