

European drug report 2017 and opioid-induced deaths

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INTRODUCTION

In June 2017, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) published the European Drug Report 2017 (EDR 2017).¹ EMCDDA is the EU agency responsible for monitoring trends on markets and use of psychoactive substances for the EU, Norway and Turkey. The report is available in 24 languages. It provides information about markets, epidemiology and responses to the use of these substances. EMCDDA published 24 country reports simultaneously with the EDR 2017.

NEW PSYCHOACTIVE SUBSTANCES

One continuing trend is the rise of 'new psychoactive substances' (NPS). This is a cat-and-mouse game between organised crime and authorities. Organised crime brings new substances to the market which are not (yet) prohibited, while the authorities prohibit the same substances as soon as possible.

NPS on the European market are mostly synthetic cannabinoids, (highly potent) synthetic opioids, stimulants (eg, cathinones) and benzodiazepines. By the end of 2016, EMCDDA monitored over 620 NPS that have appeared on the European market. In Europe in 2016, 4.0% of school students aged 15 and 16 years used NPS at least once in their lifetime. In some groups, NPS use is high risk, according to the report.

The cat-and-mouse game leads to a rapid succession of active compounds on the market. As a consequence, we know very little about these compounds and user communities do not know what they are using. They do not build any experience about how to use a specific substance in a relatively safe manner. And when it goes wrong, the emergency ward usually has no specific knowledge on the intoxicant.

Many users are hardly aware of the risks they take. By using substances about which so little is known, the user takes additional risks and one may question whether it is a good strategy to chase each substance out of the market immediately. One alternative could be to accept the reality and

establish policies that condone the least dangerous substances and prevent that user community switching from one substance to another. This may lead to user communities experienced with the substances they use and therefore to less risky substance use.

OPIOID-INDUCED DEATH

Currently, the USA has a problem with increased numbers of opioid-induced deaths. In a minority of the cases, the victims used prescription opioids. In most cases, they obtained these prescription opioids from illicit sources. Thus, they were not prescribed to them.^{2,3}

In sharp contrast to this, the attention of the American press, insurance companies, administration and politicians focuses strongly on patients with pain. Recently, American academics even addressed Europe requesting that Europe reduces patient access to opioid analgesics.^{4,5} In May 2017, 12 USA congressmen wrote a letter to WHO's Director-General warning that a pharmaceutical company (Mundipharma) was promoting opioid analgesics in countries where pain management hardly exists. Aside from the fact that these congressmen hardly seem to understand that the USA is not Europe or the rest of the world, the letter is falsely suggesting that opioid-induced deaths from opioid analgesics are a serious problem in Europe.⁶ Moreover, pain has at least a 37 times larger contribution to the global burden of disease than substance use disorders.²

The legitimate per capita consumption of opioid analgesics in the USA is 3.5 times higher than the average per capita consumption of the EU Member States, Norway and Turkey (own data, 2013). Especially in many Eastern and Southern European countries, access to opioids for pain treatment remains poor.⁷

It is against this background that more often, Europeans become confused about the situation with regard to non-medical use of opioids. They think that we might need to adopt the same policy measures as the USA did. The EDR 2017 provides excellent information to understand why the European situation is different.

Upfront, it should be clear that for designing any policy response to

opioid-induced death, distinction should be made between all sorts of sources that can cause such death: the identity of the substance, whether the substance entered the market as a medicine; whether it was prescribed or obtained through a criminal act and if it was prescribed, to whom and for which indication. All these circumstances are important.²

Any opioid can cause death. This can be street heroin, but also a substance used as a medicine or an NPS. The latter include also several highly potent fentanils which are not marketed as medicines. Furthermore, fentanyl is produced both legally and illegally. Furthermore, often it is ignored that the term *prescribed opioids* requires that these medicines were prescribed and dispensed to a patient. In contrast, *prescription opioids* can be diverted anywhere in the system without being prescribed.

