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▶ Can heroin maintenance help Baltimore? What Baltimore can learn from the experience of other countries.

Reuter P.

Baltimore: The Abell Foundation, 2009.

Though intended for Baltimore this review will be of great value for administrations everywhere considering heroin prescribing programmes. It is particularly useful for its accessible style and hands-on portrayal of existing programmes.

Abstract The review analysed heroin maintenance programs in Switzerland, the Netherlands, Germany and Vancouver, describing in detail how they operate in practice and the clinics' ambience as well as evaluation results. The latter have, the review found, all been positive. Retention in treatment has been high and drop-out has often been into other treatment modalities. Reductions in crime and improvements in health and social functioning are somewhat, but not greatly, better would be expected of a good methadone programme. However, patients in heroin assisted treatment have a record of repeated failure on methadone, so crude comparison may be misleading. It is difficult to find any evidence that heroin prescribing has caused additional harms either to users or to the broader population. There is no indication that heroin has leaked from the facilities on to the black market. Though it is difficult to develop a research design that would assess this, no one has claimed that the availability of heroin programmes has led to an increase in the number of people experimenting with heroin.

The operation of such programmes has not led to a loss of public support at any site where they have been tried. In November 2008 a referendum on continuing heroin maintenance in Switzerland resulted in a favourable vote of more than two-thirds. While there are initial local complaints about the client population, these seem to fade fairly rapidly. These complaints also do not appear to be any more serious than those surrounding a methadone clinic.

One concern is that heroin assisted treatment is substantially more expensive than methadone maintenance. That has been the experience in both Switzerland and the Netherlands. Costs were much higher not because of the cost of heroin itself, but primarily because of associated programme costs. However, studies in both countries found that the additional benefits outweighed the additional costs. For example, adding

the social costs to the costs of provision of services, a patient in treatment for a given period of time in the heroin arm of the Dutch trials cost 37,000 Euros compared to 50,000 Euros for the methadone arm of the trial. Reductions in crime were a large part of the gains, as was true in the Swiss studies. This comparison points to a chronic problem of substance abuse treatment funding; expenditures are borne by the health care sector, while benefits are primarily reaped by the criminal justice sector and the community.

Heroin assisted therapy is clearly a supplement to methadone maintenance rather than a substitute for it. Nowhere where it has been available has it attracted a substantial share of heroin users who seek treatment; 10% is a high estimate of the potential share of treatment slots that might be occupied by heroin assisted treatment patients.

In respect of Baltimore, the question for the community is: Is the undertaking worth the effort for such a small share of clients? At best there is a case only for an experiment. Population differences require caution. The potential for gain, however, is substantial. Even in the aging heroin addict population, there are many who are heavily involved in crime and return frequently to the criminal justice system. Their continued involvement in street markets imposes a large burden on the community in the form of civil disorder that helps keep investment and jobs out. If heroin maintenance could remove 10% of Baltimore's most troubled heroin addicts from the streets, the result could be substantial reductions in crime and various other problems that greatly trouble the city. That is enough to make a debate on the matter worthwhile.

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