

Norwegian addicts seek help in Schengen countries

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During the last 25 years, I treated patients coming from many European countries. When I met Norwegian patients, I understood that their problem was not only individual. There was also a problem with the treatment system. Why did those patients drive thousands of kilometers to Denmark, Germany, France and Belgium for a treatment they should get in their own country?

Norwegian authorities may think that the Belgian and French treatment systems are laxist, while we consider that the Norwegian system gives priority to regulations and moralistic attitudes above effectiveness and human respect. Several levels of limits have to be respected : scientific, legal, moral and compassionate. Human approaches of any social problems have to include those four levels.

We can do what is scientifically possible, but it does not mean that all possible things are good : science must be limited by laws (on genetic manipulations for example). But no law forbids being selfish, contemptuous or coward. Moral limits are also necessary, which may be opposite to the law. A French philosopher wrote: "Resistance and obedience are the virtues of a citizen. Obedience ensures social order; resistance ensures freedom". This explains why the head of Oslo police encouraged addicts to protest in front of the Parliament. Finally, another level is necessary for a full human attitude: love or compassion.

Some experts pay attention to the scientific and legal levels, but neglect moral and compassion. For example, in 2007, Norwegian scientists published a study on "Time-limited buprenorphine replacement therapy for opioid dependence", while it is known since forty years that heroin addiction is a chronic relapsing syndrome, requiring long-term treatment. As a consequence of this "time-limited treatment", 8 out of 80 patients died during the study. This kind of study is scientific and legal, but also immoral since human lives were wasted. Another study showed in 2002 that "people who are on the waiting-list for medication assisted rehabilitation (MAR) benefited significantly from Subutex as an interim therapy". This proves that people should not have to wait before receiving

effective medication. Nevertheless, seven years later, waiting lists for treatment still exist.

Bjarne Hakon Hanssen, the current Minister of health, protested against this in 2004 : "I cannot sit calmly and look at people dying in a queue and that doctors become criminals if they try to help... The point is to save lives" (VG, 20/4/2004). At that time, he was spokesman of health politics in the Labour Party. Now he is in charge, but little more than fine intentions and new commissions have seen the light of day so far.

Schengen rules guarantee the freedom of patients to get the treatment of their choice in any European country. This law signed by the Government of Norway includes more than rheumatic patients seeking the warmth in Spain. Norwegian addicts seek treatment in countries where decades of experience - before substitution treatment became significant in Norway - have shown several things:

- 1) Opiate addiction itself is easier to treat than most people think, as far as adequate treatment is available. In Belgium and France, opiate addiction treatment is practiced as a "normal treatment". Family doctors prescribe methadone or buprenorphine and treat 80% to 90% of opiate addicts. Addicts are not stigmatized: they do not have to attend clusters of other addicts to receive their medication. It does not seem that the role of family doctors in the treatment of opiate addicts is recognized in Norway, even in the revised regulations which are to be implemented in 2009. It seems surprising since the current Minister of Health also suggested *"to give the general practitioners the right to decide if the patients should be offered drug assisted treatment"*. Five years and little change can only be rationally explained by systemic or bureaucratic resistance.
- 2) Treatment should be available for all patients who need it, which means all addicted patients. The revised Norwegian legislation under discussion could apply this criterion. In the meantime, waiting lists increase and patients are still begging for treatment in other countries.
- 3) Too many regulations and controls are counter-productive. Strict criteria for treatment bring addicts to prolong their addiction and to delay their treatment. Their physical, psychological and social state is more damaged

than necessary – and rehabilitation consequentially more difficult. The obstacles to get treatment lead opiate addicts to abuse benzodiazepines and alcohol. This creates a multiple addiction problems. This problem, as well as the high percentage of intravenous use (80-90 %), is due to the fact that substitution treatment started too late and too slowly in Norway. In addition, because of this multiple addiction problem, inpatient detoxification is imposed. This drives off the patients or delays their long term treatment – and creates an unnecessary expensive health cost for the Norwegian society.

One of the serious consequences of restricted regulations is that many addicts who would like to be treated buy medicine on the street. Contrary to a well spread myth most buprenorphine (Subutex) sold illegally are bought by heroin addicts and not by young people trying to get high, because buprenorphine gives no rush: it is a long-acting medicine - not a short acting euphoric drug like heroin.

What happens when treatment is largely available, mainly through family doctors, as in Belgium or France? The black market of buprenorphine and methadone tend to disappear. Heroin abuse decreases, as well as criminality and drug-induced deaths (10 times higher in Norway than in France).

Unfortunately, several prejudices reduce the availability of opiate addiction treatment. The first prejudice is that heroin addicts have a “life of pleasure”, while after one or two years they use heroin mainly to avoid withdrawal. Then they look for treatment, but access is restricted by the second prejudice: methadone or buprenorphine are seen as “legal dopes”, extending the pleasure of illegal drugs. In reality, opiate addicts do not feel “high”, but just normal when they use those medicines. The last harmful prejudice is that increased access to agonist treatment could encourage young people to begin opiate addiction. The European experience show that opiate addiction treated as a chronic illness makes it unattractive for young people.