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Research paper

A high proportion of users of low-threshold facilities with needle exchange programmes in Switzerland are currently on methadone treatment: Implications for new approaches in harm reduction and care

Jean-Pierre Gervasoni*, Hugues Balthasar, Thérèse Huissoud, André Jeannin, Françoise Dubois-Arber

Institute of Social and Preventive Medicine (IUMSP), University Hospital Center and University of Lausanne, Bugnon 17, CH-1005 Lausanne, Switzerland

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ABSTRACT

Background: Increasingly, patients receiving methadone treatment are found in low threshold facilities (LTF), which provide needle exchange programmes in Switzerland. This paper identifies the characteristics of LTF attendees receiving methadone treatment (MT) compared with other LTF attendees (non-MT).
Methods: A national cross-sectional survey was conducted in 2006 over five consecutive days in all LTF ($n = 25$). Attendees were given an anonymous questionnaire, collecting information on socio-demographic indicators, drug consumption, injection, methadone treatment, and self-reported HIV and HCV status. Univariate analysis and logistic regression were performed to compare MT to non-MT. The response rate was 66% ($n = 1128$).
Results: MT comprised 57.6% of the sample. In multivariate analysis, factors associated with being on MT were older age (OR: 1.38), being female (OR: 1.60), having one's own accommodation (OR: 1.56), receiving public assistance (OR: 2.29), lifetime injecting (OR: 2.26), HIV-positive status (OR: 2.00), and having consumed cocaine during the past month (OR: 1.37); MT were less likely to have consumed heroin in the past month (OR: 0.76, not significant) and visited LTF less often on a daily basis (OR: 0.59). The number of injections during the past week was not associated with MT.
Conclusions: More LTF attendees were in the MT group, bringing to light an underappreciated LTF clientele with specific needs. The MT group consumption profile may reflect therapeutic failure or deficits in treatment quality and it is necessary to acknowledge this and to strengthen the awareness of LTF personnel about potential needs of MT attendees to meet their therapeutic goals.

Introduction

In Switzerland, low-threshold facilities (LTF) with needle exchange programmes are at the frontline of harm reduction policy (Kübler & Wälti, 2001; Uchtenhagen, 1995; Zobel et al., 2003). They mostly provide sterile injection/inhalation equipment, basic health care and sometimes counselling but they do not offer substitution treatments (Benninghoff, 1999). About half have a supervised drug consumption room (DCR) for injection or inhalation. LTF operate under the principle of anonymity so do not register clients although they may offer referrals to other services.

Methadone is widely prescribed to heroin users. Most treatments are long-term maintenance, and persistence of some consumption is generally not considered a reason to exclude patients (Swiss Society of Addiction Medicine, 2010). About two-thirds of the 25,000 estimated heroin users are in treatment (Hosek, 2006; Maag, 2003; Schorr & Künzi, 2007).

Previous studies, in Switzerland (Benninghoff, Morency, Geense, Huissoud, & Dubois-Arber, 2006; Dubois-Arber et al., 2008) and elsewhere (Toufik, Cadet-Taïrou, Janssen, & Gandilhon, 2008; Valenciano, Emmanuelli, & Lert, 2001; Wood et al., 2005) have shown that a high proportion of LTF attendees – increasing in Switzerland – are currently receiving methadone treatment. Although this may not be surprising, LTF have no specific policies for providing services to these people and little is known about their characteristics and in particular, their consumption patterns or mode of ingestion.

This paper aimed to analyse the extent to which LTF users on methadone treatment (MT) were different from other LTF users (non-MT) in terms of socio-demographic characteristics, drug use, health status, and social integration; and to discuss the implications of the findings for the management of LTF.

Methods

A national cross-sectional survey amongst attendees of all LTF ($n = 25$) in Switzerland was conducted in 2006 (Balthasar et al., 2007). The survey, which has been part of the national HIV surveil-

* Corresponding author. Tel.: +41 21 314 72 94; fax: +41 21 314 73 73.
E-mail address: Jean-Pierre.Gervasoni@chuv.ch (J.-P. Gervasoni).

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lance system since 1993, monitors consumption patterns and preventive behaviours amongst IDUs (Dubois-Arber et al., 2008; Dubois-Arber, Jeannin, & Meystre-Agustoni, 2006).

During five consecutive days, all LTF attendees were invited to complete an anonymous questionnaire. The first part, related to consumption, was conducted face to face by trained interviewers; the second part, including questions on health, was self-completed. Questions covered socio-demographics, illegal activity, drug use in the past month, number of injections in previous week, perceived health, HIV, HCV testing (ever) and self-reported results, current substitution treatment and frequency of LTF visits (everyday, less often). The number and characteristics of non-participants (sex, estimated age, reason for refusal) were documented.

The participation rate was 66.0% ($n = 1128$). Non-participants did not significantly differ from participants on sex and age. We excluded from the analysis respondents who had never consumed heroin nor cocaine ($n = 53$); who did not answer the question on injection ($n = 5$); and recruits from two LTF ($n = 54$), which provided onsite delivery of methadone treatment by a physician. To control potential bias, we also excluded respondents who had a substitution treatment other than methadone treatment ($n = 95$). The final sample size was 921 respondents.

