Re: Schechter MT, Kendall P. Counterpoint: Is There a Need for Heroin Substitution Treatment in Vancouver's Downtown Eastside? Yes There Is, and in Many Other Places. CJPH 2011;102(2):87-89

Dear Editor:

Schechter and Kendall accuse us of being opposed to heroin substitution treatment (HST) for ideological reasons. This is false; our criticisms have been based on a careful review of scientific evidence. NAOMI investigators chose to ignore these criticisms, and as a result the NAOMI trial is seriously flawed.

Schechter and Kendall continue to skirt around our criticisms. Their only stated criterion for increasing the methadone dose is the patient's 'wishes'. For decades, the standard of practice has been to increase the dose for patients who report persisting withdrawal symptoms, cravings and heroin use. Studies have shown that doses of 100-120 mg or more lead to higher rates of treatment retention than doses below 100 mg. Nor do the authors address our concern about the slow titration rate (only 60 mg by day 30). Thirty-four subjects dropped out of the MT arm between days 0-30, versus only 8 subjects in the HST arm; this trend was reversed from day 30 to month 12. Thus, the supposed benefits of HST can be attributed primarily to early drop-outs from suboptimal dose titration.

Our statement that HST is far more expensive per patient than MT is correct. The cost-effectiveness of HST versus MT is unknown. The analyses based on the Netherlands trials are of little value because the trials used very low mean methadone doses (67 and 71 mg).[1] The most one can say is that HST is more cost-effective than substandard MT.

Schechter and Kendall misinterpret our comments on the need for both ITT (intention-to-treat) and OT (on-treatment) analysis when interpreting treatment retention results. More patients were on MT than HST by the end of the trial. It is misleading to record these subjects as retained in HST when they were in fact on MT for several months before the trial ended.

The rate of life-threatening events, 0.16 per patient per year, is unacceptably high for a long-term outpatient treatment. The authors attribute the large difference in overdose rates to underreporting of off-site overdoses in the MT group. Our understanding is that the NAOMI trial recorded hospital and emergency admissions for all subjects, so off-site overdoses requiring medical treatment would have been recorded.

Finally, Schechter and Kendall's polemic does not even mention our concerns about the lack of access to optimal methadone or buprenorphine treatment in the Downtown Eastside. Policymakers should ensure that these treatments are readily available before resorting to expensive and unsafe treatments such as HST.

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REFERENCE

1. van den Brink W, Hendriks V, Blanken P, Koeter MW, van Zwieten BJ, van Ree JM. Medical prescription of heroin to treatment resistant heroin addicts: Two randomised controlled trials. *BMJ* 2003;327(7410):310.

Authors' Response

Dear Editor:

The letter by Kahan and Srivastava merits a response that we hope will be the last in a series of exchanges. We have searched our commentary but nowhere do we find an accusation that Kahan et al. are motivated by ideology, nor would we agree that our rebuttal of their criticisms amounts to a "polemic". We are surprised at their claim that not only NAOMI but also "the controlled trials that preceded it (are) seriously flawed". We ourselves place more confidence in the three research ethics boards, the CIHR Randomized Controlled Trials review panel, the Therapeutic Products Directorate of Health Canada and peer reviewers who all provided critical reviews of NAOMI, and the fact that "the prescription of heroin is now recognized in some European countries as the optimal treatment for patients for whom options are running out and in whom methadone maintenance has not worked".[1] This recognition in Europe was based on the excellent controlled trials conducted there, whose results have appeared in such journals as the *Lancet*,[2] the *British Medical Journal*[3,4] and the *British Journal of Psychiatry*.[5]

As we have stated several times in various publications, we believe that methadone, provided according to best-practice guidelines, should remain the treatment of choice for the majority of patients. We also advocate for greater accessibility to such treatment, not only in Vancouver but also outside the lower mainland of BC.

Our significant difference from Kahan and colleagues is our recognition that even when optimally provided, methadone maintenance has a non-trivial failure rate, and second-line alternatives do exist that are cost-effective and provide clinically and socially significant improvements for individuals who have not benefited from methadone maintenance alone.

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REFERENCES

1. Berridge V. Heroin prescription and history. *N Engl J Med* 2009;361:820-21.
2. Strang J, Metrebian N, Lintzeris N, Potts L, Carnwath T, Mayet S, et al. Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): A randomised trial. *Lancet* 2010;375:1885-95.
3. Perneger TV, Giner F, del Rio M, Mino A. Randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatments. *BMJ* 1998;317:13-18.
4. van den Brink W, Hendriks VM, Blanken P, Koeter MW, van Zwieten BJ, van Ree JM. Medical prescription of heroin to treatment resistant heroin addicts: Two randomised controlled trials. *BMJ* 2003;327:310-16.
5. Haasen C, Verthein U, Degkwitz P, Berger J, Krausz M, Naber N. Heroin-assisted treatment for opioid dependence: Randomised controlled trial. *Br J Psychiatry* 2007;191:55-62.