Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction

Strang, John; Groshkova, Teodora; Uchtenhagen, Ambros; van den Brink, Wim; Haasen, Christian; Schechter, Martin T; Lintzeris, Nick; Bell, James; Pirona, Alessandro; Oviedo-Joekes, Eugenia; Simon, Roland; Metrebian, Nicola

Abstract: BACKGROUND Supervised injectable heroin (SIH) treatment has emerged over the past 15 years as an intensive treatment for entrenched heroin users who have not responded to standard treatments such as oral methadone maintenance treatment (MMT) or residential rehabilitation. AIMS To synthesise published findings for treatment with SIH for refractory heroin-dependence through systematic review and meta-analysis, and to examine the political and scientific response to these findings. METHOD Randomised controlled trials (RCTs) of SIH treatment were identified through database searching, and random effects pooled efficacy was estimated for SIH treatment. Methodological quality was assessed according to criteria set out by the Cochrane Collaboration. RESULTS Six RCTs met the inclusion criteria for analysis. Across the trials, SIH treatment improved treatment outcome, i.e. greater reduction in the use of illicit 'street' heroin in patients receiving SIH treatment compared with control groups (most often receiving MMT). CONCLUSIONS SIH is found to be an effective way of treating heroin dependence refractory to standard treatment. SIH may be less safe than MMT and therefore requires more clinical attention to manage greater safety issues. This intensive intervention is for a patient population previously considered unresponsive to treatment. Inclusion of this low-volume, high-intensity treatment can now improve the impact of comprehensive healthcare provision.

DOI: https://doi.org/10.1192/bjp.bp.114.149195

Posted at the Zurich Open Repository and Archive, University of Zurich
ZORA URL: https://doi.org/10.5167/uzh-114498
Published Version

Originally published at:
Strang, John; Groshkova, Teodora; Uchtenhagen, Ambros; van den Brink, Wim; Haasen, Christian; Schechter, Martin T; Lintzeris, Nick; Bell, James; Pirona, Alessandro; Oviedo-Joekes, Eugenia; Simon, Roland; Metrebian, Nicola (2015). Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. British Journal of Psychiatry, 207(1):5-14.
DOI: https://doi.org/10.1192/bjp.bp.114.149195
Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction†

John Strang,* Teodora Groshkova,* Ambros Uchtenhagen, Wim van den Brink, Christian Haasen, Martin T. Schechter, Nick Lintzeris, James Bell, Alessandro Pirona, Eugenia Oviedo-Joekes, Roland Simon and Nicola Metrebian

Background
Supervised injectable heroin (SIH) treatment has emerged over the past 15 years as an intensive treatment for entrenched heroin users who have not responded to standard treatments such as oral methadone maintenance treatment (MMT) or residential rehabilitation.

Aims
To synthesise published findings for treatment with SIH for refractory heroin-dependence through systematic review and meta-analysis, and to examine the political and scientific response to these findings.

Method
Randomised controlled trials (RCTs) of SIH treatment were identified through database searching, and random effects pooled efficacy was estimated for SIH treatment. Methodological quality was assessed according to criteria set out by the Cochrane Collaboration.

Results
Six RCTs met the inclusion criteria for analysis. Across the trials, SIH treatment improved treatment outcome, i.e. greater reduction in the use of illicit 'street' heroin in patients receiving SIH treatment compared with control groups (most often receiving MMT).

Conclusions
SIH is found to be an effective way of treating heroin dependence refractory to standard treatment. SIH may be less safe than MMT and therefore requires more clinical attention to manage greater safety issues. This intensive intervention is for a patient population previously considered unresponsive to treatment. Inclusion of this low-volume, high-intensity treatment can now improve the impact of comprehensive healthcare provision.

Declaration of interest
J.S. and N.L. have contributed to National Treatment Agency/Department of Health English Guidelines on the role of injectable prescribing in the management of opiate addiction (2003; chaired by J.S.), and J.S. also chaired the broader-scope pan-UK working group when preparing the 2007 ‘Orange Guidelines’ for the Department of Health, providing guidance on management and treatment of drug dependence and misuse and is chairing the new expert group updating the Department of Health Guidelines (2014). J.S. and his employing organisation have provided consultancy advice and received honoraria, travel and conference support, and consultancy fees from pharmaceutical companies including current and potential future suppliers of diacetylmorphine and methadone (ViroPharma, Martindale, TEVA, Reckitt Benckiser) and have conducted research involving collaboration with the pharmaceutical industry to investigate possible new treatment medications (Martindale, Mundipharma, iGen). J.S., N.M. and N.L. have previously undertaken research study of British heroin policy and have given varied commentaries and contributed to professional and public debate. A.U. has been mandated to document and evaluate the Swiss cohort study on heroin-assisted treatment by the Federal Office of Public Health, resulting in (unpaid) scientific publications and (unpaid) presentations at conferences (expenses reimbursed); expert consultation and project participation for the World Health Organization and United Nations Office on Drugs and Crime on substitution treatment for opiate addiction. W.vdB. is chair of the working group that is currently preparing the Netherlands Interdisciplinary guideline on Opioid Addiction Treatment. He also was the scientific director of the Central Committee on the Treatment of Heroin Addiction (CCBH), which was responsible for the planning, execution and reporting on the Dutch trial on heroin-assisted treatment. W.vdB. has separately provided consultancy advice and received honoraria, travel and conference support, and consultancy fees from various pharmaceutical companies including current and potential future suppliers of buprenorphine (Reckitt Benckiser), extended-release naltrexone (Alkermes) and nalinefene (Lundbeck). C.H. has contributed to the German guidelines on opioid substitution treatment of the German Medical Association and has provided consultancy advice to the German Ministry of Health on the development of the revisions of the Narcotics Law. C.H. has undertaken research evaluation of the German and European drug policy and given commentaries and contributed to professional and public debate. He has also provided consultancy advice and received honoraria, travel and conference support, and consultancy fees from pharmaceutical companies including current and potential future suppliers of diacetylmorphine and other opioids.

