Swiss Drug Policy is characterized by its four pillar system i.e. pillars of Prevention, Therapy, Harm Reduction and Law Enforcement. Although drug consumption has not been decriminalized, Switzerland has been successful in balancing competing aims of each pillar, and this can be seen in the achievements of, et al, a great reduction in overdose deaths, reduction in HIV seroconversion rates, reduction of drug-related crime, and better overall health.

Swiss Drug Policy

Fifa Rahman
Acknowledgements

Special thanks to Erika Jüsi of the Arud Zentren für Suchtmedizin for her unbelievable hospitality during our study tour in Zürich.

Thank you to: Ambros Uchtenhagen, Thilo Beck, Martin Killias, Michael Herzig, Major Felix Lengweiler, Dr Adrian Kormann, Dr Herbert Bosshart, Jürg Kuhn, all staff at Arud, and everyone else who helped made this trip a success.
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Fifa Rahman
Drug Policy Liaison Officer, Malaysian AIDS Council
# Glossary

<table>
<thead>
<tr>
<th>Four pillars</th>
<th>Pillars of prevention, treatment, harm reduction and law enforcement that guide Swiss drug policy.</th>
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</thead>
<tbody>
<tr>
<td>HAT</td>
<td>Heroin Assisted Therapy</td>
</tr>
<tr>
<td>OMT</td>
<td>Opioid Maintenance Therapy, which includes methadone, morphine in its slow-release form, and other substitution opioids</td>
</tr>
</tbody>
</table>
Quotes

“Addiction is not a disease per se, but a secondary disorder involving complex emotional and behavioural changes stemming from social issues and/or psychiatric illness.”

~Herbert Bosshart, Psychiatrist, Arud OMT Outpatient Centre

“There are many socially-integrated users who do not attract police attention.”

~Major Felix Lengweiler, Police Department of Zurich

“The drop in crime was immediate, important, and lasting.”

~Professor Martin Killias, Professor of Criminal Law and Member of the Federal Commission on Drugs

Executive Summary

Switzerland’s drug policy is characterized by its four pillar approach to drug policy – an approach balancing aims of prevention, treatment, harm reduction and law enforcement. The success of this approach is evident in the elimination of open drug scenes, reductions in HIV seroconversion rates, drug-related crimes, drug-related deaths, and better overall health. From 19-25th February 2012, MAC with funding by the Open Society Institute participated in a study tour to Zurich, Switzerland, to learn more about Swiss drug policy and observe operations of various treatment centres in an effort to propose particular elements of evidence-based drug policy to the government. This reports details discussions of individual meetings, highlights how each party views Swiss drug policy, and reports success rates of such an approach. The recommendations in this report are based on meetings and interviews with persons who work on different aspects of Zurich drug policy and observations from a visit to the Stampfenbach HAT treatment centre, and the Aussersihl OMT treatment centre.
Purpose of Visit

The purpose of the study tour to Zurich, Switzerland was to examine evidence-based drug policy, and to analyse whether elements of their drug policy, in whole or in part, can be adopted into existing Malaysian drug policy, in particular the wide practice of voluntary treatment centers and referrals, no incarceration for drug consumption, heroin assisted treatment, and integrated referral systems. The study tour consisted of seven meetings over the course of two days, the details of which can be found on Page 5 of this report.

Background: Malaysian Drug Policy

For almost sixty years, Malaysia has practised punitive and prohibitive drug policy which has included caning for drug use and trafficking, jail sentences and compulsory ‘rehabilitation’, presumed trafficking above a certain threshold quantity, and the mandatory death penalty for trafficking offences. Similar to most countries practising the tough ‘War on Drugs’ approach, Malaysia continually exhibited signs of worsening public health conditions, increasing drug use, and increased drug-related crime. However, in the past ten years there has been a policy shift towards harm reduction due to epidemic levels of HIV infection, predominantly among injecting drug users. With the introduction of, et al, needle-and-syringe exchange programs, methadone maintenance therapy, and treatment for comorbidities, persons who use drugs and persons who are chemically dependent on drugs are increasingly being recognized as patients as opposed to criminals.

This movement has been spearheaded by ‘scientists, health practitioners, drug users, policymakers, and law enforcement officials’ worldwide.

