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Swiss Heroin Clinics – Costs & Benefits of Heroin-Assisted Treatment in Switzerland

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Dr. Barbara Gugger discussed the details of the heroin-assisted treatment chain that exists in Berne, and described the daily work of her team.

THE BERNE TREATMENT CHAIN

The canton of Berne, located in the centre of Switzerland with one million inhabitants, has about 3,000 opiate substitution treatments in 4 specialised outpatient clinics, offering heroin, methadone, and buprenorphine. About 700 of the patients are treated in these specialised clinics, with the rest treated by general practitioners (any general practitioner in Switzerland can offer substitution treatment). Needle exchange facilities are also available at 4 sites in the canton and also in the prisons, and there are 2 safe injection sites, where about 1,000 people per year get their needs covered. The recycling rate of injection equipment is 77%; Swiss people are good at recycling, and those with addictions are no different.

The treatment chain starts with street work, although this is not offered by the described Unit. The described Unit does have safe injection facilities, serving about 700 people per year – about ¾ male and ¼ female. Most patients are over 25 years old, but about 7% are younger. Minors are not accepted in the facilities. The Unit also offers a needle exchange programme, and a safe injecting and smoking room, since the younger patients no longer inject – it is now out of fashion. Most patients smoke, and it is either heroin or mostly cocaine. The Unit further offers low-threshold medical counselling, i.e.,

a treatment option every week where a doctor from the team attends to medical needs and refers patients to clinics or social support if needed.

The outpatient opiate substitution programme, where maintenance treatment takes place, has no patient limit, so the numbers fluctuate between 250 and 300 patients per year; at the moment, there are 279. Of these, about 90% are on methadone, the rest get buprenorphine or oral morphine. They are currently participating in an international clinical trial for oral morphine, which is not yet available for substitution treatment in Switzerland, although it is very common in Austria. Here, too, ¾ of the patients are male and ¼ female. 78% are Swiss, while the rest come from neighbouring countries such as Italy and the former Yugoslavia.

The Unit offers both medical and social counselling. Each patient gets a 'responsible person' or case manager, chosen to match the patient. If a patient's needs involve more social work, it is a social worker; if their needs are more medical, it is a psychiatrist or a nurse. They also network with other offices, such as social welfare, low threshold work, or housing, since networking lowers the cost for each patient. Their costs in methadone maintenance treatment, for instance, are 20 Swiss Francs per day (about £14), all of which is covered by health insurance, so neither the patient nor the government has to pay in addition.

Regarding employment, about 50% of patients are in a work situation and 30% are working in the free market, which is a quite high number. 20% work in a protected branch, mostly office work, recycling, or a woodcraft. About 17% have a disability pension, mostly because of a psychiatric disease. The rest of the patients are unemployed. In terms of legal status of the patients, about 13% are in prison, although most only a few days or weeks. The reason for imprisonment is that people do not or cannot pay their fine for consumption or possession, which after a while results in a prison sentence. About 3% are on a suspended sentence, which means they must be treated in the Unit as part of their sentence, but they do not go to prison. The rest of the patients have no convictions, which, compared to untreated persons, is an increase.

It is important to stress here that heroin-assisted treatment is a second-line treatment. Patients must have failed other treatment twice (either methadone maintenance or abstinence), and they must have clear, severe social and/or medical harm. Most patients show these problems – those who do not tend not to be interested in heroin-assisted treatment.

In Berne, there are 31.3 kilograms of Diaphin (the brand name of medical heroin), at a cost of about 531,000 Swiss Francs (£367,000). Assuming that illegal heroin is about 15% pure (a high estimate) and costs 60 Swiss Francs (about £40) per gram, totalling about 208 kg of illegal heroin, we have a black market price of about 12.5 million Swiss Francs (£8.6 million). This makes 170 Swiss Francs (£117) per patient per day that he or she would need to earn to obtain the illegal heroin. So for the patient there is clearly a benefit. Indeed, one patient who was on heroin-assisted treatment and is now abstinent and back to work stated that it was "just like being free after being on a treadmill of earning money to supply drugs."

Of course there are nevertheless a few patients that cannot be reached, e.g., because of severe psychiatric comorbidities. In response, a trial was recently started in April 2011 that involved approaching individuals at needle exchange facilities and on the street to

try to get them into methadone maintenance treatment. They already have 15 patients who are now being treated. However, inpatient treatment is limited for political reasons, i.e., in order not to nurture the impression of treatment as a trap. Therefore, there is a three month limit on inpatient treatment before being triaged to specialised clinics or general practitioners. Of the 15 patients, 13 have succeeded in moving on to a normal treatment programme with social, medical, and networking components.

Another very new trial of case management has recently started in November 2011, which includes all members invested in the addiction field in the city of Berne. It starts with the street-level work and goes up to the long-term abstinence treatment, and all parties participate in case management. They are trying to reach patients with a high treatment need (either social or medical), and they are also trying to find out whether they can reduce costs. Overall, the goal is to make a patient-treatment match. The patient is a client like in any other medical treatment; the experience of the patient and their treatment history are respected, and they participate in their choice of treatment with informed consent.

There are quite a few patients who will never achieve abstinence. But in any other medical treatment, one wouldn't stop a treatment if it reduced harm, and if one could live a stable life with the treatment. For that reason, we do not take abstinence as the one and only goal. Forced abstinence is a risk; harm reduction can be the only treatment goal for some.