LESSONS FOR DRUG POLICY SERIES

From the Mountaintops

What the World Can Learn from Drug Policy Change in Switzerland

OPEN SOCIETY FOUNDATIONS

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Joanne Csete, Columbia University

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For more information contact:
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Open Society Foundations
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Executive Summary

Switzerland, a country renowned for its solid conservatism, was shaken by seeing its cities become the point of convergence of thousands of drug users and counterculture activists, culminating in large open drug scenes in the late 1980s. The country was hit hard by HIV, which was strongly linked—both in the public mind and in reality—to growing drug injection. A confluence of events and people led Switzerland to reject digging its heels in deeper with more repressive policing and instead to rethink drug police practices and drug policy more broadly. Health professionals who were persuaded that the harms of drug injection could be controlled more effectively by public health programs than by policing were at the vanguard of shifting the parameters of Swiss drug policy.

Switzerland's system of "direct democracy" whereby citizens, if they can gather enough signatures, can challenge government policy and law in nationwide referenda meant that Swiss authorities had to be able to articulate a justification for policy change that would convince the public. Movement away from Switzerland's traditional policing-based drug policy proceeded, therefore, with caution and with great attention to public health evidence. As heroin injection was the dominant concern of public health officials, the Swiss authorized the institution of low-threshold methadone programs, needle exchanges (including in prison), and safe injection rooms on a large scale, in some cases building on services that had been started quasi-legally in response to open drug use in Swiss cities, especially Zürich. Low-threshold methadone was an especially crucial breakthrough as it marked a departure from a history of regulatory barriers to large-scale methadone prescription. In all cases, services were set up to be evaluated in detail, and evidence from evaluations helped to shape policy debates.

In addition to these services, the Swiss Federal Office of Public Health oversaw a pioneering experiment in prescribing heroin to people who had lived with opiate dependency for some time. The government's careful evaluation of this experience showed that heroin-assisted therapy was feasible, cost-effective, and associated with numerous significant health improvements among patients and a dramatic reduction in drug-related crime. Though this program was very small relative to needle exchange and low-threshold methadone, it drew enormous national and international attention. A skeptical Swiss public was persuaded of the benefits of heroin-assisted therapy and endorsed it twice in nationwide votes in spite of opposition on the domestic political scene and consistent criticism from the International Narcotics Control Board.

The Swiss public affirmed again in November 2008 the importance of drug policy based on "four pillars"—policing, prevention of drug use, treatment of drug use, and harm reduction—by a large margin. At the same time, it resoundingly rejected a proposal for decriminalization of cannabis, illustrating the complex political environment from which Swiss drug policy has emerged. Along with the cannabis debate, some policymakers and advocates question whether the Swiss approach to harm reduction has over-medicalized drug policy and resulted in the neglect of dealing with the poverty and social exclusion that drug users face.

Many lessons from the Swiss drug policy experience can be generalized, including the importance of scientifically rigorous investigation of new programs and of letting science be a basis for policymaking; bringing policing and health programs together under a coherent policy rubric; investing in public education on drug policy; opening the experience of new programs to independent review; and standing up to ideological criticisms, domestic and international, with evidence and pragmatism. It is true that Switzerland is a small and wealthy country with a coherent public health system, and for those reasons some elements of its experience will have less general application. Nonetheless, Swiss policymakers and health service providers faced some challenges that are faced the world over, and the Swiss drug policy experience has greatly enriched narcotic drug policy research and practice in the world.

I. Introduction

Switzerland is no one's idea of a leftist country. Its famous tradition of protecting bank secrets, its having granted women the right to vote only in the 1970s, and its referendum-based rejections of minarets on mosques and decriminalization of cannabis illustrate its quirky conservatism. With respect to narcotic drugs, however, Switzerland has a well-established set of policies that exemplify progressive pragmatism based on providing people living with drug dependency with a wide range of evidence-based health services.

This paper seeks to review the history of narcotic drug policy in Switzerland with a view to identifying lessons and decision points of potential relevance to other countries seeking to establish evidence-based policies. It therefore attempts to identify factors unique to the Swiss situation and society as well as those that might be applied to other political and social contexts. As in many countries, HIV was the principal driver of drug policy change from the 1980s onward. This paper is an analysis of the ways in which the Swiss response to HIV and its attendant social challenges laid the building blocks of a new regime of narcotic drug policy.

II. Methods

The findings of this paper are derived from a thorough review of scholarly literature, press reports, reports by civil society organizations, and other grey literature on Swiss drug policy and Swiss HIV and AIDS policy and from in-person interviews in French and English with Swiss policymakers, academic experts, civil society representatives, and medical practitioners. In March 2010, the author interviewed 19 persons, mostly policymakers and service providers, in Zürich, Bern, Lausanne, and Geneva; their names and affiliations appear in the annex. These included a former Swiss president, the director of the Swiss Federal Office of Public Health during the years of HIV-related drug policy change, several former federal health officials now in the academic world, two members of the Swiss Parliament, directors of health services for people who use heroin, a cantonal director and deputy director of narcotic drug services, the president and vice president of the Swiss Society of Addiction Medicine, and representatives of organizations that advocate for the rights of people who use drugs and for evidence-based drug policies. Interviewees also included three of the physicians whose pioneering actions in delivering street-based services to drug users helped spur policy debate and change. The author of this paper also had a small number of conversations with some of the people living with drug dependence who were present at the services visited.

III. Key Developments in Swiss Drug Policy

The Ground Is Laid: The Open Drug Scene

Until the 1980s, Switzerland's approach to control of narcotic drugs was based, as in many countries, on policing. The 1960s counterculture movement in Switzerland, as in other European countries, was associated with widespread and public use of narcotic drugs and cannabis. Heroin came into Switzerland significantly only in the 1970s, assisted partly by transit points at U.S. military bases in neighboring Italy (Hämmig, personal communication).

The response of the Swiss authorities to more widespread use of narcotics was to revise the federal law on illicit drugs to define rigorous criminal sanctions for the widening range of illicit drugs appearing on the Swiss scene (Klingemann 1996). The federal drug law of 1975 resulted in a significant increase in arrests and registration of illicit drug users and sellers by the police. The abstinence-oriented 1975 law also rejected the provision of syringes as a public health measure (Grob 1995) and imposed onerous licensing requirements on any doctor wishing to prescribe methadone for the treatment of heroin dependency (Uchtenhagen 2009).

In spite of an increased focus on and resources for policing, drug injection continued to grow and became a very visible social phenomenon, especially in German-speaking Switzerland. Zürich in particular became a hub of a "youth revolution" movement that united proponents of alternative culture, students, and people who used illicit drugs (Klingemann

1996). By the early 1980s, concentrations every evening of several hundred people who used drugs around the "Riviera," a riverside public stairway in Zürich, were commonplace (Grob 1995). The number of people who injected drugs in Zürich grew steadily from under 4,000 at the time of the revision of the drug law to an estimated 10,000 in 1985, 20,000 in 1988, and about 30,000 in 1992 (Grob 2009). The police regularly dispersed drug users from public places, but the displacement did not seem to reduce the prevalence or harms of drug use.

Increasingly desperate to find a way to control crime and social and health harms associated with injection drug use, in 1987 the Zürich authorities allowed people who used illicit drugs to gather in a defined space near the main train station—the Platzspitz park, which sat on a small spit of land surrounded by the water of two converging rivers (Grob 1995). This space came to be known as the "needle park." Up to 1,000 drug users per day would come to the park at its peak (Grob 2010). Surveys conducted in the Platzspitz showed that by 1990 these included not only young people but significant numbers of older working and professional adults among whom heroin use had spread (Grob 1995).