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1 Adeeba Kamarulzaman, ‘Impact of HIV Prevention Programs on Drug Users in Malaysia’ (2009) 52(1) Journal of Acquired Immune Deficiency Syndromes S17 at S18
2 Harm reduction is an ideology that seeks to reduce harms related to drug use, and accepts that drug use will always exist.
Swiss drug policy is characterized by a four-pillar approach i.e. Prevention, Treatment, Harm Reduction, and Law Enforcement, balancing needs and roles of voluntary treatment centres, public security concerns, and harm reduction services. Below is a summary of key features of each pillar:

| Prevention: | Healthy Schools programs, Health promotion in prisons, etc. |
| Treatment: | Outpatient centres providing OMT, HAT, maternal health, general health and psychiatric services, National programs for continued training of professionals. |
| Harm Reduction: | Supervised injection sites, drop-in/contact centres, outreach workers, needle and syringe distribution centres. |
| Law Enforcement: | Local police focus on penalizing drug use in public, public security, zero tolerance for open drug scenes, but do not arrest for drug use in private. Cantonal and Federal police focus on drug policy. |

Swiss four-pillar policy has been proven to result in great regressions of heroin and cocaine use, improvement in individuals’ fitness to work, improvement in physical health, and reduction in crime.\(^4\)

A key feature of the Treatment pillar, aside from treatment centres having services for multiple comorbidities and general health treatments, is Heroin Assisted Therapy (HAT), a therapy for which the main pharmacotherapy agent is heroin. Benedikt Fischer et al. comment that the public health problem resulting from punitive drug policy is reduced by ‘attracting new illicit opiates users into therapy as well as by offering an alternative treatment for users who have failed in conventional treatment modes.’\(^5\)

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### Study Tour Itinerary

#### Thursday, 23\(^{rd}\) February 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>13:00pm - 15:00pm</td>
<td><strong>Arud Outpatient Centre Aussersihl (OMT)</strong>&lt;br&gt;Sihllahenstrasse 30/Schöneggstrasse 23, Zurich&lt;br&gt;Main objective: Visit of one of the first low threshold methadone substitution clinics in Zurich</td>
</tr>
<tr>
<td>15:30pm - 16:30pm</td>
<td><strong>Adrian Kormann, Head Physician,</strong>&lt;br&gt;<strong>Arud Outpatient Centre Stampfenbach</strong> (HAT)&lt;br&gt;Address: Stampfenbachstrasse 106, Zurich&lt;br&gt;Main objective: Visit of one of the first heroin-assisted treatment centres in Zurich</td>
</tr>
<tr>
<td>17:00pm - 19:00pm</td>
<td><strong>Michael Herzig, Head of Addiction and Drugs Division,</strong>&lt;br&gt;<strong>Social Services Department of Zurich</strong>&lt;br&gt;Address: Werdstrasse 75, Zurich&lt;br&gt;Main objective: Drug Policy of Zurich, visit one of the “shooting galleries” (safe consumer rooms for intravenous, oral or nasal application)</td>
</tr>
</tbody>
</table>

#### Friday, 24\(^{th}\) February 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00am - 10:30am</td>
<td><strong>Felix Lengweiler, Head of High Crime Areas Division,</strong> Police Department of Zurich&lt;br&gt;Room 333, Amtshaus 1, Bahnhofquai 3, Zurich,&lt;br&gt;Main objective: Zurich Drug Strategy - The Role of the Police</td>
</tr>
<tr>
<td>11:00am - 12:00pm</td>
<td><strong>Martin Killias, Professor of Criminal Law and Member of the Federal Commission on Drugs</strong>&lt;br&gt;Address: Room H-0181, Rämistrasse 74, Zurich&lt;br&gt;Main Objective: “Opiate Substitution Therapy as a Way to Reduce Street Crime”</td>
</tr>
<tr>
<td>14:00pm - 15:00pm</td>
<td><strong>Ambros Uchtenhagen, Chairman of the Board at ISGF</strong>&lt;br&gt;(Research Institute for Public Health and Addiction – WHO Collaboration Centre at Zurich University), Member of WHO Expert Panel on Drugs,&lt;br&gt;Address: ISGF (2nd floor), Konradstrasse 32, Zurich&lt;br&gt;Contact on location: Erika Jüsi (Arud, ground floor)&lt;br&gt;+41 76 567 22 65&lt;br&gt;Main Objective: Swiss Drug Policy – Implementation and Main Effects</td>
</tr>
<tr>
<td>15:30pm - 16:00pm</td>
<td><strong>Review of the afternoon with Thilo Beck (Head of Psychiatry, Arud)</strong>&lt;br&gt;Address: Arud (ground floor) Konradstrasse 32, Zurich</td>
</tr>
</tbody>
</table>
Individual Meeting Summaries: Lessons Learned and Policy Concerns

