politicians pointed to France's poor ranking in international statistics on opioid consumption as evidence of the health system's failure to deliver relief from suffering and pain management was set as a priority of new health policy. Just as in the United States, opioids were destigmatized and became the symbol of pain management. Contracts were signed between the French government and global pharmaceutical companies in order to increase the health-care system's capacity to provide opioids; yet no disaster followed [7]. Where American pain specialists were convinced by insurance companies and hospital administrators to champion opioids as a means of cutting costs, French doctors were able to resist the pressure thanks to more favourable institutional conditions which allowed them to mute the effects of neoliberal health-care reform and to maintain a multi-modal approach to pain treatment [8].

KEYWORDS

France, harm reduction policy, lessons, pain medicines, policy analysis, regulation

DECLARATION OF INTERESTS

None.

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What lessons from Norway's experience could be applied in the United States in response to the addiction and overdose crisis?

The causes and characteristics of opioid deaths are dynamic and differ between regions. Most regions experience heterogenic opioid-using populations with a range of treatment needs. To turn the US opioid crisis, coordinated, multi-faceted, long-term and significant interventions need to be applied. Large-scale increases in the provision of suitable opioid agonist treatment (OAT) to all in need will probably be key to turning the tide.

In the United States, widespread and extremely liberal prescription opioids access started in the 1990s. The current fentanyl-dominated opioid crisis stems from that liberalization of opioid access [1]. Today, opioid deaths in the United States are more than 10-fold European levels [2].

What can we learn from the overdose situations occurring on two different continents?

An ongoing and escalating crisis, as in the United States, can be defined as a situation where the level of needs in the population is not met by appropriate resources and interventions to counter the problem. Another feature of a crisis is often the experience that 'if we had responded with counteractions sooner' the current situation could have been different. The latter does not help to solve the crisis, but appreciation of the fact may help others to be more alert to similar developments. In Europe, we can learn from the United States to be much more restrictive in providing widespread access to potent opioids for long-term and outpatient/community pain management.

As the US opioid crisis has complex causes and explanations with long historical backgrounds, no single intervention or quick fixes can be expected to resolve the crisis. Somewhat long-term coordinated efforts with sufficient resources need to be implemented to turn the rising opioid death curves [3].

What can be learned from Norway's experience?

Norway has recently been ranked as having favorable drug policies [4]. Since 2014, Norway has had a coordinated National Overdose Prevention Strategy [5], initiated and funded by the Norwegian Government. The strategy has garnered pan-political support during the last 8 years. The strategy includes multiple elements, such as a focus on low-threshold access to opioid agonist treatment (OAT), ample access to harm reduction services [6], including take-home naloxone [7] and safe drug consumption rooms. Additionally, a funded research-based monitoring strategy allows identifying new priority areas within the strategy, as overdose prevention is 'chasing a moving target'. Also, national prescription guidelines for opioid treatment of chronic pain are issued by public health agencies.

Suggested key areas of priorities

Changes and limitations in prescribing practices are needed to prevent new people from becoming opioid-dependent. Alternatives to opioid pain management need to be applied to a larger extent. This is critical in addressing prescription opioid dependence for future generations.

Next, for people already prescribed outpatient opioid pain treatment, systematic monitoring of benefits of the treatment should be implemented, as well as guidelines for supervised tapering and switching to non-opioid types of pain management to reduce current use. The latter strategies need to be accompanied by access to such non-opioid management options. National public health institutions and clinicians should share responsibility for implementing national prevention, treatment and prescription guidelines, without involvement from the pharmaceutical industry.

For all people with opioid dependence, the provision of readily accessible and high-quality treatment is urgently needed. Access to OAT for large numbers of currently untreated people will be required. Similarly, access to evidence-based treatments such as depot naltrexone [8, 9] will allow meeting the varied needs among OUD populations. Currently, in the United States, only approximately one-third of those in need receive treatment [10]. The goal should be at least 60–70% or more [11] of the target population in stable long-term OAT. Widespread access to OAT and harm reduction is probably the key and has proved to be cost-effective [12]. Barriers to treatment access should be identified and diminished.

From Norway we have shown OAT to reduce the overdose burden, with one life saved from overdose death for each 100 person-years in OAT [13]. Enrollment into OAT crucially needs to be scaled-up in the United States, including access to all available OAT medications. To respond to various individual treatment needs, multiple treatment options should be equally available to meet the spectrum of needs.

An important message is that, in a complex crisis, government support is needed for a coordinated public health effort and sufficient resources, including for research, to turn the situation. 'Epidemic curves' often show a bell-shape, with fairly balanced shapes on both sides of the peak level. The severity of the US opioid crisis, which is still rising, will probably require a 25-year perspective ahead to really see an improvement.

Finally, in Europe and Norway characteristics of the societies include universal access to 'free of charge' health care, strong public health institutions, universally available systems for social welfare and generally lower levels of socio-economic disparities. All factors probably contribute to a lower risk of developing an opioid crisis with US dimensions in Europe, as well as potential lessons learned for the United States. Appreciation of the differences in dealing with an ongoing and escalating crisis, as in North America, and the situation where focus is more upon primary prevention and maintaining lower levels of problems, as in Europe, is needed. Learning will continue to be bi-directional.

KEYWORDS

Deaths, harm reduction, opioid, prevention, public health policy, treatment

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Addressing the overdose crisis in North America with bold action

The unregulated drug supply is predominantly composed of fentanyl and responsible for accelerating the overdose crisis across North America. Scaling-up safer supply and implementing decriminalization of drug use are two major policy shifts needed to reduce overdose deaths and begin to displace frameworks focused on criminalization that have dominated health and drug policy.

North America is facing a devastating public health crisis of unintentional drug poisoning overdose deaths driven by an unpredictable unregulated drug supply, which has significantly worsened since the onset of the COVID-19 pandemic. However, the volatility of the unregulated drug supply predates the pandemic, with fentanyl supplanting heroin over the last 5–7 years in much of Canada and the United States. It is this shift that has driven the acceleration in opioid-related death rates, with unregulated fentanyl responsible for 87% of opioid-overdose deaths in Canada in 2021 [1].

Historically, the overprescribing of pharmaceutical opioids has been implicated in increased opioid-related harms, and rates of opioid prescribing in North America remain elevated in comparison to other jurisdictions [2]. Despite this, significant reductions in rates of opioid prescribing in North America have not led to decreases in opioid-related harms; in fact, multiple studies have found that decreases in pharmaceutical opioid prescribing have translated into increased rates of overdose from unregulated opioids such as heroin and fentanyl [3,4]. Although the preponderant contribution of fentanyl to overdose burden in North America is increasingly recognized, drug policy responses in many jurisdictions continue to focus on overprescribing, overlooking the decreasing contribution of pharmaceutical