In Zürich physicians and social service providers had encouraged local officials for a number of years to consider alternatives to policing-based drug policy (Grob, Seidenberg, personal communications). They had a degree of success when city officials permitted a group of physicians and social workers, including Peter Grob, then professor at the University of Zürich, and André Seidenberg, a private practitioner, to provide medical care and other services in the heart of the scene at the Platzspitz. These services included provision of sterile syringes and needles, a practice prohibited by the 1975 federal law. (In the mid-80s, provision of syringes by physicians to patients became an issue in the canton of Zürich when the medical director of the canton said he would revoke the medical license of anyone found to be distributing syringes. In response, however, some 300 physicians in the canton signed a declaration stating that they intended to hand out syringes anyway, and the cantonal legislature of Zürich voted to allow the distribution and sale of syringes by qualified medical persons (Kübler 2001, 632).

Services in the Platzspitz especially sought to address the high rate of overdose death and other adverse consequences of concentrated drug use, including HIV. A program led by Grob and colleagues from 1988 to early 1992, known as ZIPP-Aids (Zürich Intervention Pilot Project–AIDS, or *Aids fur Drogengefahrdete und Drogenabshangige*) responded to 6,700 episodes of overdose in the park, vaccinated thousands of persons for hepatitis B, and furnished about 10 million sterile syringes at the site, as well as millions of alcohol pads, condoms, and sachets of ointment for injection sites on the skin (Grob 1995). Keeping good statistics on the outcome of the services delivered was an important part of the informal agreement ZIPP-Aids had with local officials (Grob, personal communication). These pioneering actions would help inform an emerging drug policy discussion fueled by the failure of law enforcement-based policies to resolve the social and public health problem that injection drug use had become.

While the "needle park" did enable some level of geographical containment of drug injection and facilitated targeted health services, neighboring residents and some local officials grew impatient with the spillover effects of crime, desperately ill persons in the streets, and the deaths that persisted in spite of the health outreach (Eisner 1995). In 1992, the Zürich authorities abruptly closed the Platzspitz to drug users. The city of Bern closed a smaller but similar drug scene near the Parliament soon after the closing of the Platzspitz (Klingemann 1996).

One of the frustrations of the Platzspitz for the people and public officials of Zürich was the perception that many of the persons frequenting the needle park were not from Zürich. Surveys conducted by ZIPP-Aids indicated that more than half of the young people at the site were originally from rural or semi-rural areas outside the city of Zürich (Grob 1995, 54). In planning to close the Platzspitz, the Zürich authorities secured the agreement of most of the communities in the canton to provide drop-in centers and work and housing programs for drug users who originated from those towns (Klingemann 1996, 731). Unfortunately, the establishment of such services was impeded by difficulties in finding welcoming neighborhoods for them, and the opening of low-threshold services was not sufficient to absorb those no longer in the Platzspitz (Ibid.). An elaborate effort to "repatriate" drug users to their towns of origin, which included for one year a center where drug users were detained to await transfer to their home communities, did not appear to make a dent in the continued visibility of the drug scene in Zürich, which had re-established itself around the abandoned Letten train station on the Limmat River.

The new drug scene at Letten station tested the patience of Zürich residents. In the lead-up to the 1993 cantonal election in Zürich, the conservative political party SVP (Schwezerische Volkspartei, or Swiss People's Party) sought to profit from the public's fear and frustration, for example, by disseminating a poster showing a woman being threatened by a knife-wielding thug with the caption "Thanks to the leftists and the 'nice guys' we now have more crime, more drugs, more fear" (Ibid., 730). In the neighborhood around Letten station in 1994, a group of residents told the government that it had raised $180,000 and was prepared to break up the drug scene on its own if the city did not do it officially (Ibid., 732).

From another perspective, the persistence of the drug scene seemed to underscore the point that some health and social professionals had been making for some time—that the traditional system of drug dependency treatment, which included extended periods of inpatient care, did not seem to respond to the needs of a new generation of street-based drug users (Seidenberg, personal communication). A growing group of harm reduction advocates in the medical and social services communities pushed for expansion of low-threshold services—that is, those having few or no admission requirements. By the time Zürich closed down the Letten station drug scene in exasperation in 1995, a national dialogue was already well under way about new strategies for addressing narcotic drug use.

Political Structures, Direct Democracy, and Health Policy in Switzerland

Switzerland, a country of about 7.5 million, is a constitutional confederation comprising 26 cantons or small states. The Federal Council is the chief executive body of the confederation. It consists of seven persons selected to four-year terms by the two houses of the Federal Assembly or Parliament. The president of the Federal Council is elected each year by the Parliament and is thus the head of state of the country and "first among equals" on the Federal Council, though with limited executive powers compared to heads of state in most other countries. Since 1959, the Federal Council has represented the four major political parties—the Social Democrats, the Liberal Democrats, and Swiss People's Party (or SVP in German, UDC in French), and the Christian Democrats.

The bicameral Parliament consists of an upper house, the Council of States, which has two representatives from each canton elected according to methods established by the cantons, and the lower house or National Council, which has 200 members elected based on proportional representation. Representatives to both bodies are elected to four-year terms.

The federal government makes regulations in matters of importance to the confederation and to Switzerland's positions internationally, but the basic day-to-day services of government—health, social services, policing, education—are cantonal responsibilities or in some cases responsibilities of city government.

Switzerland is famous for its system of "direct democracy" whereby a majority vote of the full citizenry can overturn (or endorse) an act of Parliament. Two types of challenges can be made by referendum. Through a federal referendum, gathering 50,000 signatures within 100 days of the passage of a law by Parliament allows citizens to challenge the law by a simple majority vote of the population. Any coalition of eight cantons can also force a federal referendum. Secondly, through a constitutional initiative, gathering 100,000 signatures endorsing a proposed constitutional amendment within 18 months can force a challenge to a constitutional provision. In this case, the Parliament can put a counter-proposal on the same ballot. To achieve a constitutional amendment in this way, there must be a majority of all voters and majority approval in the majority of cantons.

Sources: Websites of the Swiss Federal Council (www.admin.ch) and the Swiss Parliament (www.parlament.ch) and Collin (2002).

HIV and AIDS in Switzerland

HIV and AIDS-related deaths were the specters that most haunted public health authorities facing down the drug scene of the late 1980s and early 1990s. In 1986, one of the first years when most Western European countries reported HIV data, Switzerland's estimated reported prevalence of about 500 cases per million population was the highest in Western Europe (EuroHIV 1999). In 1986, Switzerland's officially reported 3,252 cases of HIV exceeded by far the next highest—2,600 in the UK, a much larger country (Ibid., 36). Incidence and prevalence of HIV would remain higher than elsewhere in Europe through 1995 (Uchtenhagen 2009). By 1988–89, half of all new cases of HIV transmission were linked to injection of drugs (Savary et al. 2009). In 1990, some 22 percent of persons reached by health services in the Platzspitz were HIV-positive; prevalence was over 40 percent among those who reported having used drugs for more than 10 years. Mortality was high as effective therapy for HIV would come only after the mid-1990s, well after the height of the open drug scenes.

HIV was cited by every person interviewed for this report and in published literature as the prime motivating factor behind the fundamental revisiting of narcotic drug policy that was undertaken by federal, cantonal, and commune authorities in Switzerland in the early 1990s. AIDS dramatically exacerbated the morbidity and mortality that would have resulted from the open drug scenes. The disease was prominent in the minds of the Swiss public, who associated it with the drug problem, which was in turn identified by the public in the late 1980s as among the most serious problems of the country (Dreifuss 2009; Reuter and Schnoz 2009).