Meeting No. 1 (23rd February 2012): Dr Herbert Bosshart, Psychiatrist, Arud Opioid Maintenance Therapy (OMT) Outpatient Centre, Aussersihl

The Aussersihl Outpatient Centre began operations in 1991. At time of writing, the centre had 4 full-time psychiatrists, 8 psychologists, 89 therapeutic staff, 13 physicians (7 of which were physicians for internal medicine), and 5 social workers. Since 1992 up to the time of writing, the Aussersihl centre has received 4100 patients.

Bosshart stated that the key philosophy of the centre is that ‘addiction is not a disease per se, but a secondary disorder involving complex emotional and behavioural changes stemming from social issues and/or psychiatric illness.’

OMT is the primary form of therapy given out at Aussersihl, although patients can also access antiretroviral treatment, psychotherapy, see an in-house general practitioner, and see social workers. 92 percent of Aussersihl patients are funded by private insurance. According to Bosshart, OMT offers many new avenues for an individual to return to society, while keeping in mind that addiction is a chronic and relapsing disorder. He reiterated that substance use is a ‘dysfunctional coping strategy for psychological stress or psychiatric disorders.’ In addition to that, OMT has been proven to decrease criminality. There is a clear objective of maintaining the therapeutic dose for as long as the patient needs it.

The in-house GP also provides contraception free-of-charge and antenatal care for pregnant patients. Bosshart described the centre as having state-of-the-art treatment the full spectrum of psychiatric disorders, in particular attention deficit disorders and personality disorders.

Bosshart described the Aussersihl centre as being highly accessible, which is shown in the fact that it is a walk-in clinic, i.e. that there are no appointments system to ensure maximum accessibility. Having a formal appointments system, in his experience, reduces patient attendance and adherence to therapeutic interventions. In terms of requirements for admission, an opioid positive urine sample is sufficient for admission.

A member of our team enquired as to the average time period an individual is kept on methadone maintenance. In Malaysia, patients can only receive free methadone for 3 years. After that, he is required to purchase it. In response to this enquiry, Dr Bosshart said that every patient is different. Some individuals require methadone for weeks, whereas others have been on methadone for 20 years or longer. However, most patients remain on methadone for years. Those who discontinue their treatment often relapse relapse and, after a while, return to the treatment centre. The rationale for this enquiry may have been rooted in the mistaken notion in Malaysia that each individual can receive methadone for a state-determined period of time. At present in Malaysia, methadone is provided free by the state for a maximum of three years.
In response to an enquiry about who makes the decision about the particular type of substitution/therapy prescribed to the patient, i.e. whether the patient is to take methadone, buprenorphine, or morphine in its sustained release formulation. Dr Bosshart responded that at Aussersihl, the decision as to the substance is made both by the physician and the patient. Either way, the patient can be given OMT immediately after registration. This is to ensure that patients are not lost from treatment, which frequently happens if patients need to come back the following day for enrolment into the program.

We were then given a tour of the facilities.

The picture shows the methadone counter at the Aussersihl Outpatient Centre. On the right are flavoured cordials to mix with the methadone, to make it more palatable. On the left are six holes through which patients may deposit their used cups.

The picture on the left shows methadone bottles beneath the counter. The Aussersihl centre uses a computerized system that measures the dosage needed automatically based on the patient name in the database. The methadone from the bottles is pumped out and deposited in the cups in the picture on the right.
The pictures both show treatment and diagnosis rooms in the Aussersihl centre. The picture on the right shows ultrasound equipment; and the picture on the left is the GPs office.

Meeting No. 2 (23rd February 2012): Dr Adrian Kormann, Psychiatrist and Doctor for Internal Medicine, Arud Heroin Assisted Therapy (HAT) Outpatient Centre, Stampfenbach

Dr Adrian Kormann is the head of the Arud Outpatient Centre at Stampfenbach, a centre which practices heroin assisted therapy as its main method of substitution.