It is difficult to design responses that solve the problems if these distinctions are not properly made.⁸ Because the debate often focusses on opioid analgesics, measures taken in the USA focus on pain patients. As a result, many pain patients complain on the internet that they have inadequate access to pain management and that they suffer pain again.

With an American anti-opioid lobby interfering with the European situation and unfamiliar with the difference between the USA and the EU, it seems only a matter of time until voices to restrict patient access to pain management will also be heard in Europe.

DATA FROM THE EDR 2017

Traffickers do not submit their data to the national statistical offices, and therefore, it will always be a guess what is going on, on illicit markets. Fortunately, there are two important types of figures in the EDR 2017 that help us to analyse the current situation in Europe. One is figures on illicit opioids seized in 2016 and the other is figures on the substances used by people seeking treatment for opioid use disorder. Furthermore, qualitative data are presented in the text body of the report. Together, they give a rough impression of the type of opioids that could be the cause of accidental opioid-induced death in Europe.

Data for seized opioids are not as concrete as we wish. Police do not report such seizures in defined daily doses, but in kilograms, litres and number of tablets. These three numbers are incomparable and cannot be totalled. Therefore, the best way to summarise opioid seizures may be

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by their numbers, but it is important to realise that these do not necessarily relate to quantities. The EDR 2017 provides more detail: most seizures relate to opioids not primarily used as opioid analgesics; 84.4% is (street) heroin and 8.5% is methadone and buprenorphine, both primarily used in opioid agonist therapy. Then, there are fentanils, which constitute less than 1% and consist for 60% of NPS. Other seized substances are codeine and opium (together 1%) and opioid analgesics (tramadol, morphine and oxycodone; together 5.5%).

Regarding the people who enter treatment for opioid use disorder, 80% uses heroin, 8% methadone, 5% buprenorphine and <1% uses fentanyl. Seven per cent use 'other substances'.

Furthermore, although heroin use disorder is the usual reason for patients to enter treatment, the report mentions that fentanyl is the most common substance in Finland and buprenorphine in Estonia. In Czechia, heroin accounts only for less than half of the substances used by those who enter treatment.

Buprenorphine and methadone are mainly used for the pharmacological treatment of dependence. Codeine is hardly prescribed any more as an analgesic in Europe, while it is available as an over-the-counter antitussive. Opium is also not used as an analgesic any more.

Combining the data above, we may assume that out of all people who seek treatment for opioid use disorder roughly 6% are on *prescription* opioids analgesics. The figure for those being on *prescribed* opioids can be assumed to be equal or lower.

As explained above, a clear distinction should be made between *prescription* opioids and *prescribed* opioids. There is no evidence in the EDR 2017 supporting that opioids prescribed to patients with pain are problematic in Europe. There is some suggestion that the methadone and buprenorphine on the illicit markets originate from patients in opioid agonist therapy. However, adequate access to opioid agonist maintenance therapy with

methadone, buprenorphine and other long-acting opioids should be ensured as this is proven to reduce morbidity and mortality.⁹

CONCLUSION

The EDR 2017 provides no evidence that there is a public health problem from the *prescription* of opioid analgesics to pain patients in the countries it covers. Yet, if any Member State experiences problems suspected to originate from *prescribed* opioids, a proper analysis should be made of diversion pathways. Appropriate measures that can be expected to intervene effectively in the diversion mechanisms should be identified and applied. Such measures should not unnecessarily interfere with legitimate patient access to opioid medicines.

Only if there is evidence that pain patients play a substantial role in diversion, measures could aim at the practice of pain management, but without undermining the physicians' autonomy to treat pain adequately. Therefore, when analysing any situation related to opioid analgesics, a proper distinction should always be made between *prescription* opioids and *prescribed* opioids.

Policies to reduce harm from non-medical use of psychoactive substances, including opioids, require a scientific approach, fair for pain patients and respectful of human rights.

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