Copyright and usage
© The Royal College of Psychiatrists 2015. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial No Derivatives (CC BY-NC-ND) licence.
Fifteen years ago, Bammer et al.

Inclusion criteria and selection of studies

The methodology was designed to collect evidence in a sequential and logical manner. The review has a clear focus on evidence of SIH treatment efficacy as well as allowing a broad scope for learning about the scientific and political response to the published findings. Only studies that had the key search terms in the abstract and also had oplate use, retention in treatment, mortality and side-effects as outcome variables were considered. Thus, methodological papers were excluded. Papers were also excluded if they were assessing the pre-existing unsupervised heroin treatment provision, which focused on policy aspects, which were only reporting profile of trial participants or which were separately reporting on measures of cost-effectiveness, community perspectives and patient satisfaction or longer-term (beyond the trial follow-up period) effects.

Data extraction

Information extracted from each study included the location of the study, author names, year of publication, sample size, groups studied, time to follow-up, outcome measures and effect-size estimates.

Statistical analysis

Mantel–Haenszel random effects pooled risk ratios and corresponding 95% CI for SIH treatment patients v. comparison groups were calculated using Review Manager 5.2 for Windows 7 with fuller (compared with the latest Cochrane review of 2011) outcome data. Heterogeneity between studies was assessed through the $I^2$ statistic. Lastly, funnel plots were used to assess potential publication bias for the meta-analyses.

Results

A total of 2599 records were identified using the search terms (Fig. 1).

In addition to the six main papers from the individual trials, a broader set of papers is available, reporting other data such as secondary SIH treatment outcomes, observational longer-term outcomes, health economic data, family perspectives, community perspectives and patient satisfaction. Alongside the results of a meta-analysis of the effects of SIH treatment, this broader set of papers is outlined, although not integrated in our formal analysis for the reasons listed in Table 2.

Six randomised trials in six countries over 15 years: synthesis of findings

In this section, we present the trials in historical sequence. The early heroin trial from the 1970s was not included since this was not based on the new approach of supervised injecting. The series of SIH treatment trials commences with the 1998 Perneger trial in Switzerland, the crucible of the new supervised injecting clinic approach. All of the new randomised trials summarised in this article have taken as their study participants chronic heroin-dependent individuals who have repeatedly failed in orthodox treatment (either currently still failing in treatment as evidenced by continued regular heroin injecting, or alternatively currently no longer engaged in treatment), apart from a subsample of the German study, and they have included randomised comparison with the standard treatment of oral MMT. Generally, the results were consistent and each trial has

Method

Search strategy

The review was conducted according to the PRISMA guidelines (www.prisma-statement.org). The search strategy targeted studies that reported on the effect of SIH treatment in a range of outcome domains among individuals with heroin-dependence unresponsive to standard treatments. Computer-based internet databases used for this search included MEDLINE (PubMed database), Web of Science and Scopus. There were no language or publication year restrictions. The combinations of keywords used in the database search included 'addiction', 'assisted', 'supervised', 'dependence', 'diacetylmorphine', 'diamorphine', 'heroin', 'maintenance', 'prescription' and 'treatment'. The initial data searches and screening of irrelevant abstracts were conducted by T.G. Subsequent data checking and searches were overseen by N.M. and J.S. Lead clinicians and/or researchers who have been at the forefront of testing and trialling SIH trials co-authored this paper.
well as the good short-term outcome at 6 months. Supervised injectable clinic modality, the high doses of randomised trial study design, the potential acceptability of the This early trial contributed to establishing the feasibility of the 22% of the heroin-prescribed group treatment. Continued illicit heroin use was self-reported by only reductions in illicit heroin use and in crime after 6 months of MMT. The two groups had equivalent retention, but the studied over a 6-month period of injected diamorphine or oral conclusions. One of the trials studied the efficacy and safety of inhalable diacetylmorphine (conclusions. This small study was important as the first randomised trial of this new supervised treatment approach. Participants were studied over a 6-month period of injected diacetylmorphine or oral MMT. The two groups had equivalent retention, but the diamorphine-prescribed group had significantly greater reductions in illicit heroin use and in crime after 6 months of treatment. Continued illicit heroin use was self-reported by only 22% of the heroin-prescribed group v. 67% of the control group. This early trial contributed to establishing the feasibility of the randomised trial study design, the potential acceptability of the supervised injectable clinic modality, the high doses of diamorphine maintenance that could safely be administered, as well as the good short-term outcome at 6 months.