In this meeting, Dr Kormann described the main reason for the establishment of the centre, i.e. that not all patients are sufficiently substituted with only methadone. The Stampfenbach centre was founded in 1993, and has treated 700 people from 1994 to early 2012. Although heroin assisted therapy is the main service provided at the centre, patients can also access psychiatric treatment, social services, and general health services. At the time of writing, he described the centre as having 2 full-time psychiatrists, 2 general practitioners/physicians for internal medicine, 2 social workers, 5 administrative employees and 15 front desk staff. He stated that the reason for the large amount of personnel is because the effects of heroin do not last very long, and for that reason more personnel is needed to attend to the needs of the patients.

He then went on to describe the historical reasons for the change of policy in Zurich. He stated that in Zurich, there are 385,000 inhabitants, with 30,000 known persons with problematic consumption of heroin in the whole of Switzerland, and an estimated fourth of that number in Zurich. 17,000 of these persons are in therapy Swiss-wide. 1400 are receiving heroin assisted treatment. He described the open drug scene in Zurich at the height of its public health disaster, an incident that seemed wholly focused in a park in Zurich called the Platzspitz, where persons openly injected heroin.
He then described the adoption of the four pillars strategy, i.e. prevention, treatment, harm reduction and law enforcement, and stated that the strategy has resulted in the improvement of both physical and psychiatric health, as well as a large reduction of homelessness.

Heroin assisted therapy is a therapy which has been proven to work well with patients who have a history of heavy heroin use, and who have failed other substitution therapies. The Stampfenbach centre practices the following admission criteria: that the person is 18 years old or older, has been addicted to heroin for at least 2 years, and has 2 failed treatment attempts. Dr Kormann commented that in Zurich, it is cheaper for society to integrate addicted people into heroin assisted therapy than it is for him to be in jail.

Dr Kormann then described the aims of heroin assisted therapy at Stampfenbach, i.e. the aim of a **guarantee of survival**. He added that abstinence is an option if brought up by patients, although this aim is never forced upon patients by staff at the centre. He stated that approximately 1 percent of patients a year achieve abstinence.

The Stampfenbach centre has long opening hours, and ensures that patients are treated as human beings and not as ‘junkies’. Patients are not allowed to take prescribed injectable heroin home, to avoid the chance of that heroin being sold on the street. Oral heroin in tablet form, however, is allowed to be taken home for patients who have reached some stability. The centre also ensures that there are no changes of therapists throughout the treatment period, which ensures patients’ trust remains, and also not to disrupt any existing therapeutic relationships. 34 percent of the patients at the centre receive oral heroin, and these are patients who are heavily addicted, but have never injected prior to treatment, but instead consumed by ‘chasing’. Dr Kormann stated that 30 percent of his patients were in stable employment, and patients had access to social workers, and organisations who deal with family welfare.

In regard to patients who are given injectable heroin, the procedures are as follows: patients can have a maximum of 8 injections per day, or a maximum of 1600 milligrams per day, whereas patients receiving oral heroin can receive a maximum of 3 applications per day (or a maximum of 1800 milligrams per day).

Dr Kormann described how some patients no longer had functional veins, so physicians at Stampfenbach are allowed to teach them how to inject directly into the muscles. Post-injection, the patients give the needles-and-syringes back to the doctor, to ensure equipment is not shared. He then stated that the average age of patients at Stampfenbach as being 40 years old, so it is natural that they have many other comorbidities. 80 percent of patients there had a psychiatric diagnosis, and 47 percent have personality disorders. Many patients are also polysubstance users, but this does not exclude him from being accepted as a patient at Stampfenbach.

A member of our team enquired as to the source of prescribed heroin. Dr Kormann responded that heroin is imported from countries having licenses to grow poppies and produce heroin legally, which are generally countries having the optimum climate for growth and having good governance, i.e. France, Spain, Australia and Turkey. The heroin used in the Stampfenbach centre is heroin produced in the United Kingdom (intravenous heroin) and Switzerland (tablet heroin) from plant material cultivated in Australia. The heroin is delivered to Stampfenbach in protected trucks.
Legal heroin for use in treatment is called Diaphin, and appears as a white, sticky-looking paste.