Federal Assistance Sought in Revisiting Drug Policy

While services for drug users in Switzerland, like most health and social programs and policies, are under the administration of cantons and not the federal government, by the early 1990s some of the cantons were ready to seek the assistance of the federal authorities in Bern in addressing recalcitrant drug problems. In 1991, at the request of communal authorities and with the endorsement of the cantons, the Federal Council took on the task of a reconsideration of narcotic drug policy (Rihs-Middel and Hämmig 2005). It established a national program in the Federal Office of Public Health to assess the extent and nature of the problem, draw lessons from experiences of the cities and cantons, look at the legal and policy framework, and make recommendations for new courses of action (Ibid.). A first national drug conference was held in the same year.

Some degree of tolerance for new services, especially in the cities of German-speaking Switzerland, had already furnished a set of experiences from which dialogue could emerge. In addition to the activities in the Platzspitz in Zürich, the city of Bern had addressed its own open drug scene near the Parliament by allowing for a short period a supervised injection room—that is, a place where drug users could inject illicit drugs under medical supervision and with clean injection equipment without fear of arrest (Hämmig, personal communication). In 1990 and 1991, the citizens of Zürich and Saint Gall respectively had rejected injection room proposals in referenda (Kübler 2001), but there remained strong proponents of this kind of service among medical professionals (Hämmig, Uchtenhagen, personal communications).

Low-threshold methadone for persons with opiate dependency also had an important following among many physicians and increasingly among some public officials, especially in Zürich, who saw the licensing provisions of the 1975 law to be outmoded barriers to care of drug users and HIV prevention. When the Platzspitz closed, a Zürich-based nongovernmental organization, ARUD (*Arbeitsgemeinschaft für Risikoarmen Umgang mit Drogen* or Association for Reducing the Risk of Drug Use), established a low-threshold methadone program that attracted 800 patients in the first year (Klingemann 1996: 727; Staub, personal communication). ARUD's bold early action, led by Dr. André Seidenberg who had long protested limits on methadone prescription, broke new ground and was a model for expanded methadone access, which became an anchor of the new Swiss policies (Grob, personal communication).

By 1990, there was also considerable interest among drug addiction experts in German-speaking Switzerland in the possibility of closely supervised administration of injected heroin as therapy for the subset of people living with opiate dependency who did not have satisfactory outcomes from other forms of treatment. A number of Swiss medical practitioners and policymakers had visited the heroin-assisted therapy (HAT) service run by psychiatrist John Marks, near Liverpool, England (Uchtenhagen 2009). The idea of HAT was politically loaded, challenging more directly than any other intervention the central place of abstinence-based programs in the 1975 law. In 1992, the Swiss government passed a law that provided the legal framework for prescription of narcotics, including heroin and methadone, and mandated the federal government to conduct rigorous scientific studies of initiatives in this area (Rihs-Middel and Hämmig 2005).

While HAT, in terms of cost and number of patients involved, would be only a small part of the activities entailed by the emerging shift in drug policy, it was unsurprisingly the biggest political lightning rod. As Uchtenhagen (2009) noted in his excellent account of the history of HAT in Switzerland, the sensation of HAT drew international attention and negative reactions from some countries. Thomas Zeltner (personal communication), who

headed the Federal Office of Public Health (FOPH) from 1991 to 2009, said the country that was the most vocal critic was not the United States, as might be expected, but Sweden, which had a long history of abstinence-oriented drug policy and was an outspoken advocate of prohibitionism in international debates.

Based on its 1992 call for proposals, the Federal Office of Public Health authorized HAT trials in Zürich, Bern, Basel, and Geneva involving about 1,000 persons in the first instance (Bammer et al. 2003). Studies of HAT continued in Switzerland beyond the first trials. The full results of this work are beyond the scope of this paper, but what may be hundreds of peer-reviewed journal articles on the trials, as well as a book produced by FOPH (Rihs-Middel et al. 2005), attest to the care taken to document a wide range of health and social outcomes from the HAT experience. In brief, some of these results are as follows (See esp. Uchtenhagen 2009, 34 and Bammer et al. 2003, 365):

- It was possible to stabilize dosages of heroin, usually in two or three months, without a continuing increase of dosages, which some had feared.
- There was significant and measurable improvement in health outcomes for patients, including significantly reduced consumption of illicit heroin and even illicit cocaine.
- There was a significant reduction in criminal acts among the patients, to the point where the estimated benefits of this effect well exceeded the cost of the treatment (See also Killias et al. 2005).
- Heroin from the trials did not find its way into illicit markets.
- Initiation of new heroin use did not increase.
- Utilization of treatments other than HAT, especially methadone, increased after the advent of HAT rather than declining as some had feared.

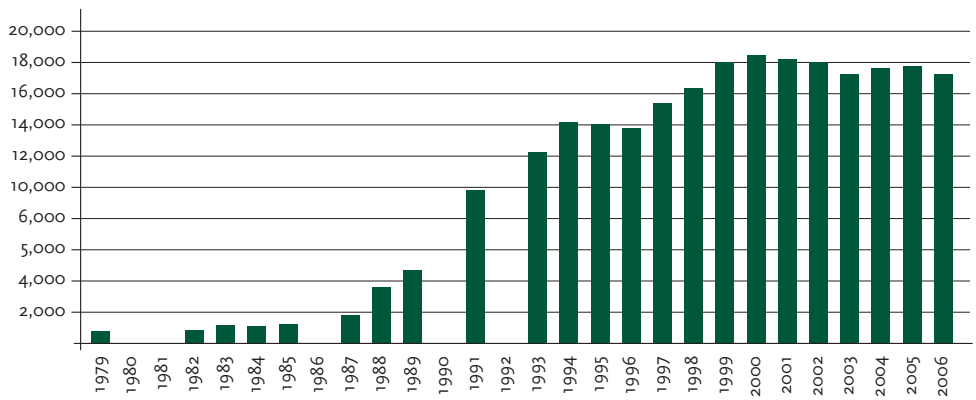
In short, the fears of opponents of HAT were largely refuted by solid evidence, though, of course, political debate would continue.

While heroin-assisted therapy attracted a lot of attention in Switzerland and abroad because of the sensational idea of the government giving out heroin, the bulk of the effort to bring people living with opiate addiction into the health system was accomplished largely through the dramatic expansion and normalization of low-threshold methadone services. Figure 1 below shows that enrollment in methadone programs went from practically zero in the early 1990s to over 18,000 at their peak in 2000 (Reuter and Schnoz 2009, 43). Over 50 percent of people with opiate dependency were enrolled in methadone programs at their peak (Collin 2002). In this population of patients, HIV was prevented and treated on a scale that dwarfed HAT. Switzerland also established numerous low-threshold needle exchanges,

ensured sale of needles and syringes in pharmacies, and led a growing move in Europe to open safe injection rooms (Ibid., 47–48).

Deaths from AIDS among people who used illicit drugs and other mortality among drug users (from overdose and other causes) dropped precipitously from the early 1990s to 1998 (Ibid.). The policy seemed to be paying off. More drug users were in some kind of care, and drug use was no longer so visible on the streets of Swiss cities. Some 64 percent of the Swiss population saw drugs as one of the five most serious problems in the country in 1988, a figure that fell by 1995 to 34 percent and would fall to 12 percent in 2002 (Boggio 2005, 3).

FIGURE 1: Number of methadone patients, Switzerland, 1979–2006



Source: Act-info: Nationale Substitutionsstatistik (Methadon) http://www.nasuko.ch/nms/db/index.cfm

Four Pillars

Following various consultations with the cantons and health experts, the Federal Council in 1994 announced its endorsement of a new drug policy based on the idea of "four pillars"—namely, prevention of drug use, therapy for drug dependence, harm reduction, and law enforcement or policing (often referred to in Switzerland as "repression"). As described by Rhis-Middel (who was in the Federal Office of Public Health at the time) and Hämmig (2005), the policy was a shift but seemed to be one that most stakeholders could live with:

> [The process of making the policy] brought about a shift in perspective from public order to public health, and this resulted in allocating of proper resources to the

> department response for health policy. . . . Here, problematic and dependent drug use is seen primarily as a disorder and/or illness, and it is this view that guides the development of concepts and any discussion of measures. At the time, with images of down-and-out drug addicts featuring regularly in the media, nobody expected measures taken by the police or the judiciary to reduce the problem in any way (p 12).