(a) Switzerland, 1998
This small study (n = 51) was important as the first randomised trial of this new supervised treatment approach. Participants were studied over a 6-month period of injected diacetylmorphine or oral MMT. The two groups had equivalent retention, but the diamorphine-prescribed group had significantly greater reductions in illicit heroin use and in crime after 6 months of treatment. Continued illicit heroin use was self-reported by only 22% of the heroin-prescribed group v. 67% of the control group. This early trial contributed to establishing the feasibility of the randomised trial study design, the potential acceptability of the supervised injectable clinic modality, the high doses of diamorphine maintenance that could safely be administered, as well as the good short-term outcome at 6 months.

(b) The Netherlands, 2003
The two Dutch multi-site randomised trials constituted a significant step-change in the evidence-base, bringing sufficient sample size (n = 594) and study rigour to reach more robust conclusions. One of the trials studied the efficacy and safety of injectable diacetylmorphine (n = 174), the other the efficacy and safety of inhalable diacetylmorphine (n = 375) and will not be considered further in this article. Retention rate for MMT at 12 months was higher (85%) than for SIH (72%), but a much larger proportion of the heroin-prescribed group were ‘responders’ on the pre-determined composite scale of response (57% v. 32%). In addition, the Dutch trials showed that SIH was cost-effective for this target population. The study method and the results from the Dutch trial guided the construction of the later trials reported in this article.

(c) Spain, 2006
This small (n = 62) randomised trial was undertaken in Andalucia and found equivalent retention, and significantly greater reduction in self-reported illicit heroin use in the diamorphine group at their selected 9-month follow-up point. Despite the small sample size and the continued reliance on self-report, these findings provided further evidence of benefit to previous studies and also contributed the perspectives of the families of the heroin addicts in SIH treatment.

(d) Germany, 2007
This multi-site trial is the largest conducted to date (n = 1015), and found slightly higher retention in the heroin compared with the methadone group. It found greater proportions of the heroin-prescribed group reporting reduced heroin use and being ‘responders’ on the multidimensional outcome measure. An advance in this trial was the attention to ensuring good dosage for participants randomised to oral MMT (thus addressing concern that the apparent advantage of heroin-prescribing may be an artefact of suboptimal treatment in the control group). This trial also incorporated various other study elements (two different recruitment strands; and two styles of counselling therapy – neither of which was associated with meaningful differences in outcome). This trial was the first to include objective laboratory test results for illicit heroin, but these were not available across all participants, were only incorporated into the composite score and were not reported separately.

(e) Canada, 2009
The Canadian NAOMI (North American Opiate Medication Initiative) trial (n = 226), a two-site randomised trial, was the first of the randomised trials to be conducted outside Europe and was carried out in severely affected participants not currently in treatment but with multiple previous treatment attempts. Significantly higher rates of retention (in SIH or other treatment) and clinical response scores occurred in those randomised to diamorphine. This trial also included a small subsidiary arm (n = 25) that was an exploratory double-masked evaluation of injectable hydromorphone and which included objective laboratory urinanalysis, and the results showed broadly equivalent benefits.

(f) England, 2010
The UK three-site RIOTT (Randomised Injectable Opioid Treatment Trial) was important as the first trial to be conducted with laboratory illicit opioid test results as the pre-declared primary outcome measure. This three-way randomised trial compared two forms of supervised injectable maintenance (SIH and supervised injectable methadone maintenance) against an optimised version of oral MMT. Although the sample size was modest (n = 127 across the three groups), the investigators had the benefit of the previous trials to guide calculations of sample size and power, as well as improved laboratory analytical methods involving assay for papaverine and other components of illicit heroin. Good retention was achieved in all groups. At months 4–6, the heroin-treated group was significantly more likely to provide urine specimens negative for markers of illicit heroin than the optimised MMT group. This trial also reported on the speed of onset of the benefit observed in the heroin-treated group (as had the Dutch trial), and again benefits were evident within 2 months of treatment.
**Table 1** Six randomised trials of supervised injectable heroin (SIH) (plus flexible supplementary doses of oral methadone): key features and outcomes