The room containing the medicine cabinet in the Stampfenbach centre is locked at all times, and contains medicines ranging from antiretrovirals to naloxone to anti-psychotics. At the bottom left, you can see a medicine called Fragmin which is used to treat pulmonary embolisms, and at top left there is a medicine called Co-Amoxi-Mepha, which is used to treat bacterial infections. This picture shows that the centre is well-equipped to treat multiple comorbidities.
Meeting No. 3 (23rd February 2012): Michael Herzig, Head of Addiction and Drugs Division, Social Services Department of Zurich, Werdstrasse 75

Michael Herzig is the Head of Addiction and Drugs at the Social Services Department of Zurich, which operates a drop-in or ‘contact’ centre which includes drug injection and smoking facilities within. He explained that in 1994, when the centres were first established, there were 16,000 injections per day, whereas now there are only 1500 injections per day, showing the success of Zurich drug policy as a whole.

Herzig explained that the social services department of Zurich provides substitution programs, outreach work, security intervention, and youth counseling, the primary purpose of which is social integration of persons who use drugs. Clients of these services are persons considered to be ‘threatened with social exclusion’. Also within this centre are services to assist with the restructuring of individual debt.
The contact centre in Werdstrasse receives about 70 clients per day, who cook for themselves. Herzig explained that all drugs consumed within the facilities are illegal, and the contact centre does not at any time provide drugs. The contact centre merely ensures that clean injection equipment is used. A nurse is on standby in injection rooms in case of overdose, and is authorized to administer oxygen to patients. The centre maintains a strict policy of no dealers in the institution. Herzig went on to say that Zurich police work together with the Social Services Department in this regard because it is known that this system is better for the system as a whole.

Outreach workers are uniformed and do social work, maintain public order, crisis intervention, conflict mediation, and brief counseling. Herzig stated that this may include calling parents of the intoxicated person and saying: ‘Your daughter is drunk, please come and get her.’ Outreach workers are not authorized to hand out fines for marijuana consumption; the police however, are. Outreach workers also do party drug prevention and drug checking in entertainment facilities. The Social Services Department as a whole also conducts counseling for women, deals with violence in street prostitution services, and cares for clients with multiple dependencies.

The Social Services Department also has regular meetings with neighbourhood councils and residents of neighbourhoods to ensure compatibility with the Department’s programs and to hear neighbours’ concerns. Herzig explained that there is a huge focus on residents because they are the ones that communicate with politicians.

The above two pictures are from the contact centre at Werdstrasse. The picture on the left shows a phone directory containing contact numbers for, et al, heroin assisted treatment centres, psychiatrists, opioid substitution therapy centres, welfare services, employment services, and housing services. The picture on the right shows the seat within the injection room where the nurse sits, and beyond the glass is the smoking room. There is no nurse in the smoking room.
Meeting No. 4 (24th February 2012): Major Felix Lengweiler, Head of High Crime Areas Division, Police Department of Zurich

Major Felix Lengweiler is the head of the High Crime Areas Division of the Police Department of Zurich, a law enforcement body which understands harm reduction and treatment objectives, and hence focuses its efforts on public security.

Major Lengweiler explained that in Switzerland, there are three police bodies that concentrate on different parts of drug policy; the Federal police, the Cantonal police, and the local level police i.e. the Stadtspolizei. The Federal police focus mainly on international drug trafficking into Switzerland, whereas Cantonal police deal with drug trafficking outside city borders, and Stadtspolizei concentrate on local public security and safety issues arising out of public drug consumption. Lengweiler went on to say that narcotics detectives within the Stadtspolizei carry out these functions, and that there is much police interagency cooperation.

Penalties for drug use and possession can range from CHF 150-300 (USD$ 165-330) up to a maximum of CHF 50,000 (USD$ 54981). Police do not have the power to arrest the user, and the prosecutor can waive the charge if the use or possession is regarded as insignificant. However, possession of more than 18g of cocaine or 12g of pure heroin can attract a prison sentence of up to twenty years.

Lengweiler stated that the four pillar strategy is ‘fully supported’ by police, and the support began immediately as a result of the human tragedy in the Platzspitz. Jürg Kuhn, a police officer who also attended the meeting, stated that the open drug scene in the Platzspitz ‘left a deep mark’. Kuhn stated that motivation among police officers was not very high as they knew it wasn’t working and they knew politicians had to do something. He continued and said, ‘It’s an illusion that we can have a drug-free city.’