From 1991 at the time of the first national drug conference to 1999, the Federal Office of Public Health supported the development of over 300 programs, many of which also received cantonal or municipal support, with federal expenditure of over 15 million Swiss francs annually (Collin 2002). The Federal Council in 1997 established a Federal Commission for Drug Issues (known by its German acronym EKDF) that advises the government on drug policy. It includes 14 persons selected by the Federal Council to serve in their individual capacities. The current membership includes mostly medical doctors and academic health experts (Federal Commission for Drug Issues 2010).

The four-pillar policy was not well received in some quarters. By the mid-1990s, the FOPH had gathered significant evidence showing good results from harm reduction measures, including low-threshold methadone programs and HAT. But a popular prohibitionist movement with links to the SVP called Youth Without Drugs (*Jeunesse sans drogues* in French or *Jugend ohne Drogen* in German) organized a formal challenge to the policy by gathering enough signatures to force a national referendum in 1997. The proposal put before the country by Youth Without Drugs, if approved, would have made syringe programs, methadone treatment and safe injection rooms virtually impossible and would have eliminated HAT from authorized programs (Bühler 2005). The population rejected the proposal with a majority of 70 percent, showing a significant level of support for a policy that included harm reduction.

The use of the referendum mechanism to protest the four-pillar policy was not limited to the political right. From the other end of the political spectrum, a coalition of organizations and activists brought to the nation in 1998 a proposal for complete legalization and government regulation of narcotic drugs, a direct repudiation of both prohibitionist ideas and the four pillars (Kübler 2001). It too was rejected by a large percentage of the population.

In 1998, the Federal Council passed an executive order creating a permanent legal and policy basis for HAT. The order was challenged with a nation-wide referendum in 1999. The Swiss people used the referendum to endorse HAT with a majority of 54 percent. The four pillars were becoming increasingly sturdy.

The 1999 referendum enabled the government to proceed to normalize HAT. The heroin used in HAT was registered for medicinal use in Switzerland in 2001 (Uchtenhagen 2009), and the government ordered the private insurers that comprise Switzerland's health insurance system to cover HAT (Dreifuss, personal communication). Procuring heroin to

sustain HAT services was no mean feat. At first, it was possible to procure medicinal heroin from France, but when it was publicly known that the French were providing the heroin, the French government demurred and cut off the supply (Rihs-Middel, Dreifuss, personal communications). The Swiss government wound up having to acquire the raw ingredients and set up its own heroin production facility (Zeltner, personal communication).

INCB and International Pressure

For the four-pillar policies but especially HAT, Switzerland was criticized publicly by the International Narcotics Control Board (INCB), a group of experts paid for by the United Nations that is meant to oversee the compliance of national governments with the UN drug control conventions. Switzerland is a state party to the UN conventions of 1961 and 1971, which restrict the production, consumption, and transportation of narcotic drugs. INCB is meant to oversee the designation of controlled narcotics for scientific and medical purposes. Concerned about the government's authorization of HAT, INCB delegations visited Switzerland in 1994 and 1995 (INCB 1995, para 382). Appreciating that the Swiss authorities recognized that they had an "uncontrollable" drug problem (Ibid., para 383), the INCB nonetheless consistently berated Switzerland for the "controversial experiment" of HAT (Ibid., para 384) and insisted that the World Health Organization (WHO) convene an expert group to conduct an independent evaluation of HAT in Switzerland (Ibid., para 385). The Swiss authorities agreed to allow a WHO review.

The Swiss Federal Council's 1998 order legalizing heroin-assisted therapy was issued on the basis of the government's own extensive studies of the HAT experience before the results of the WHO evaluation were available, a move also criticized by the INCB (INCB 1998, para 436). When the WHO concluded its evaluation in 1999 (Ali et al. 1999), it largely endorsed the government's findings, and stated the following:

> (1) it is medically feasible to provide an intravenous heroin treatment programme under highly controlled conditions where the prescribed drug is injected on site, in a manner that is safe, clinically responsible and acceptable to the community; [and] (2) participants reported improvements in health and social functioning and a decrease in criminal behaviour and in reported use of illicit heroin (p 1).

The WHO group's main concern about the HAT trials, iterated also by the INCB (INCB 1997, para 368; INCB 1999, para 452), was that the observational design of the main arm of the trial could not justify causal conclusions about whether heroin performed better than other clinical interventions or whether the positive results of the trials were due in

particular to the medicinal heroin or to the psychosocial and other support given to patients in the trials (Ali et al. 1999). As Swiss experts (Uchtenhagen 2009) and others (Small et al.) point out, it is difficult to set up heroin prescription as a randomized controlled trial as against other forms of therapy not least because patients can tell the difference between heroin and other substances and are unlikely to comply with being in a study arm that does not suit their needs. The INCB was dismissive of the Swiss results and pronounced them inadequate to justify any such initiatives by other governments (INCB 1999, para 452), suggesting also that the "considerable financial means" made available by the Swiss to provide services for drug users could not easily be replicated in other countries (INCB 2000, para 502). In addition, INCB annual reports urged the Swiss not to overemphasize harm reduction as it developed its four-pillars policy (INCB 2000, para 501).

Ruth Dreifuss, who was president of the Swiss confederation in 1999 and minister of the interior from 1993 to 2002, was at the center of many of the interactions with the INCB in this period. She said that INCB never accused Switzerland outright of being in violation of the UN drug conventions and praised Switzerland for keeping close control over controlled substances in all of the clinical work (Dreifuss, personal communication). Swtizerland wanted to be in compliance with the UN conventions but found evidence from the HAT trials and other harm reduction programs to be compelling to steer policy and did not regard HAT as a violation of the UN conventions. The government made this position clear to the INCB. Nevertheless, right-wing elements in Switzerland opposed to the four pillars made use of statements of the INCB to justify their stance (Klingemann 1996, 734).

Harm Reduction and Law Enforcement

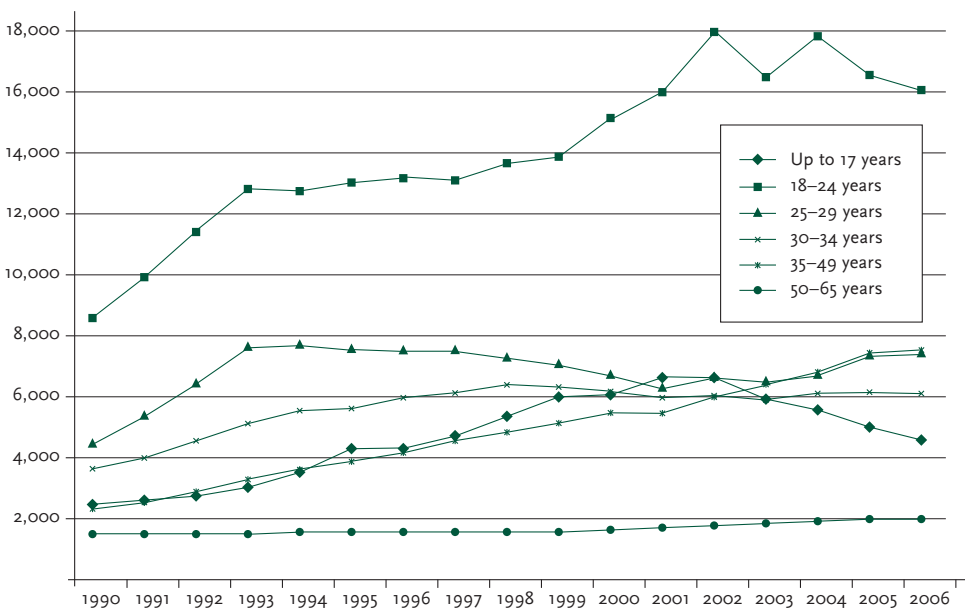
Policymakers in Switzerland had to deal with shifting attitudes of the police and judicial system, who might have felt that the four-pillars policy slighted them. Indeed, policing was the center of Swiss drug control policy throughout its history until the time of the Platzspitz, and the Swiss were renowned for the rigor of their drug policing and the resources devoted to it (Reuter and Schnoz 2009; Seidenberg 1999). The police in some parts of Switzerland initially resisted the four-pillars approach but in time recognized that public order issues would still feature prominently in drug policy (Rhis-Middel and Hämmig 2005, 13). As a whole, it seemed that many police leaders saw that the goals of the new public health measures included public order improvements such as reduction in crime, reduction in the number of problem drug users, and reduction in accidents related to drug use (Ibid.).