<table>
<thead>
<tr>
<th>Main paper</th>
<th>Country</th>
<th>Sample size; groups studied</th>
<th>Time to follow-up</th>
<th>Cochrane risk of bias using five criteria recommended by the Cochrane Handbook</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perneger et al&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Switzerland</td>
<td>n = 51</td>
<td>6 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) H Blinding (subjective outcomes) H</td>
<td>Retention: SIH: 93% v. OM 92% Self-reported illicit heroin use: SIH: 22%, OM: 67% (P = 0.002) SAEs' data not reported</td>
</tr>
<tr>
<td>van den Brink et al&lt;sup&gt;12&lt;/sup&gt;</td>
<td>The Netherlands</td>
<td>Injectable trial: n = 174 SIH (+OM): n = 76 OM: n = 98 (also SinH trial, n = 75)</td>
<td>12 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) L Blinding (subjective outcomes) L</td>
<td>Retention: SIH: 72% v. OM 85% Self-reported 40% improvement in at least one domain (physical, mental, social): SIH 56% v. OM 31% (P = 0.002) SAEs: reported data limited to 11 SAEs (two definitely or probably and nine possibly related to injectable heroin)</td>
</tr>
<tr>
<td>March et al&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Spain</td>
<td>n = 62</td>
<td>9 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) U Blinding (subjective outcomes) U</td>
<td>Retention: SIH: 74% v. OM 68% Self-reported illicit heroin use in past 30 days (mean days): SIH = 8.3 v. OM = 16.9 (P = 0.022) SAEs: SIH = 7 (two unrelated and five probably or definitely related to study drug) v. OM = 7</td>
</tr>
<tr>
<td>Haasen et al&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Germany</td>
<td>n = 1015</td>
<td>12 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) U Blinding (subjective outcomes) U</td>
<td>Retention: SIH: 67% v. OM 40% Improvement in drug use (measured by either UDS and self-report): SIH 69%, OM 55% (P &lt; 0.001) Improvement in physical/mental health: SIH 80%, OM 74% (P = 0.023) Combined reduced drug use and improved physical/mental health (responder): SIH 57% v. OM 45% (P &lt; 0.001) SAEs: SIH = 177 (58 possibly, probably or definitely related to study drug) v. OM = 15</td>
</tr>
<tr>
<td>Oviedo-Joekes et al&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Canada</td>
<td>n = 251</td>
<td>12 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) L Blinding (subjective outcomes) L</td>
<td>Retention: SIH 88% v. OM 54% (P &lt; 0.001) Self-reported reduction in illicit drug use or other illegal activities (improvement of 20% for either domain): SIH = 67%, OM = 48% (p = 0.004) SAEs: SIH = 51 v. OM = 18</td>
</tr>
<tr>
<td>Strang et al&lt;sup&gt;17&lt;/sup&gt;</td>
<td>England</td>
<td>n = 127</td>
<td>6 months</td>
<td>Random sequence generation L Allocation concealment L Incomplete outcome data L Selective reporting L Blinding (objective outcomes) L Blinding (subjective outcomes) L</td>
<td>Retention: SIH (or other treatment) 88% v. OOM 69% Reduction in 'street' heroin – 50% or more negative UDS during weeks 14–26 (responder): SIH 66% v. OOM 19% (P &lt; 0.0001) SAEs: SIH = 7 (two probably related to study drug) v. OOM = 9</td>
</tr>
</tbody>
</table>

SAEs, serious adverse event; OM, oral methadone; OOM, optimised oral methadone; SIM, supervised injectable methadone; SinH, supervised inhalable heroin; SIHM, supervised injectable hydromorphone; L, low risk of bias; U, unclear; H, high risk of bias.

**Effects of SIH treatment**

Opiate use outcome data

Across the trials, different opiate use reduction (or abstinence) outcome measures were used, which prevents exploration of the pooled results in relation to this outcome. Nonetheless, there was a positive effect of SIH on illicit heroin use reported by each individual study.<sup>6,13–17</sup>

Retention in treatment outcome data

Utilising available data from four studies,<sup>5,13,14,17</sup> our meta-analysis identified a significant advantage of SIH over oral MMT treatment in retention in treatment: overall RR = 1.37 (95% CI 1.03–1.83), heterogeneity (P < 0.00001), I² = 91% (Fig. 2). The Dutch<sup>13</sup> and the Spanish<sup>14</sup> studies were excluded from the analysis of retention because of the specific construction of the two study conditions, i.e. as per trial designs, the participants in the MMT groups had an automatic right to be offered SIH at the end of the randomised trial period. The possibility of exclusion of the RIOTT for the same reason was considered; however, this was not required as there was no automatic right to be offered injectable maintenance at the end of the 6-month randomised trial period, even though there was, in practice, a sympathetic consideration of this request if it was made.