Lengweiler then continued with his presentation, stating that the Stadtspolizei conducts proactive, problem-oriented policing in high crime areas – but the focus is on drug use in public, and not drug use in private. Occasionally, however, police carry out random stop-and-searches in hotspot areas. Lengweiler commented that Swiss drug policy has resulted in heroin becoming less attractive to use, and that there are many socially-integrated users who do not attract police attention.

Police generally do not enter supervised injection sites, to ensure that individuals are not discouraged from frequenting them, but plainclothes detectives may enter to search for wanted persons. They also attend at supervised injection sites if employees of the supervised injection sites require help.

In response to my question as to whether he viewed seizures had effects on use, Lengweiler responded that he views that seizures have very little impact upon use.
Meeting No. 5 (24th February 2012): Martin Killias, Professor of Criminal Law and Member of the Federal Commission on Drugs

Professor Martin Killias, as a Professor of Criminal Law at the University of Zurich, provided a detailed description of the effects of Switzerland’s four pillar drug strategy on crime in Zurich. He stated that needle-and-syringe distribution programs began first during the introduction to harm reduction, and the drop in crime was ‘immediate, important, and lasting.’

He went on to display statistics showing that pickpocketing and burglary rates dropped by 100 percent, and street robberies and muggings dropped by 85 percent. He also stated that heroin assisted therapy was a big factor in the reduction of these rates, as heroin reduces delinquency more than methadone. The likely reason for this, he commented, was the fact that persons on methadone are likely to want other drugs too.

Meeting No. 6 (24th February 2012): Ambros Uchtenhagen, Chairman of the Board at ISGF (Research Institute for Public Health and Addiction – WHO Collaboration Centre at Zurich University), Member of WHO Expert Panel on Drugs

Ambros Uchtenhagen, Chairman of the Board at the Research Institute for Public Health and Addiction, and certainly a legend in his own right, provided an overall description of progression of drug policy in Switzerland and key elements of each of the four pillars.

He described how in 1980-1990, Switzerland had the highest seropositivity conversion rate in Europe. Switzerland decided to adopt a four pillar strategy as a result from the public health emergency, the four pillars being: prevention, treatment, harm reduction and law enforcement.
Uchtenhagen described the Prevention pillar in detail, speaking about a program called National Prevention Healthy Schools, which integrated information about drug use in school teaching, and also speaking about health promotion in prisons. The Treatment pillar was also comprehensive, in that there is an emphasis on making methadone and psychiatric services available in all treatment centres, implementation of quality standards, and a national program for continued education of professionals.

The Law Enforcement pillar was described as having zero tolerance for open drug scenes. Uchtenhagen went on to say that the efficient exercise of these four pillars has resulted in a reduction of new heroin use down to one-fifth the use prior to the four pillars policy.6

In response to an enquiry by the Malaysian AIDS Council president on his opinions on the cannabis legalisation movement in the United States, Uchtenhagen stated that he disapproved of the policy, as it is proven that cannabis can alter the psychopathology of certain persons.

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Commentary and Concerns by Members of our Delegation

Tan Sri Mohd. Zaman Khan, President of the Malaysian AIDS Council

Having visited Lisbon, Berlin and Zurich I have no doubt in my mind; with the hindsight of some 35 years of enforcement, irrespective of what drove them into misusing drugs, people who use drugs must be recognised as sick people who need scientifically researched treatments similar to that given other patients such as diabetics; only that they are more complicated and serious.

The facilities provided, especially at Zurich is the most comprehensive and co-ordinated that I have seen thus far. It is a one stop service with all the state of the arts equipment and expertise. They have qualified human resources and the funding.

In all three places we learnt that drug offenses such as consumption and possession of a certain fixed amount for personal use either have been decriminalised or had sanctions alternative to incarceration. In Lisbon possession of 1 gram of cocaine for personal use for 10 days whilst it is an offense will not be punished through court procedures and the police would pushed the case to a Dissuasion Commission. In Zurich those who cannot do without heroin may undergo heroin assisted therapy at the clinic. Some individuals may have obtained the drug from the pushers but consume in private places, and the police leave them alone. There is no practice of invasion of privacy into private homes to raid for illicit drug use. This helps to create a favourable environment for Harm Reduction activities. Malaysia has adopted the NSEP. However, the DU has to look for the drug on his own and this forced him to go underground and in many cases they would crime to get the money to buy the drug. We should adopt the Policy as practiced by Zurich and Berlin.