According to former Swiss president Ruth Dreifuss, the Federal Council was always careful to ensure that the police and the public knew that law enforcement remained an

important part of the four-pillars approach. As in many countries, law enforcement expenses have remained the most costly pillar of Swiss drug policy (Dreifuss, 2009). The police were also motivated to support the four-pillars policy by the fact that policing-centered methods had failed to deliver results (Rihs-Middel and Hämmig 2005; Zeltner, personal communication). Police and judicial system officials were included in Federal Council discussions as equal partners with public health and medical specialists as the new drug policy was developed (Dreifuss, personal communication). The federal drug policy and plans of action are now jointly issued by the Federal Office of Public Health, the Federal Office of the Judiciary and the Federal Office of the Police (Federal Office of Public Health 2006).

It is notable that by many measures, policing did not decline with the advent of the four-pillars policy. As Figure 2 shows, policing continued to be very active well after the drug policy changes occurred, though the bulk of arrests since the early 1990s have been related to cannabis use by young persons (Reuter and Schnoz 2009). Relatively few of these arrests, however, led to incarceration and many resulted in administrative fines not registered on a person's criminal record (Ibid.; Killias 2009).

Figure 2: Number of persons arrested for drug offenses in Switzerland by age group, 1990–2006



Source: Reuter and Schnoz 2009: 51.

Having studied the politics of bringing harm reduction into the center of drug policy in Switzerland, Kübler (2001) concluded that the notion of public order, rather than strictly policing and repression as such, was the central concern of the Swiss public in the face of visible drug use. In his view, harm reduction advocates succeeded—as drug legalization advocates did not—in highlighting that harm reduction and public order were compatible. Kübler's view is that "moderate" harm reduction activists recognized that the new health services for drug users had to be run in ways that would in their perception and reality contribute to public order (Ibid.). This perspective was corroborated to a great degree in visits to the harm reduction services conducted for this report and conversations with numerous service providers, who were quick to emphasize their safety procedures, their outreach to neighboring residents and business-owners, and the virtual absence of conflict with neighbors (Kaufmann, Kaye, personal communications).

The federal drug policy also made explicit that day-to-day policing is the domain of the cantons, which retained their authority to determine their own protocols for drug policing within the general principles of the four-pillar policy (Federal Office of Public Health 2006). The canton of Saint Gall in eastern Switzerland, for example, announced that it would adopt the policy of treating all infractions related to narcotic drugs and cannabis as punishable by an administrative fine unless there was evidence of trafficking (Addiction Info Suisse 2010a). According to the cantonal prosecutor, this system would result in more effective policing because the police previously thought twice about the heavy procedures that would be involved with imposing criminal penalties for relatively minor crimes (Ibid.).

As it became clear on the public health level that the spread of HIV and hepatitis C in prisons and jails in Switzerland was also a challenge for drug policy, Dreifuss (personal communication) said policymakers were challenged to find a way to make progress on this front. In her view, a key hurdle was overcome when the government came to the point of being able to admit that in spite of everyone's best efforts, it was not possible to stop drug use in the prisons. From there, and with the help again of courageous and innovative service providers, introducing sterile syringe programs, methadone and HAT in prisons became possible. Switzerland has the world's longest and best documented experience with syringe exchange in prisons (Lines et al. 2006) and now heroin-assisted treatment in some corrections facilities (Uchtenhagen 2009).

Changing Political Winds

After 2000, the right-wing Swiss People's Party (SVP), which opposed the four-pillars approach, enjoyed a dramatic rise in popularity (Savary et al. 2009). This was one factor

that complicated the final promulgation of a new federal law on narcotics to give all elements of the new policy a firm legal grounding. Indeed, the failure of Parliament to pass a new drug law in 2003 and 2004 made some observers wonder how so much ground was lost so quickly since 1999–2000 when the results of bringing thousands of drug users into medical care were apparently well appreciated by the public. A high-quality, rational, unemotional debate seemed to have been replaced by the opposite, and the Swiss pragmatism that was an effective answer to the pain of HIV and the frustration with open drug scenes seemed to have dissipated (Boggio 2005). The debate on the narcotics law was also complicated by continuing controversies over how to handle cannabis in Switzerland. The upper chamber of the Parliament, the Council of States, had by 2004 twice voted for decriminalization of personal use of cannabis, but the National Council (lower chamber) did not agree (Wutrich 2004; Savary et al. 2009). The Swiss People's Party got political mileage from the purported dangers that decriminalization posed for Swiss youth (Kapp 2003).

Eventually, in 2008, both houses of parliament succeeded in passing a revision of the narcotics law that gave legal grounding to the four pillars but did not include the decriminalization of cannabis. It should have surprised no one that the opponents of the four pillars—the opponents effectively of harm reduction—quickly gathered the required signatures and forced a referendum on the law.

Public statements from many quarters of Switzerland's vibrant civil society and extensive attention from mass media animated lively debate in the run-up to the referendum, which was held on November 30, 2008. The 2008 vote was the opportunity to see if four pillars, as accepted clearly by the majority of members of Parliament and even more clearly by the medical community, was also understood by the public in spite of a right-wing campaign to discredit it (Graf and Savary 2008). The Youth Without Drugs Association (*Association Jeunesse sans drogues* 2008) disseminated public statements suggesting that heroin prescription was a slippery slope that would lead the government to start giving out cocaine and other narcotics, though the Federal Office of Public Health and other authorities had clearly repudiated such ideas (Zeltner, personal communication). The group and its allies also repeatedly raised the specter that under the four-pillars policy, the federal government would force the cantons to open safe injection rooms (*Assoc. Jeunesse sans drogues* 2008; Guex 2008), though the law itself and federal officials consistently made clear that cantons could (and certainly did) opt out of harm reduction measures (Dreifuss, personal communication; Federal Office of Public Health 2006).

In this case, the parties pushing for a "no" vote were up against an organized coalition of professional associations, academic experts, NGOs, labor groups, and well-known Swiss leaders, cultural figures, and social observers of many stripes who supported cementing the four pillars in law (see list of groups that spoke for the "yes" side at *Révision de la Loi*, 2008).

The public statements, posters, and media work undertaken by this coalition was a lesson in itself for crafting messages that would resonate with a general, nonexpert public. Two posters that were widely disseminated are in Figure 3 below.