Mortality outcome data

The six trials collectively identified 16 events of death (SIH: n = 6; oral MMT: n = 10) resulting in a numerical advantage of SIH
Test for overall effect:

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>SIH (+OM) Events</th>
<th>Oral MMT Events</th>
<th>Weight (%)</th>
<th>Risk ratio M-H, Random, 95% CI</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perneger et al17</td>
<td>25</td>
<td>22</td>
<td>24</td>
<td>25.4</td>
<td>1.01 (0.86 to 1.19)</td>
</tr>
<tr>
<td>Haasen et al15</td>
<td>346</td>
<td>200</td>
<td>500</td>
<td>26.3</td>
<td>1.68 (1.48 to 1.90)</td>
</tr>
<tr>
<td>Oviedo-Joekes et al16</td>
<td>101</td>
<td>111</td>
<td>24.8</td>
<td>23.5</td>
<td>1.28 (1.02 to 1.61)</td>
</tr>
<tr>
<td>Strang et al17</td>
<td>38</td>
<td>29</td>
<td>42</td>
<td>100.0%</td>
<td>1.37 (1.03 to 1.83)</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>700</td>
<td>677</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td>510</td>
<td>311</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2 = 34.13$, d.f. = 3 ($P = 0.00001$); $I^2 = 91$

Test for overall effect: $Z = 2.19$ ($P = 0.03$)

**Fig. 2** Supervised injectable heroin (SIH) + flexible doses of oral methadone v. oral methadone: retention in treatment.

**Table 2** Thirty papers excluded from this review presented in chronological order (from the most recent to the oldest), country and reason for exclusion

<table>
<thead>
<tr>
<th>Paper</th>
<th>Country</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Byford et al19</td>
<td>England</td>
<td>Outcomes not in the scope of this review (health economics)</td>
</tr>
<tr>
<td>Groshkova et al20</td>
<td>England</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Verthein et al21</td>
<td>Germany</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Vogel et al22</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Nosyk et al23</td>
<td>Canada</td>
<td>Outcomes not in the scope of this review (health economics)</td>
</tr>
<tr>
<td>Marchand et al24</td>
<td>Canada</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Verthein et al25</td>
<td>Germany</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Blanken et al26</td>
<td>The Netherlands</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Blanken et al27</td>
<td>The Netherlands</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Eiroa-Orosa et al28</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Haasen et al29</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Karow et al30</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Lasnier et al31</td>
<td>Canada</td>
<td>Community perspectives</td>
</tr>
<tr>
<td>Miller et al32</td>
<td>England</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Oviedo-Joekes et al33</td>
<td>Spain</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Oviedo-Joekes et al34</td>
<td>Canada</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Oviedo-Joekes et al35</td>
<td>Canada</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Oviedo-Joekes et al36</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Haasen et al37</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (health economics)</td>
</tr>
<tr>
<td>Perea-Milla et al38</td>
<td>Spain</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Haasen et al39</td>
<td>Germany</td>
<td>Outcomes not in the scope of this review (secondary outcomes)</td>
</tr>
<tr>
<td>Romo et al40</td>
<td>Spain</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Miller et al41</td>
<td>England</td>
<td>Patients’ perspective</td>
</tr>
<tr>
<td>Dursteler-Macfarland et al42</td>
<td>Switzerland</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Dijkgraaf et al43</td>
<td>The Netherlands</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Rehm et al45</td>
<td>Switzerland</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Guttinger et al46</td>
<td>Switzerland</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Rehm et al47</td>
<td>Switzerland</td>
<td>Study not RCT (longer-term outcomes)</td>
</tr>
<tr>
<td>Hartnoll et al48</td>
<td>England</td>
<td>Unsupervised heroin treatment provision</td>
</tr>
</tbody>
</table>

**Fig. 3** Supervised injectable heroin (SIH) = flexible doses of oral methadone v. oral methadone: mortality.
over oral MMT, but crossing the mid-line: RR = 0.65 (95% CI 0.25–1.69), heterogeneity ($P = 0.89$), $I^2$ = 0% (Fig. 3).

**Side-effects data**

Taking all side-effects together (serious adverse events probably or definitely related to study medication), the five trials (the Swiss study did not report side-effects data) showed a significant higher risk of side-effects in the SIH compared with the oral MMT treatment groups: RR = 4.99 (95% CI 1.66–14.99), heterogeneity ($P = 0.25$), $I^2$ = 26% (Fig. 4).

**Publication bias**

Figure 5 presents the funnel plots to assess potential publication bias for the meta-analyses. We have restricted this to a visual inspection of the plots in line with recommendations not to perform statistical tests of asymmetry where there are a small number of trials.49 The first two funnel plots (Fig. 5a and 5b) relate to the outcomes of retention (as reported earlier and in Fig. 2) and of mortality (as reported earlier and in Fig. 3), and they indicate that the studies had, respectively, very small and small standard errors and RR estimates spanning from below 1 to approximately 2. However, with the outcome of side-effects, the funnel plot in Fig. 5c indicates that the studies included much more variable standard error estimates, with RR above 10, which may reflect small sample size or other limitations.

**National and international impact on clinical practice and policy**

At the international level, the 1961 and 1971 UN conventions50,51 contain no explicit regulations concerning the prescribing of diamorphine (heroin) in the context of substitution treatment provision, leaving it to the competence of national governments to regulate in this area. National legislation differs greatly between countries. With the exception of the UK, the development of regulation by means of law and guidelines around heroin prescribing for opioid treatment is a very recent matter.

