Harm Reduction in Bern: From Outreach to Heroin Maintenance

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Abstract. *In Switzerland, harm-reduction programs have the support of the national government and many localities, in congruence with much of the rest of Europe and in contrast with the United States, and take place in public settings. The threat of AIDS is recognized as the greater harm. This paper describes the overall national program and highlights the experience from one city; the program is noteworthy because it is aimed at gathering comparative data from controlled trials.*

The prescription of heroin to addicts in Switzerland attracted wide international attention. To observers not acquainted with the circumstances in Switzerland, it must have seemed revolutionary. But this heroin prescription embedded into a scientific research program was only a logical next step in the development of drug policy in Switzerland. To understand this step it is instructive to review the last 10 years of Swiss drug policy.

The Situation in Switzerland

Switzerland is a small country in the heart of Europe. It has a population of 7 million. About 30,000 people are addicted to opioids and cocaine. Heroin is mainly injected, but youngsters have been using it lately also by inhaling the vaporized powder (a procedure called "chasing the dragon"). Cocaine is mostly injected, too, often together with heroin; the combination is then called a "cocktail." There is no crack in Europe. A few of the addicts inhale cocaine as free base. The number of addicts stabilized after rising for several years, and the price for hard drugs has fallen substantially in the same period.[1]

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The first AIDS cases among intravenous drug users (IVDUs) appeared in 1985. In 1994, 298 new cases among IVDUs were registered; that is, 41% of all new cases.[2] In 1994 there were 131 therapeutic facilities, with 1,532 beds, for drug users working in the abstinence model. The average occupancy rate was 78%. Also in 1994, about 10,000 persons were taking methadone at specialized clinics or at pharmacies by prescription from the family doctor.

The Law

The Swiss narcotics law last was revised in 1975. According to this law, the nonmedical use of any drug is prohibited. This is the case for cannabis, opium, cocoa leaf, and all hallucinogenics. There is a special clause for heroin: it is allowed, but only for limited medical research.

Drug Policy in the Eighties

In the first half of the 1980s abstinence was the only goal of all drug help. There was a network of counseling agencies and inpatient treatment. In every major city there were some outreach workers whose task was to stay in close contact with IVDUs.

Then, in the midst of the 1980s, AIDS burst out with unexpected vehemence. Suddenly it was realized that recovery from drugs was possible even after a long history of use, but there was no recovering from AIDS. Rapidly, the specialists for AIDS and drugs adopted the view that IVDUs should be primarily prevented from acquiring a lethal disease such as AIDS. Abstinence became a secondary goal.

At the same time addicts were encouraged to leave the toilets, the traditional place of drug use at that time in Switzerland, and to go into the parks, where help was made available. In Switzerland there is no paraphernalia law, so giving out needles and syringes to addicts is not prohibited, but the cantons (equivalent to states in the United States) are allowed to take measures themselves. This resulted in different policies in different cantons. Slowly, however,

all health authorities recognized that clean needles and syringes are the primary tools of AIDS prevention among IVDUs.

Harm Reduction and Contact Points with Injecting Room ("Fixerstuebli")

In addition to the existing help system, a substantial number of private and public initiatives evolved to improve contact with the drug users, to facilitate access to treatment and to reduce the risks of drug use in general and especially to reduce the risks for acquiring or transmitting HIV. The idea was to lower the threshold of the institutions and to attract the addicts with a suitable offer. By these means it was possible to contact a maximum number of addicts and simultaneously it was possible to spread the AIDS-prevention message in the drug scene. The first aim was to ensure the survival of the addicts to keep open a second possibility: to get them out of drugs. Many of the new projects were situated directly in the setting of the drug scene: in the parks, which became known as "an open drug scene" because it was no longer a hidden phenomenon.