Figure 3: Posters used by the "yes" coalition for the four-pillars referendum, November 2008

Source: J-F Savary, GREA

The first, showing a photograph of an older couple, has a caption that reads "Thanks to treatment, our son could quit drugs." The second, showing a mother and baby, says "I want to keep our public parks free of syringes." The "yes" coalition thus linked the treatment services developed under the four pillars to the public's desire to see drug users be "clean." The second poster is an implicit endorsement of needle exchange but mostly speaks to the popular concern for public order and safety. The organization GREA (*Groupement Romand d'Etudes des Addictions* or Francophone Group for Addiction Studies) played an important part in the "yes" coalition even though it favored a regulated legal market for controlled drugs, which is not part of the four-pillars policy. At the time of the referendum many of those who hoped for eventual drug legalization worked for the "yes" vote because the most

pertinent fear was that right-wing attacks on harm reduction would cause a movement back to pure prohibition (Savary, personal communication). AIDS organizations and others highlighted in their public statements that a "no" vote would directly endanger thousands of methadone patients and more broadly public order as people would be forced back to prostitution and criminality to maintain illicit drug habits (Aide Suisse contre le Sida 2008).

While the technical ministries of the federal government did not disclose their position on the referendum, the Federal Commission for Drug Issues did not hesitate to do so, emphasizing the unanimity of health and social service experts across the country in favor of continuing the four-pillars approach (Federal Commission for Drug Issues). The Commission also pressed its view that children and young people would be best protected by the mix of judicious policing and comprehensive health services that the policy offered (Ibid.).

As it happened, the vote on the new narcotics law was put before the Swiss public at the same time as a vote on decriminalization of cannabis—the issue that dogged drug policy discussions in Bern and would not go away for significant segments of the public. In the end, a resounding 68 percent of the population voted in favor of the new narcotics law based on four pillars, which included heroin-assisted therapy, while in the same referendum, only 33 percent endorsed decriminalization of cannabis (Savary et al. 2009, 9). The result may have seemed schizophrenic to the world, but it was unsurprising to many Swiss experts. Opponents of cannabis legalization had succeeded somewhat in dominating the debate with a narrative about the corruption of youth, whereas the heroin problem was seen as a more contained clinical problem not affecting youth on a wide scale (Zeltner, Lehmann, personal communications). Other observers judged that the Swiss people were convinced that occasional use of cannabis was not a serious public health threat, which meant that the cannabis debate moved from the domain of public health evidence to the much more politicized arena of social perceptions and moral pronouncements on the duty of individuals (Savary et al. 2009, 9). Evidence of the ineffectiveness of prohibition of cannabis, which seemed abundant, was apparently not completely convincing to the electorate.

Though the four-pillars approach now is solidly established, drug policy debates continue in Switzerland. Organizations such as GREA in Francophone Switzerland and many advocates of a regulated regime of legal drugs across the country raise the concern that the "medicalization" of drug policy represented by the Swiss experience is treating the symptom but not the cause of the problem. They argue that housing and social services for people living with addictions have been neglected by the policy premise that social benefits would flow automatically from clinical stabilization and medical treatment (Savary, personal communication).

And the cannabis debate continues. In spite of the voters' rejection of decriminalization of cannabis in 2008, in March 2010 the Parliament had not completely dropped the

matter of cannabis policy reform. Based on the experience of the Saint Gall canton described above, in late 2009 the health committees of both houses of Parliament pushed those bodies to adopt the Saint Gall system of treating most drug offenses as administrative infractions rather than crimes potentially punishable by incarceration (Addiction Info Suisse 2010b). It remains to be seen whether the houses of Parliament will move this proposal to a vote.

IV. Did Policy Change Improve Health and Social Outcomes?

There was a precipitous reduction in both incidence and prevalence of illicit heroin use in Switzerland after the peak of both in the early 1990s. There were fears, perpetuated especially by anti-harm reduction forces, that readily providing heroin and even low-threshold methadone would cause a flood of new opiate use, among other problems (Uchtenhagen 2009). Paradoxically, however, the expansion of these treatment programs was associated in time with the opposite phenomenon of dramatic reductions in the apparent attractiveness of heroin use (von Aarburg and Stauffacher 2004). The impact of low-threshold methadone and HAT on illicit heroin use may not have been as direct as taking a given number of persons out of the population of illicit users but rather may have been in "turning the once rebellious image of heroin use into a painstakingly monitored illness" (von Aarburg and Stuaffacher 2004, 39). Or, as Ambros Uchtenhagen noted: "It wasn't sexy anymore" (Uchtenhagen, personal communication).

Indeed, Reuter and Schnoz (2009), who were invited by the Swiss government to do an independent evaluation of the impact of Swiss drug policy changes, concluded that the direct impact of these extensive policy changes that preoccupied Swiss politics for so many years is negligible. Heroin use declined possibly as a function of the aging of the population that initiated heroin use during the peak years with younger populations being attracted to other kinds of drugs (Ibid.,11). As these authors note, this is not to deny the profound benefits of low-threshold methadone and HAT on patients in these programs and the probable

benefit of needle exchange programs and safe consumption rooms on infectious disease incidence.

It may be that some of the most important impacts of Swiss drug policy were to widen the parameters of policy discussions and program possibilities in other countries. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) credits the Swiss experience with opening discussion of harm reduction programs in virtually all member states of the European Union (EMCDDA 1998; see also Fischer et al. 2007). The extensive engagement of policymakers and experts from Europe and Australia in the Swiss government's publications and symposia on drug policy attest to this influence (Rihs-Middel et al. 2005).

HAT trials have taken place in a number of countries, including Canada, but the service has only been institutionalized outside Switzerland in health systems in the Netherlands, Germany, and to some degree Spain (Small et al. 2006; Uchtenhagen 2009). Nonetheless, the Swiss HAT experience and the clinically more important expansion of methadone access and the rigorous evaluations and studies that accompanied these programs contributed greatly to the reframing of heroin dependency as a treatable condition rather than a problem "shrouded in a medieval cloak of moral disapproval" and mired in a policy "nightmare that has relegated millions of people living with serious addictions to poverty, prison and early death" (Small et al. 2006). A heated political debate on whether to continue a heroin prescription pilot in Canada has made consistent reference to the Swiss experience (Rehm et al. 2008). The Swiss experience with syringe programs in prisons, the first and best evaluated of such measures, has similarly opened policy discussion and policy and program change in numerous countries (Lines et al., 2006; Dolan et al. 2003).

V. Discussion and Lessons Learned

Switzerland is not unusual in having been pushed by HIV into seeing drug policy in a different light, though the scale of the HIV problem in its borders was large compared to its neighbors in the late 1980s and early 1990s. Across the world, HIV has occasioned fundamental rethinking of drug policy, not always resulting in expansion of evidence-based services, as was the case in Switzerland. These changes, again, happened in spite of a general tendency toward political conservatism and indeed at a time when the right-wing party in Switzerland enjoyed an increase in popularity. One federal health official noted: "It is a happy outcome that the Swiss population, known rather for its general conservatism, could agree to innovative measures if they are convincing" (Jann 2006).[1]

Some key factors related to the Swiss experience are summarized here along with observations on lessons that may be learned for policy and decision-making in contexts very different from Switzerland.

- **Willingness to experiment at the border of the law and to be guided by experimental evidence**: From ZIPP-Aids to low-threshold methadone and the HAT trials, Switzerland's experience is full of stories of new approaches being allowed to go forward,

1. "Il est également réjouissant que la population suisse, par ailleurs plûtot connue pour son conservatisme général, puisse être acquise à des mesures novatrices si elles sont convaincantes."

even in technical contravention of national or cantonal law or regulations, and being set up to be studied carefully so that political decision-making around them could be informed by empirical evidence. Several informants interviewed for this report judged that it was the keen sense of pragmatism central to the Swiss character that allowed Switzerland to move from frustration with old methods to some level of experimentation with new public health approaches, rather than digging in its heels with more repressive law enforcement (Uchtenhagen, Zeltner, Lehmann, personal communications). It was certainly the Swiss attention to documenting results and to setting up new programs as scientific studies that enabled the amassing of an impressive body of program- and policy-relevant evidence. It is also notable that the Swiss trials of HAT and the early low-threshold methadone programs were undertaken at a scale that was unlikely to allow the programs to be stuck in a perpetual pilot phase; rather the first experiences proved to be of an adequate scale on which to build bigger programs quite directly.