(a) Countries in which diamorphine exists as a medicinal product

(i) Full approval of diamorphine as a medicinal product (UK). The medical use of heroin is, and always has been, recognised in the UK as a legitimate medicine which a doctor may prescribe for the relief of pain and suffering, as well as for the treatment of opioid dependence.52,53 However, since the late 1960s, the authority to prescribe diamorphine for addiction treatment has been restricted to doctors with a special licence

---

**Table:**

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>SH (+OM) Events</th>
<th>Oral MMT Events</th>
<th>Weight (%)</th>
<th>Risk ratio M-H, Random, 95% CI</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>van den Brink et al13</td>
<td>1 76</td>
<td>1 98</td>
<td>13.0</td>
<td>1.29 (0.08 to 20.28)</td>
<td>2003 Aug 9</td>
</tr>
<tr>
<td>Haasen et al15</td>
<td>24 515</td>
<td>7 500</td>
<td>50.7</td>
<td>3.33 (1.45 to 7.66)</td>
<td>2006 Sep</td>
</tr>
<tr>
<td>March et al14</td>
<td>5 31</td>
<td>0 31</td>
<td>12.3</td>
<td>11.00 (0.63 to 190.79)</td>
<td>2007 Jul</td>
</tr>
<tr>
<td>Oviedo-Joekes et al16</td>
<td>24 115</td>
<td>0 111</td>
<td>12.8</td>
<td>47.31 (2.91 to 768.63)</td>
<td>2009 Aug 20</td>
</tr>
<tr>
<td>Strang et al17</td>
<td>2 43</td>
<td>0 42</td>
<td>11.3</td>
<td>4.89 (0.24 to 98.85)</td>
<td>2010 May 29</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>780</td>
<td>782</td>
<td>100.0%</td>
<td>4.99 (1.66 to 14.99)</td>
<td></td>
</tr>
</tbody>
</table>

Total events 56 8

Heterogeneity: $\chi^2 = 0.44$; $\chi^2 = 5.40$, d.f. = 4 ($P = 0.25$); $I^2$ = 26%

Test for overall effect: $Z = 2.87$ ($P = 0.004$)

---

**Fig. 4** Supervised injectable heroin (SIH) + flexible doses of oral methadone v. oral methadone maintenance treatment (MMT): side-effects (serious adverse events probably/definitely related to study medication).

**Fig. 5** Funnel plot of comparison: supervised injectable heroin (SIH) + flexible doses of oral methadone v. oral methadone – outcomes: (a) retention in treatment; (b) mortality; and (c) side-effects.
(essentially being addiction specialists), while all medical practitioners continue to have the authority to prescribe diamorphine for other conditions (e.g. severe pain relief, acute management of coronary infarction).

(ii) Approval of diamorphine as a medicinal product for the specific indication of treatment-refractory heroin dependence (Switzerland, Germany, The Netherlands and Denmark). In Switzerland, Germany and The Netherlands, heroin has been given approved medication status as a legitimate (albeit reserved for severe cases) opioid substitution treatment. In 2001, injectable heroin was registered in Switzerland as a medication for maintenance treatment in opioid dependence, followed by its inclusion on the list of provisions to be fully paid by health insurance in 2002; and, finally, a legal basis was obtained through revision of the narcotic law in 2008. A similar process has been followed and completed over the last decade in The Netherlands (and still is, in most countries). An additional option has been included in this review. Based on the evidence that has been accumulated through these clinical trials, heroin-prescribing, as approved medication status, has been included along the lines of the above analyses, whereas we have regarded the SIH approach as a distinct treatment necessitating its own specific scrutiny and analysis. We consider this distinction important because we wish to avoid any possible contamination of analyses, which could result from inclusion of findings from earlier trials in which supplies of heroin were given to addicts on a take-home basis. We thus consider it more appropriate to analyse solely the trials of the new clinical approach of SIH, and this is the basis of our analyses above. The overall conclusions are similar, but a clearer and stronger signal emerges from the more specific narrower approach we have taken.

Main findings

A total of six randomised trials from six countries have been included in this review. Based on the evidence that has been accumulated through these clinical trials, heroin-prescribing, as a part of highly regulated regimen, is a feasible and effective treatment for a particularly difficult-to-treat group of heroin-dependent patients. Diamorphine hydrochloride (pharmaceutical heroin) is now registered as a medicinal product for this indication in five European countries (Switzerland, The Netherlands, Germany, UK and Denmark). New research is now testing whether further improvements could be achieved with combination of SIH and incentive reinforcement (termed contingency management, CM) or other specific rehabilitation strategies. Following the conduct of this series of rigorous randomised trials, several countries have altered research restrictions and there has also been new regulatory approval and politically supported changes in narcotics laws of these countries, so that this potentially effective treatment is now becoming available for at least some of the patients whose addiction was previously considered untreatable (and still is, in most countries). An additional option has been added to the clinical algorithm, which can improve personalisation of individually relevant treatment provision, to the benefit of individuals as well as society at large.