The most revolutionary endeavor was the "Fixerstuebli" project, a low-threshold contact point with a room where drug injection is tolerated. It was first introduced in Bern in 1986. After some negotiations, agreements with the police and the justice administration could be reached. Police do not intervene, so long as the social workers on the premises keep out drug dealing and minors, and as long as the counseling is under medical supervision. The general idea of these places is to stimulate drug users to take better care of themselves. Hygienic conditions for injecting are better than in a public toilet, the traditional place of injecting drugs. Counseling can be obtained. Warm meals and showers are available. Risky injecting techniques can be influenced, because injecting happens under the supervision of professionals.[3,4] These shelters still seem to be attractive for drug users and are well frequented; thus, contact with a maximum number of problematic addicts is guaranteed.

Initially there was the fear that these places would attract beginners. Several surveys have shown, however, that they have attracted mainly the heavy IVDUs with a long history of drug use and clear signs of dissocialization.

The places caused some political controversy in Switzerland. Some had to be closed, some could not open, and some are still working, with governmental grants.

Drug Policy in the Nineties: the Trials

The main problem with a "Fixerstuebli" is that people inject dirty drugs. The logical next step in the further development of these contact points would, therefore, be dispensing of clean drugs. In Switzerland, the Mersey Harm Reduction and the work of John Marks served as a model for new ideas in this direction.

The major cities of the German-speaking part of Switzerland asked the federal government to introduce prescription of heroin. They hoped to alleviate their problems with the open drug scenes in the cities. After long hesitation, the federal government agreed to take the leadership in drug policy. It presented a program based on four elements: (1) repression/prosecution, (2) prevention, (3) therapy, and (4) help for survival. Officially, it spoke out in favor of survival strategies, i.e., to help the people to live through their phase of addiction, and expressed the will to try out and evaluate various innovative actions. One of them is the controlled and scientifically evaluated prescription of heroin, morphine, and injectable methadone to addicts.

A search of the literature on maintenance prescription of heroin and morphine has shown that little is known.[5] It was not possible, therefore, to rely on a scientifically ensured base. According to the literature, addicts should not be able to discern blindly if they are getting heroin or morphine.[6] If morphine had effects equal to heroin, it would have been easy to run a large-scale program of morphine prescription without any special problems with international treaties and national narcotics laws. The pharmacokinetics of heroin and morphine dictate that these drugs must be applied

TABLE I
SWISS HARM-REDUCTION PROJECTS

Group	Research	Substances (IV)	Design	Control
1.	Specific effects of heroin vs. morphine	Heroin Morphine	Double blind; Random assignment	Oral methadone
2.	Specific effects of the substances without individual factors	Heroin Morphine Methadone	Random assignment	Groups 3 and 4 oral methadone
3.	Contextual factors	Heroin Morphine Methadone	Regional distribution; Individual indications	Group 2 oral methadone
4.	Specific effects of the substances including individual factors	Heroin Morphine Methadone	Individual indications	Group 2 oral methadone
5.	Effects of the special program for women	Heroin Morphine Methadone	Individual indications	Women from other projects; oral methadone

several times a day. Because addicts in Merseyside reported pleasing effects of injected methadone and using it once a day seemed enough, it was introduced as a third substance in the trials.

A multicenter study was designed, involving 700 addicts. Several different research questions must be answered. One centers on how individual patients do in the program in terms of health and social situation. The aims are to improve physical and psychological health and social integration; to promote detachment from the drug scene; and to reduce illegal activities and the use of illegal and legal drugs. Another research question concerns the project structure: there are questions of feasibility, efficiency and effectiveness. On the level of the substances prescribed there are questions of pharmacological effects and therapeutic utility.

Originally, 250 patients were to receive heroin; another 250, morphine; and the last 200, injectable methadone. Each project was supposed to have 50 patients—there were five heroin projects, five that used morphine, and four with injectable methadone. The projects were assigned to five groups and each group of projects had a specific research question to answer (Table I).