Univariate analysis and logistic regression were performed to identify characteristics of patients in treatment (MT), versus non-treated (non-MT). Variables included were age in years and age squared, sex, heroin use (past month), cocaine use (past month), injection lifetime, number of injections (previous week), education, sources of income, own accommodation, perceived health status, self-reported HIV and HCV status, LTF attendance, and recruitment in a LTF with an injection room (Table 1).

Missing data (less than 3.0%) were excluded in the univariate analysis. The data were processed using SPSS software (version 15.0) for Windows (SPSS Inc., Chicago, IL 60606).

Results

The average age of LTF attendees was 35.8 years and a quarter were women. Nearly one-third (29.8%) had completed only a mandatory 9 years of schooling. The large majority (85.1%) of participants lived in their own accommodation and 39.4% reported having a job in the past month. Forty-three per cent reported an income from public assistance, one-third (33.1%) from social insurance, and 21.2% from illicit activities.

Drug use in the past month included heroin (71.9%) and cocaine (62.6%) and 94.7% reported ever using heroin. Seventy-eight per cent had ever injected drugs, 47.1% in the past week. HIV and HCV prevalence (amongst tested) were 7.3% and 49.3% respectively. Over half (57.6%) of respondents were receiving methadone treatment. The average dosage was 72 mg/day (median, 60 mg/day; range, 25–275 mg/day). The average treatment duration was 6.2 years (median, 4.2 years; range, 1–288 months).

MT were more likely to be female and supported by social insurance or public assistance, and less likely to have a paid job. They reported living in their own accommodation more often and used LTF less regularly than non-MT.

MT were less likely to report heroin use in the past month (67.2% versus 78.4%, $p < 0.001$), but no significant difference was observed regarding cocaine use. One third of non-MT compared to 14.6% of MT had never injected drugs in their lifetime. Amongst those who had ever injected drugs, 57.0% (non-MT) and 62.4% (MT) had injected in the last 7 days (NS). More MT reported having been tested for HIV and HCV (data not shown) and the reported prevalence of both was significantly higher amongst MT.

In logistic regression analysis (Table 1), the following variables were positively associated with the dependent variable (MT): older age, female sex, own accommodation in the past month, having a public assistance income, being HIV-positive, having ever injected, and having used cocaine during the past month. MT also tended to be less likely to have used heroin (not significant), and were less likely to visit the LTF daily. No association was found with the frequency of injection in the previous week.

Discussion

The profile of MT attendees is that of ageing drug users with a long history of injection. They may be considered persons for whom methadone treatment is not fully effective (doses too low to suppress consumption) and/or inadequate (medical follow-up of insufficient quality to identify the persistence of consumption and injection). Although the average dose of methadone reported by MT is in line with the current Swiss recommendations (60–80 mg) (Swiss Society of Addiction Medicine, 2010), the range is large. Regarding consumption, the profile of MT compared with non-MT is worrying, having a higher proportion of cocaine users (probably replacing heroin in those who still need "shoots"), an absence of significant differences regarding the proportion of current heroine users, and no difference in the number of weekly injections. MT are also more likely to be HIV-positive. The picture emerging for MT in LTF is of a high risk population who would benefit from being identified as such and offered special attention in order to improve their treatment situation, including being offered supervised heroin treatment. Currently, this special attention is not offered in Switzerland and in some countries in Western Europe, who share the same LTF development (Hedrich, 2004).

Switzerland was one of the first countries to develop LTF in the 1990s in the context of an HIV/AIDS epidemic and an open drug scenes. The role of LTF, when methadone treatment was not well developed, was to attract marginalised drug users and to be the first contact they had with health services. This required low threshold access, strong harm reduction orientation, anonymity (no registration, no history taking), no treatment requirement and no follow-up. This harm reduction orientation has been successful (Benninghoff et al., 2006). Over the same period, methadone treatment was developed in parallel. However, harm reduction and treatment domains remained somewhat separated conceptually, with different professional identifications and tracks (mostly medical in treatment centres, predominantly socio-educational in LTF). The situation has evolved, since, and the overlap between these two "worlds" is significant, although insufficiently acknowledged in Switzerland. Generally, in the articles cited above describing LTF clients (Toufik et al., 2008; Valenciano et al., 2001; Wood et al., 2005), the high proportion of LTF users receiving methadone treatment is often mentioned, without further comment.

Various studies have shown that participation in a needle exchange programme may have a positive impact on the identification of health and social problems and referral to treatment programmes (Committee on the Prevention of HIV Infection among Injecting Drug Users in High-risk Countries, 2006; Hagan et al., 2000; Henderson, Vlahov, Celentano, & Strahtdee, 2003; Mac Master & Vail, 2002; Riley, Safaeian, Strathdee, Beilenson, & Vlahov, 2002). At population level, combination of LTF and adequate methadone treatment has been shown to contribute to decreasing HIV and HCV transmission risk (van den Berg, Smit, van Brussel, Coutinho, & Prins, 2007). In countries where development of LTF is more recent, the objective of referring drug users to treatment is more prominent (Wood, Tyndall, Montaner, & Kerr, 2006). For example, in the context of the Vancouver DCR (Wood et al., 2006), increased referral was noted when a social worker was actively working on LTF. In Switzerland, however, LTF staff report having