Comparison with Cochrane

It is appropriate to compare and contrast the conclusions from the above analyses with the conclusions from earlier and more recent Cochrane Reviews. The original 2005 Cochrane Review examined studies published up to 2002 (and with only two of the studies included in our analysis above) and concluded that, even though there were some results in favour of heroin treatment, ‘no definitive conclusions about the overall effectiveness of heroin prescription was possible’. By the time of the later Cochrane Review in 2011, all six of the above-randomised trials were included in the new Cochrane analysis, and the Cochrane group concluded that, on the basis of the expanded current evidence, ‘heroin prescription should be indicated to people who (are) currently or have previously failed maintenance treatment, and it should be provided in clinical settings where proper follow-up is ensured’, while also noting that adverse events were consistently more frequent in the heroin groups.

However, a major difference exists in the approach taken by our analyses versus the main approach taken by the Cochrane Review: the Cochrane group have included all trials of heroin prescribing, regardless of whether the administration was supervised or for take-home administration (although with additional analyses later included along the lines of the above analyses), whereas we have regarded the SIH approach as a distinct treatment necessitating its own specific scrutiny and analysis. We consider this distinction important because we wish to avoid any possible contamination of analyses, which could result from inclusion of findings from earlier trials in which supplies of heroin were given to addicts on a take-home basis. We thus consider it more appropriate to analyse solely the trials of the new clinical approach of SIH, and this is the basis of our analyses above. The overall conclusions are similar, but a clearer and stronger signal emerges from the more specific narrower approach we have taken.

Obstacles to fuller impact

The introduction of effective interventions, even when demonstrably effective, can sometimes, at first, be viewed as controversial. SIH treatment is often viewed thus. A number of concerns have been raised and we address these in turn.

(a) Concerns about the adequacy of the scientific evidence

This was previously a major obstacle, but has now largely been addressed by the series of trials described above. All of the trials have broadly shown similar benefits and in the same direction – with regard to ‘street’ heroin and other drug use as well as in secondary outcome domains such as physical, mental health and social functioning where these have been studied (Spain, Germany, Spain and Canada). Also, the latest 2011 Cochrane review reaches a more positive conclusion on SIH than the original 2005 Cochrane review. However, scientific questions still remain. The new empirical evidence from randomised trials on heroin treatment has mostly focused on short-term outcome, with the randomisation phase of treatment being a maximum of 12 months. Nevertheless, longer-term data are also available from eight extended follow-up studies in four countries (Switzerland, Spain and Germany) with a consistent finding of additional sustained benefit across a range of different outcome categories. We also need to learn more about the process and influences on remission
of illicit drug use and elimination of related problems, and, more importantly, enhanced quality of life and social functioning of these patients.

(b) Concerns about security, public safety, and potential for diversion and abuse

Much concern has been expressed over security, public safety and potential for diversion of prescribed heroin. Three of the randomised trials have evaluated the impact of newly established injectable clinics on crime in trial localities: The Netherlands,27 Canada31 and the UK.32 Findings to date suggest no negative effects of the new supervised injecting clinics on public safety, and actual reports of growing local public support.

(c) Concern about rebound damage to other treatments such as oral MMT and rehabilitation

Concern that prescribed diamorphine would preferentially attract heroin users and would undermine other treatments has not been borne out. Most of the six trials actually experienced difficulty in recruiting participants, either failing to reach target recruitment44,16,17 or needing to extend the planned recruitment time15.17 It appears that for many marginalised heroin users, the attraction of prescribed diamorphine is rarely sufficient to promote engagement in highly structured treatment. Recent documented experience20,24,27,40,41,61,62 suggests that many patients attending the new injecting clinics aim at sobriety in the longer term or return to healthier stability in existing MMT programmes. However, this still needs to be studied further. A suitable response to the needs and aspirations of this patient group will involve investment of collective effort to developing recovery-oriented heroin maintenance – an approach that will combine heroin pharmacotherapy and a sustained menu of recovery support services to assist patients and families in achieving long-term addiction recovery.

(d) Financial costs

In a context of ever-increasing health costs and competing health priorities, heroin prescribing might be difficult for governments to embrace. Findings of international research14,23,37,44 have consistently demonstrated a considerable economic benefit of SIH because of the reduction in the costs of criminal procedures, imprisonment and healthcare. Different models of possible service provision of heroin treatment may identify variants of SIH treatment which are more affordable, and this was being explored in England63,64 up until 2015 when the central funding for this new treatment was not renewed

(e) Hijack by campaigning groups

The encouraging findings from the randomised trials has been picked up by groups campaigning for major changes in the law and the trials have been described as if they were trials of legalisation (which they were not). These misrepresentations are not only misleading but also risk damaging the robustness of the conclusions and the integrity of the clinical procedures. This difficulty is not unique to the heroin trials, and it similarly interferes with objective discussion of harm reduction policies and practices65–67 however, careful attention to accurate secondary reporting of the findings of the heroin trials is important so that they are properly understood and the potential for advancement properly identified.