It was decided that three groups of patients could enter into the research programs. The first group consists of marginalized people with severe health and social problems, who could not be reached by the existing offers for help because of their living conditions (homelessness, prostitution, unemployment, etc.). The second group consists of people who could not be stabilized by participating in one of the existing methadone programs and who continued to use illegal drugs. The last target group consists of people who are partly socially integrated, live in a more or less steady home and working situation, and are in acute danger of losing these social contacts. The general criteria for admission are long-term addiction (at least 2 years of daily use of opiates) and at least two failed attempts of therapy (rehabilitation, methadone, etc.) as well as a minimum age of 20. The endpoint of the study is December 31, 1996. Participation is voluntary and written informed consent is required.[7]

For the scientific evaluation, a group of experts was appointed, which included some of the most renowned scientists in Switzerland. The research is funded by the Swiss government. The plan then was presented to an ethical committee for approval and to the international narcotic control board (INCB) in Vienna to secure a license to import the needed drugs. Drugs in the program are not free. The daily fee is 15 Swiss francs, equivalent to about 13 US dollars, regardless of the amount and kind of drug the patient receives.

Heroin is available in injectable form or as a smokable woodruff cigarette; morphine is available only in injectable form. Both may be combined with oral methadone. Injectable drugs can only be used on clinic premises; other forms of drugs can also be taken home if the patient has proven to be trustworthy. The medical doctors of the projects are responsible for the doses and the form of administration, but both items are negotiable. Psychosocial assistance is offered by the projects, but integration of the patients into the existing help system is one of the goals of all projects.

Preliminary Results

Seven of the original nine projects started in 1994. It was possible to find localities and staff to run the projects and it was possible to finance them. One locality submitted a project to a vote for financing: an overwhelming percentage voted for it. The projects are well accepted; there are no neighboring problems. It has been shown that heroin is the most unproblematic substance of the three. Unpleasant side effects, such as itching, flushing, and swelling, occurred in some morphine-based projects; these reactions seemed to be related to the release of histamine or a similar reaction and prompted an additional study of morphine. It could be shown that the acceptance of morphine was too low for a large-scale prescription. On the other hand, the acceptance of morphine is higher than the acceptance of injectable methadone.

The average age of the participants in the trials is higher than the people in methadone maintenance or in abstinence-oriented therapy. The average time of their addiction tends to be 10 years. More than 80% are without work and show previous criminal detention. Most of the patients have experience in other treatment modalities. First data indicate that the participants in the Swiss opiate trials are poorly integrated, heavily addicted drug users, for whom other treatment efforts have failed. It can be concluded that the target population has been reached.[8]

In our Bernese project 50 persons use heroin, 14 use morphine, and one is injecting methadone. From a clinical point of view it is astonishing how fast most of the patients improve physically soon after entering the project. Because the patients come to our clinic every day, it is possible to have good compliance with any somatic or psychiatric treatment.

People in the projects generally tend to take too much of the drug. Many seem to have a concept that their only real problem in life is to get enough drugs. In the projects, for the first time in their lives, they can have as much they need. In the course of time it gets depressing for them to realize that they have problems other than just getting enough drugs.

If people take too much heroin, they no longer feel the "rush" associated with the drug. To feel a rush they actually have to take less heroin. It is hard for them to accept that less heroin is better than more of it.

Patients who are taking benzodiazepines in large quantities tend to overdose on even small amounts of heroin. This cumulative effect can be dramatic. It seems that there are regional differences in patients' characteristics because the Bernese project is the only one with a problem of overdosing, although our average doses are not higher. These differences remain to be evaluated. HIV prevalence in the projects ranges from 7% to 41%. In the Bern project, the prevalence is 17% at the moment.

The projects are open 7 days a week, 365 days a year. Hours are long and controls are strong. As a result, the projects are very costly.

Because of the good acceptance and the low level of problems with heroin as compared to the other two drugs in the trials, the initial plan has been reconsidered. Morphine-dispensing sites are to be changed to heroin projects, thus doubling the heroin-dispensing sites to a total of 500. This change has been approved by the Swiss government, the ethical commission, and the INCB.

Conclusion

Prescription of heroin as a further development of a harm-reduction strategy and thus, as an amendment to existing treatment facilities, seems to be less problematic than originally supposed. It has a good acceptance among the addicts and the general public.[9]

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