A hallmark of the Swiss drug policy experience is the openness of the government and front-line service providers to independent review—through the 1999 WHO-commissioned expert study of HAT, a major study by an outside expert commissioned by the federal government (Reuter and Schnoz 2009), and the extensive reporting on outcomes of new services by Swiss scholars and practitioners in peer-reviewed academic journals. Indeed, whether one agreed with the Swiss policies or not, it would be difficult to sustain a critique uninformed by the massive evidence of the impact of public health approaches without seeming to be making a purely political attack. The strength of scientific evidence facilitated decisions such as requiring HAT from qualified providers to be covered by private insurance, which resulted in a normalization of heroin-assisted therapy even in some prison health services. The Swiss reliance on well-reviewed evidence and the practice of setting up pilot projects at significant scale are exemplary practices that all countries might well emulate.

- **Medicalization**: In countries where drug policy remains a matter largely of repressive policing, harm reduction advocates struggle toward the objective of balancing law enforcement with stronger public health and medical approaches to drug use. In Switzerland, this counterweighing of law enforcement with public health approaches seems to have been achieved beyond what many might have hoped. Medical professionals have been extremely influential in the shaping of drug policy.

  In this regard, Jean-Félix Savary of GREA and other experts who are focused on the rights—more than just health rights—of people who use drugs raise a fundamental question about the nature of "harm reduction" in Switzerland: Has it been reduced to

a notion of access to health services rather than a holistic notion of choices, rights, and responsibilities of drug users as citizens and persons? Did "harm reduction" need to be sanitized and medicalized to be politically viable? Is it time for Switzerland, having achieved some level of equilibrium in its four pillars, to think more broadly about the rights of people who are marginalized by the harms of drug use to a point that cannot be addressed by health services and criminal justice alone but should also include more engagement of social services and support? One wonders if a more direct and organized voice of drug users, perhaps in the Federal Commission for Drug Issues, would have attenuated the medicalization thrust toward a broader social support and human rights effort. From the perspective of other countries, to be in a position to ask these questions seems like a far-off luxury, but they may be important to the continued evolution of policy and programs in Switzerland and the many countries that follow its experience closely.

- **Direct democracy and centrist positions**: Switzerland's system of popular checks on government through referenda is not a mechanism that many countries, especially larger countries and those with more fragile democratic institutions, will ever have. Using the referendum system was the last recourse of both prohibitionist and drug legalization coalitions when they couldn't get measures through the Parliament or Federal Council (Kübler 2001). The direct democracy system settled the debate, to a great extent, on harm reduction measures that were part of the four pillars, but it also was something of a guarantee of centrist positions that could satisfy the majority of voters and, again, a notion of "harm reduction" that focused mostly on medical harms and crime reduction.

  The direct democracy system certainly required Swiss policymakers to keep the public informed about drug policy decisions. The government's investment in popular awareness of drug issues and in sharing the results of program evaluations through both popular and scholarly publications is an example for other countries. By the time of the 2008 referendum, the memory of open drug scenes and high AIDS mortality had faded somewhat. The Federal Commission for Drug Issues and many public officials did a lot to remind people of the social benefits of drawing drug users into medical care rather than relying only on policing. Persons interviewed for this report differed in their view of how deeply the Swiss population actually understands drug issues, but several of the policymakers and former policymakers said that almost everyone knew someone with a drug problem, and many people sought to be informed about how effective the new programs might be for their friends or loved ones.

- **The pillar of policing and public order**: Many persons interviewed for this paper and many published articles noted that the police in Switzerland accepted the four pillars largely out of a level of despair born of unsuccessful efforts to disperse a highly visible and offensive drug scene in affected cities (see, e.g., Grob 1995). It would be useful to understand better the process by which the police came to accept the four pillars. Attempts were made to contact officials of federal, city, and cantonal police forces, but it was not possible in the end to meet with them. Other policymakers interviewed suggested that in the late 1980s and early 1990s, the police bore the brunt of public opposition to the open drug scenes and were relieved that a new policy framework might offer other approaches (see also Maurer 2006). As noted by former president Dreifuss (2009), policing still captures the lion's share of resources among the four pillars, so in the end the police may not feel that they have been greatly constrained in their actions. In addition, federal policy documents and pronouncements clearly leave the details of day-to-day policing to the cantons, except in the matter of border interdiction and other international criminal law issues (Federal Office of Public Health 2006).

  Countries in Eastern Europe and parts of Asia facing significant outbreaks of HIV and visible drug problems have often responded, unlike the Swiss authorities, by strengthening policing and making health services, if anything, another arm of state repression. Switzerland kept policing in the political conversation and in every concrete sense at the center of drug policy but created a new drug policy environment in which there could be and indeed had to be some level of collaboration between policing and public health. Esther Maurer (2006, 4), who in 2006 was both the director of the police department of Zürich and the chairperson of the Federal Drug Commission, made the following remark:

  > Before we didn't consult each other: the Department of Social Affairs did its work on the ground, then the police came and confiscated from the drug users the needles that had been distributed. . . . [T]here wasn't any common denominator. Since we created the drug committee [based on four pillars] and we all work together, the decisions taken constrain all the departments, and we pursue one and the same strategy. This is the price of our success.[2]

2. "Auparavant nous ne nous consultions pas: le département des affaires sociales faisait son travail sur le terrain, puis venait la police qui confisquait aux toxicomanes les seringues distribuées....il n'y avait aucun denominateur common. Depuis que nous avons créé la délégation drogue et que nous travaillons tous ensemble, les décisions prises sont contraignantes pour tous les départements et nous poursuivons, tous ensemble, une seule et même stratégie. Le succès est à ce prix."

This is perhaps not the most ringing endorsement of four pillars, but it is a realistic one that may be edifying for policymakers and police officials in other countries.

- **Jurisdictional issues in health services**: A number of persons interviewed as well as authors of articles reviewed (e.g. Klingemann 1996) noted that since health services and policing were very much established as the domain of the cantons or in some cases the bigger cities and not of the federal authorities, it took the open drug scenes and the ensuing level of frustration to move the cantons to invite federal action in this area. This kind of solicitation would be unlikely to happen in places where the central public health authority is regarded as highly politicized or otherwise lacking in independence or technical competence. The cantons and cities were pushed by health service providers who were ahead of the curve, and they needed the independent authority of federal health officials and technical staff as both gatherer and evaluator of evidence and dispenser of program guidance. The federal government left largely to the cantons and cities the day-to-day experience by which new programmatic approaches were developed and refined. Not only in the area of new health programs but also with respect to policing, the cantons' experience informed federal policy or proposed policy, as the Saint Gall experience shows.

  The four pillars approach in Switzerland was a coming together not only of law enforcement and public health but also of policy and program managers at all levels of government. A joint strategy for federal, cantonal, and municipal authorities in a social policy area was somewhat out of the ordinary (Klingemann 1996, 731). The cantons did not sacrifice power but were wise enough to know when a more active federal role was needed. Flexibility and pragmatism in this matter are lessons of the Swiss experience that may be applicable more generally.