(f) Diamorphophobia

A critical concern relates to public and political anxiety about the acceptability of the idea of heroin being a medicinal product. While diamorphine has existed as a pharmaceutically manufactured medicinal product in the UK for more than a century, the situation is very different in most other countries where heroin is usually regarded as always an illicitly manufactured drug of abuse and addiction. This has contributed to an inability to establish clinical research trials (e.g. Australia68) and to the refusal to provide continuity of diamorphine treatment for individuals beyond the end of trial treatment (e.g. Spain). It is possible that the Canadian identification of similar benefits with injectable hydromorphone19 may point to an avenue which might circumvent more severe expressions of such diamorphophobia.

(g) Safety

Several of the trials have reported instances of sudden-onset respiratory depression in people receiving injectable diamorphine, at a rate of about 1 in every 6000 injections,16,17 hence well below the hazard from injecting street heroin but nevertheless producing clinically critical events. These have all been safely managed with resuscitation measures, but, as noted in the 2011 Cochrane review, this necessitates specific attention and emphasises the importance of supervision of injection by appropriately trained staff.63 This repeated finding warrants fuller study, and future research will clarify whether it relates to the medicinal product (diamorphine/heroin) itself or to some other aspect of drug-taking behaviour or drug treatment provision. Some such work is ongoing.

Next steps

A trial of SIH treatment has been conducted (2011–2013) in Belgium and future versions of the analysis will be likely to include data from this trial also, once the findings from this further trial have been peer-reviewed and published.

Limitations

The key limitation of this review is that the analysis synthesised the interpretation of the primary data in each paper rather than considering the primary data directly. Future research could compare SIH treatment outcomes across these trials for a number of outcomes by analysing individual patient data generated by the different research groups.

John Strang, MD, MBBS, FRCPsych, FRCP, Professor of the Addictions, National Addictions Centre, King’s College London, Institute of Psychiatry, London, UK, and South London and Maudsley NHS Foundation Trust, London, UK; Teodora Groshkova, PhD, Researcher, National Addictions Centre, King’s College London, Institute of Psychiatry, London, UK, and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal; Ambros Iechtshenagen, MD, PhD, Emeritus Professor of Social Psychiatry, The University of Zürich, Switzerland; Wim van den Brink, MD, PhD, Professor of Psychiatry and Addiction, Amsterdam Institute for Addiction Research, The Netherlands; Christian Haasen, MD, PhD, Director, Centre for Interdisciplinary Addiction Research, Department of Psychiatry, Hamburg, Germany; Martin T. Schechter, OBE, MD, PhD, FRCs, FCAHS, Professor and Director, School of Population and Public Health, The University of British Columbia, Canada; Nick Lintzeris, MBBS, PhD, FACHM, Associate Professor, Faculty of Medicine, The University of Sydney, and Director, Drug and Alcohol Services, SESLHD, New South Wales, Australia; James Bell, MD, FRACP, FCHM, South London and Maudsley NHS Foundation Trust, London, UK; Alessandro Pirona, MSc, PhD, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal; Eugenia Oviedo-Joekes, PhD, Associate Professor, School of Population and Public Health, University of British Columbia, Canada; Roland Simon, Head of UNO, Interventions, Best Practice and Scientific Partners, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal; Nicola Metrebian, PhD, Senior Research Fellow, National Addictions Centre, King’s College London, Institute of Psychiatry, London, UK.

Correspondence: John Strang, Director, National Addictions Centre, King’s College London, London SE5 8BB, UK; Email: john.strang@kcl.ac.uk

First received 31 Mar 2014, final revision 8 Sep 2014, accepted 12 Nov 2014
Acknowledgements

We thank Marina Davoli, Marica Ferri and the Cochrane Drugs and Alcohol Group for their contribution. I.S. is supported by the National Institute for Health Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King’s College London.

Funding

Funding was received from the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) to support review of the international randomised trials of supervised injectable diamorphine (heroin) prescribing and the preparation of a 2012 European report on the evidence-base for this approach for the treatment of entrenched heroin addiction and associated evolving practice.

References

Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction

John Strang, Teodora Groshkova, Ambros Uchtenhagen, Wim van den Brink, Christian Haasen, Martin T. Schechter, Nick Lintzeris, James Bell, Alessandro Pirona, Eugenia Oviedo-Joekes, Roland Simon and Nicola Metrebian

BJP 2015, 207:5-14.

Access the most recent version at DOI: 10.1192/bjp.bp.114.149195

References

This article cites 48 articles, 9 of which you can access for free at:
http://bjp.rcpsych.org/content/207/1/5#BIBL

Reprints/permissions

To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at

/letters/submit/bjprcpsych;207/1/5

Downloaded from

http://bjp.rcpsych.org/ on November 9, 2015
Published by The Royal College of Psychiatrists