the columns

correspondence

Difficulties with buprenorphine

Taikato *et al* (*Psychiatric Bulletin*, June 2005, **29**, 225–227) provide a useful summary of the benefits of buprenorphine as a treatment for heroin misuse. However, the optimism with which it is described may have misled readers. Most importantly, they claim superior efficacy compared with methadone without citing supporting evidence. In terms of the most important outcome measures (retaining individuals in treatment and reducing heroin use) a recent Cochrane review clearly came down on the side of methadone (Mattick *et al*, 2004).

Buprenorphine undoubtedly remains an important treatment option because of its safety profile. However, in Cornwall, where we have more than 200 people receiving it and where supervised consumption at the local chemist has become the norm, this apparent advantage may not justify the extra cost and may be negated by problems with administration. Our experience has been that community pharmacists are unable to properly supervise consumption of the drug because administration under the tongue takes so long (sometimes up to 5 min). This difficulty, which is in contrast to methadone, has led to diversion of buprenorphine onto the black market, and subsequent intravenous use. Unfortunately, in France intravenous use has been linked with a large number of deaths (Kintz, 2001).

KINTZ, P. (2001) Deaths involving buprenorphine: a compendium of French cases. *Forensic Science International*, **121**, 65–69.

MATTICK, R. P., KIMBER, J., BREEN, C., *et al* (2004) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *The Cochrane Database of Systematic Reviews*, issue 2. Oxford: Update Software.

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Authors' reply: Drs White and Adams raise several points which we wish to address. First, in any discussion of the comparison of the clinical efficacy of buprenorphine and methadone it is important to delineate treatment for opioid detoxification withdrawal and substitution/maintenance. The Cochrane review (Mattick *et al*, 2004) referred to by White and Adams compares these two drugs for opioid maintenance/substitution. The conclusion reached is that buprenorphine is an effective intervention for use in the maintenance treatment of heroin dependence but that it is no more effective than methadone at adequate doses. This result hardly 'clearly came down on the side of methadone' as declared by White and Adams.

The significance of the methadone dose in relation to efficacy was emphasised in our paper. There is evidence (Ward *et al*, 1999) to demonstrate that methadone stabilising doses of less than 50 mg are associated with higher patient drop-outs and doses greater than 60 mg are associated with longer stays in treatment and greater reductions in heroin use.

An updated Cochrane review (Gowling *et al*, 2005) investigated the effectiveness of buprenorphine in managing opioid withdrawal/detoxification and concluded that buprenorphine was more effective than clonidine but that there was no significant difference compared with methadone in terms of completion of treatment. However, it was suggested that the withdrawal symptoms might resolve more quickly with buprenorphine.

Second, our intention was to inform clinicians of the viability of buprenorphine as a treatment option for opioid dependence. The import of procedures and protocols for prescribing was emphasised. In this regard, we were interested in the Cornwall experience and particularly the difficulties encountered by community pharmacists with supervising buprenorphine administration. White and Adams poignantly bring to light the risks of diversion into the community when drug administration is not carefully monitored. Surely this highlights the need for local protocols and as such is in keeping with clinical governance principles. This approach should address the roles of pharmacies, diversion into the community, supervision, care plans and prescribing because it may be the best choice for the patient.

Finally, White and Adams comment on the 'optimism' which 'may have misled readers'. At no stage did we state that buprenorphine was superior in its efficacy to methadone, neither did we state that buprenorphine should be the mainstay treatment for opioid dependence. Furthermore, reference to the French situation is of limited relevance to the UK. In France, methadone is not as readily available as a treatment option and buprenorphine is the mainstay treatment. It is also wise to remember that although systematic reviews underscore good clinical practice, they do not always translate accurately into clinical practice and the context within which one prescribes is an important factor.

If any element of optimism was present, it most likely reflected the authors' enthusiasm about the potential for extending the treatment options for those who struggle with opioid dependence.

GOWLING, L., ALI, R. & WHITE, J. (2005) Buprenorphine for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, issue 2. Chichester: Wiley InterScience.

MATTICK, R. P., KIMBER, J., BREEN, C., *et al* (2004) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews*, issue 2. Oxford: Update Software.

WARD, J., HALL, W. & MATTICK, R. (1999) Role of maintenance treatment in opioid dependence. *Lancet*, **353**, 221–226.

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Specialist perinatal mental health services

We read with interest the paper by Drs Oluwatayo & Friedman on the provision of specialist perinatal mental health services in England (*Psychiatric Bulletin*, May 2005, **29**, 177–179). It is particularly worrying that, despite two confidential enquiry reports into maternal deaths identifying psychiatric disorder as the most common cause of death during pregnancy or within the first postnatal year (Confidential Enquiry into Maternal and Child Health, 2004), the number of specialist facilities has actually declined, and trusts in England do not regard such provision as a priority. We agree wholeheartedly with

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