Recommendation

I feel that the AADK is on the right track with its open door concept and its Care and Cure Clinics. It is appreciated that qualified and trained human resources is a scarce commodity at the moment. However, with foresight and planning and with injection of more funding and more humane drug policy Malaysia will be able to blunt the HIV/AIDS epidemic and related diseases.

ACP Jamaludin Kudin, Narcotic Crimes Investigation Department, Royal Malaysia Police

From the Malaysian perspective, it is difficult to condone the use of heroin in treatment because in my view, the majority of the public disagree with those policies. In addition to that, NGOs in Malaysia depend too much on government grants to run their activities. Furthermore, Malaysia does not have laws requiring persons to have health insurance, and even if persons have private health insurance, addiction therapy is not covered.

Izhar bin Abu Talib and Suhaimi bin Abdullah, National Anti-Drug Agency

19 | Swiss Drug Policy
The study visit has given us broad exposure on treatment and rehabilitation particularly in the “Harm Reduction” programme. Other treatment methods (other than methadone, Suboxone & Buprenorphine) can be discussed further to suit the recovery needs of our Malaysian addicts. Nonetheless, experts are crucial in implementing the necessary programme.

Zurich has shown positive views on providing addicts with a specific facility to use drugs in a controlled environment. This method has reduced the number of addicts using drugs in public places which had led to positive acceptance in the community. This approach, to take place in Malaysia, requires studies/research multi prospects such as the law, constitution and politics and probably best done by NGOs.

Professionals such as social workers, psychologists, psychiatrists and other medical professionals play significant role in treating addicts in visited countries. The collective approaches of different professional skills will help addicts to be treated as patients (individual under medical care) and able to be treated for improved health, social well-being and quality of life as a whole.

There is an urgent need for government or intergovernmental organization officials to recognize the best practice or any potential approaches which are to their best knowledge. We would recommend that the treatment and rehabilitation approaches implemented in both countries to be adapted and whichever best to suit Malaysian culture.

_Gunasegaran Suppiah, Malaysian AIDS Council_

Guna tragically passed away on 23rd March 2012 prior to the completion of this report, but prior to his death, informed Fifa Rahman of his positive views on heroin assisted therapy, and mentioned to her that he would write about the efficacy of HAT in this report. He was also amazed at how services within treatment centres were comprehensive, and included access to psychiatrists and social workers.

_Fifa Rahman, Malaysian AIDS Council_

The key take away point for me was that each centre had a psychiatrist specialising in addiction, and that multidisciplinary services worked synergistically to address conditions of each patient. Psychiatric services, social services, opioid substitution therapy, maternal health services, HIV treatment etcetera were all accessible within each treatment centre, which maximises the ability of an individual to address multiple factors for his dependence on drugs, and to reduce harms caused by his drug use.

Malaysia must, in my view, take efforts to increase integration, efficiency, and skill set of each worker within a treatment centre. Social workers must be aware that persons who are dependent on drugs often have health problems, housing problems, employment problems, and/or psychiatric comorbidity, all of which must be addressed. Physicians and social workers alike must be able to design treatment plans for each individual and must be prepared to engage the patient
in terms of asking what that patient would like to try. Most importantly, we must begin to invest in the training of addiction psychiatrists.

I am also of the view that similarly to Zurich, addiction treatment should be covered under private health insurance, and any proposed state-imposed public insurance in the future.

Finally, I cannot say enough about the fact that heroin assisted therapy is needed to help those who have used heroin for long periods and simply cannot take methadone. HAT, along with other services provided at the treatment centre has been proven to reduce crime, increase employment rates and increase general health.

**Recommendations**

- Integrated services within treatment centres, meaning that each centre to have physicians for internal medicine, social workers skilled in addiction and comorbidities, nurses and psychiatrists.
- Training of social workers with specialised addiction syllabi, or integration of units on addiction in existing undergraduate and postgraduate courses.
- A review by AADK and Ministry of Health of viability of heroin assisted therapy in Malaysia.
- An examination of viability of safe injection facilities that keep drug users of the streets and increase the chances of persons who inject drugs coming into contact with health professionals.
- The inclusion of addiction treatment in future public health insurance plans.
- The removal of the 3-year time restriction for state-provided methadone.