- **Role of INCB**: The Swiss faced the complaints of INCB with evidence and political courage. They were concerned about being in violation of the UN drug conventions, but they did not allow themselves to be bullied into a narrow interpretation of the UN conventions. Lessons from this experience for other countries are as much for the INCB as they are for national governments. The INCB should know better than to put itself in a position where its ideological pronouncements—as its consistent objection to HAT, needle exchange, and safe injection rooms must be characterized (Csete and Wolfe 2007)—stand in the way of accumulation of evidence on programs that are within the scope of the discretion of states that are party to the UN conventions. In Switzerland, the INCB contributed to the politicization of health policymaking by taking positions that it had to know would be exploited selectively by one side of a

contentious debate on prohibition. The Swiss experience is one of many that should make the United Nations rethink its support of the INCB as an "independent" body.

VI. Conclusion

It is impossible to say whether a less severe HIV problem or less visible and offensive open drug scenes would have pushed Switzerland to a different kind of drug policy in the 1980s and beyond. One might suppose that the strong espousal of the importance of scientific evidence as a basis for policy—at least health policy—as well as the experience of other Western European countries might have led Switzerland eventually to the range of health services it offers to people who use drugs, but perhaps not at the same pace.

In any case, Switzerland's adoption of the policies and programs that it has placed under the four-pillars umbrella shows that pragmatic drug policy can be built even in an environment of political conservatism. It may need to be couched in some level of rhetoric about eventual abstinence and it may need to include explicitly strong support of policing, but with some level of respect for objective scientific evidence, harm reduction can be a strong part of drug policy among people of varying political persuasions.

One imponderable not discussed above is the degree to which the Swiss experience relied on exceptional individuals and, in that sense, would be difficult to replicate. Many of the persons interviewed for this report were pioneers in extending services to people who were suffering the harms of illicit drug use and in fighting policy battles to institutionalize services. In the course of these interviews, the author frequently asked these people where they found the courage to do what they did. The degree of modesty in the responses—sometimes combined with expressions of great faith that the majority of the Swiss population would come to understand sensible and pragmatic policy—was striking. The doctors who ventured into the Platzspitz seemed unconcerned that they would lose their livelihoods or

social standing. The physicians and politicians who persevered to expand needle exchange and methadone and make HAT a "normalized" public health service understood the opposition they would face but felt that the evidence on their side was overwhelming. Nonetheless, though this is a subjective judgment, it seems that drug policy in Switzerland relied on the coming together of an unusual group of persons who were motivated to stop a raging HIV epidemic, to improve the quality of life of both drug users and people around them, and to base policy on objective scientific evidence in spite of political obstacles.

Switzerland also enjoyed the advantage of a well endowed public sector and a highly educated cadre of health professionals who understood and to some degree defined the cutting edge of health services for drug users. In spite of the country's wealth, the government's evaluations of the new health initiatives included cost-effectiveness considerations, evidence that helps make the Swiss interventions more relevant to countries where cost is a more central impediment than it was in Switzerland.

There are many elements of the Swiss drug policy experience that can be generalized to diverse social and political contexts. Most significant among these would be the importance of scientifically rigorous investigation of new programs, and letting science speak to policymakers; bringing policing and health programs together under a coherent policy rubric; investing in the education of the general public on drug policy issues; opening new experiences to independent review; and facing down ideological criticisms from other countries and international bodies with evidence and pragmatism. The Swiss experience shows that harm reduction measures, inevitably controversial when they are new, can emerge from a relatively conservative political base. The world of drug policy research and practice would be vastly poorer without the Swiss experience and the expansive effort to share it widely and objectively.

Annex: Persons Interviewed

Federal government officials and former officials

- Mme Ruth Dreifuss, former member of the Federal Council and Minister of Home Affairs (1993–2002), vice president of the Swiss Confederation (1998), and president of the Swiss Confederation (1999)
- Dr Thomas Zeltner, director of the Swiss Federal Office of Public Health (1991-2009)
- Dr Margaret Rihs-Middel, professor, University of Lausanne; formerly with the Swiss Federal Office of Public Health
- Dr Philippe Lehmann, professor, University of Lausanne; formerly with the Swiss Federal Office of Public Health
- Dr Felix Gutzwiller, professor, University of Zürich; member of the Swiss Parliament (Liberal Democratic Party)
- Dr Jean-Charles Rielle, member of the Swiss Parliament (Socialist Party)

Cantonal government officials

- Dr Daniele Zullino, chief medical officer for addiction services, Canton of Geneva
- Dr R. Khan, deputy chief medical officer for addiction services, Canton of Geneva

Academic experts

- Dr Peter J. Grob, professor emeritus, University of Zürich, and founder, ZIPP-Aids
- Dr Ambros Uchtenhagen, professor emeritus, University of Zürich, and director, Addiction and Public Health Research Foundation, Zürich

Medical practitioners and service providers

- Dr André Seidenberg, private medical practitioner, Zürich (formerly with the Association for Reducing the Risk of Drug Use)
- Dr Robert Hämmig, Bern, private practitioner and president, Swiss Society for Addiction Medicine
- Dr Barbara Broers, addiction service, Cantonal Hospital of Geneva, and vice president, Swiss Society for Addiction Medicine
- Dr Nelson Feldman, practitioner, Consultation Rue Vert, Genevaü
- Dr B. Kaufmann, director, Consultation Navigation (HAT and methadone service), Geneva
- Mr Bart Kaye, nurse, Consultation Navigation (HAT service), Geneva
- Dr Toni Berthel, medical practitioner associated with the Association for Reducing the Risk of Drug Use, Zürich

Representatives of civil society organizations

- Mr Jean-Félix Savary, president of GREA (Groupe Romande d'Etudes sur l'Addiction), Yverdon-les-Bains
- Mr Athos Staub, member, board of directors, the Association for Reducing the Risk of Drug Use, Zürich

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About the Author

Joanne Csete is associate professor of Clinical Population and Family Health at Columbia University's Mailman School of Public Health. The objective of her teaching, research, and service work is to find ways to overcome human rights-related barriers to health services for marginalized and criminalized populations, especially people who use illicit drugs, sex workers, prisoners and detainees, and people living with HIV. As the founding director of the HIV and Human Rights Program at Human Rights Watch, she oversaw the building of a body of research on human rights abuses as barriers to access to HIV services and conducted advocacy with many governments on removing those barriers. She was executive director of the Canadian HIV/AIDS Legal Network in Toronto, one of the world's leading health and human rights research and advocacy organizations. She previously was a senior technical advisor at UNICEF and taught at the University of Wisconsin–Madison.

Global Drug Policy Program

Launched in 2008, the Global Drug Policy Program aims to shift the paradigm away from today's punitive approach to international drug policy, to one which is rooted in public health and human rights. The program strives to broaden, diversify, and consolidate the network of like-minded organizations that are actively challenging the current state of international drug policy. The program's two main activities consist of grant-giving and, to a lesser extent, direct advocacy work.

At present, global drug policy is characterized by heavy-handed law enforcement strategies which not only fail to attain their targets of reducing drug use, production, and trafficking, but also result in a documented escalation of drug-related violence, public health crises, and human rights abuses.

Open Society Foundations

Active in more than 70 countries, the Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. Working with local communities, the Open Society Foundations support justice and human rights, freedom of expression, and access to public health and education.

In the late 1980s and 1990s an open drug scene associated with rapid transmission of HIV in some Swiss cities, especially Zürich, led Switzerland to rethink drug policing and drug policy more broadly. Persuaded by evidence that intensifying policing alone would not address the problem, Swiss authorities opted for a strategy of institutionalizing specialized health services, including harm reduction services for people who use drugs, as part of a comprehensive policy that included prevention of drug use, treatment of drug dependency, and policing of drug crimes. Dramatic expansion of low-threshold methadone and needle exchange programs was an essential part of the harm reduction pillar, which was endorsed by the Swiss public in several referenda. While not every aspect of the Swiss experience can or should be applied elsewhere, there is much to be learned from the substantial and enduring changes that Switzerland instituted in reforming its approach to illicit drugs.

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