

# Heroin-assisted treatment in Switzerland

## Results of 2015 survey

Damian Hildebrand

Michelle Dey

Elena Mayorova

Heidi Bolliger

Michael Schaub

**ISGF Report No. 366**

March 2016

# Table of Contents

<b>Introduction</b> .....	3
1. Overview of patient population.....	3
2. Progression of patient population .....	4
3. Treatment history .....	6
4. Socio-demographic data .....	8
5. Substance use .....	12
6. Reasons for discharge.....	14
7. Hepatitis and HIV .....	15
7.1 Hepatitis A.....	16
7.2 Hepatitis B.....	16
7.3 Hepatitis C.....	18
7.4 HIV.....	18
8. Psychiatric disorders.....	19

# Introduction

This report presents the results of the 2015 survey on heroin-assisted treatment monitoring in Switzerland. Heroin-assisted treatment (HAT) has been monitored since 2001. Monitoring is embedded in the current Narcotics Act, the Ordinance on Narcotics Addiction as well as the Ordinance on the Conduct of Federal Statistical Surveys. HAT facilities are therefore obligated to participate in monitoring (i.e. collecting data on clients and delivering data to the Swiss Research Institute for Public Health and Addiction ISGF).

As part of the monitoring, socio-demographic data of each admitted client are recorded along with their treatment history, drug use habits and their health. When clients are discharged from HAT, besides repeating the central questions from the entry questionnaire, the reasons for discharge and the clients' psychiatric diagnoses are also recorded.

For chapter 2 (progression of patient population), longitudinal comparisons in this report go back as far as the HAT test phase in 1994. Chapters 3, 4 and 8 (treatment history, socio-demographic data, and psychiatric disorders on discharge) present longitudinal data as from 2005. Chapters 5, 6 and 7 (substance use, reasons for discharge, and hepatitis and HIV), meanwhile, go back to 2001. Longitudinal data reported here should be interpreted with caution, as they may be affected by methodological changes due to questionnaire revisions in 2005 and 2013. If and where that assumption is likely, this is indicated in the appropriate place in the report. Regarding comparability of results over the years, it should also be noted that the HAT database is constantly being updated, for example by adding late-arriving client data. Data are also continually adjusted (e.g. subsequently reported discharges or deaths are recorded in the database). As a result, minor deviations in the number of evaluated cases may occur compared with earlier annual reports, resulting in corresponding minor deviations in the results.

## 1. Overview of patient population

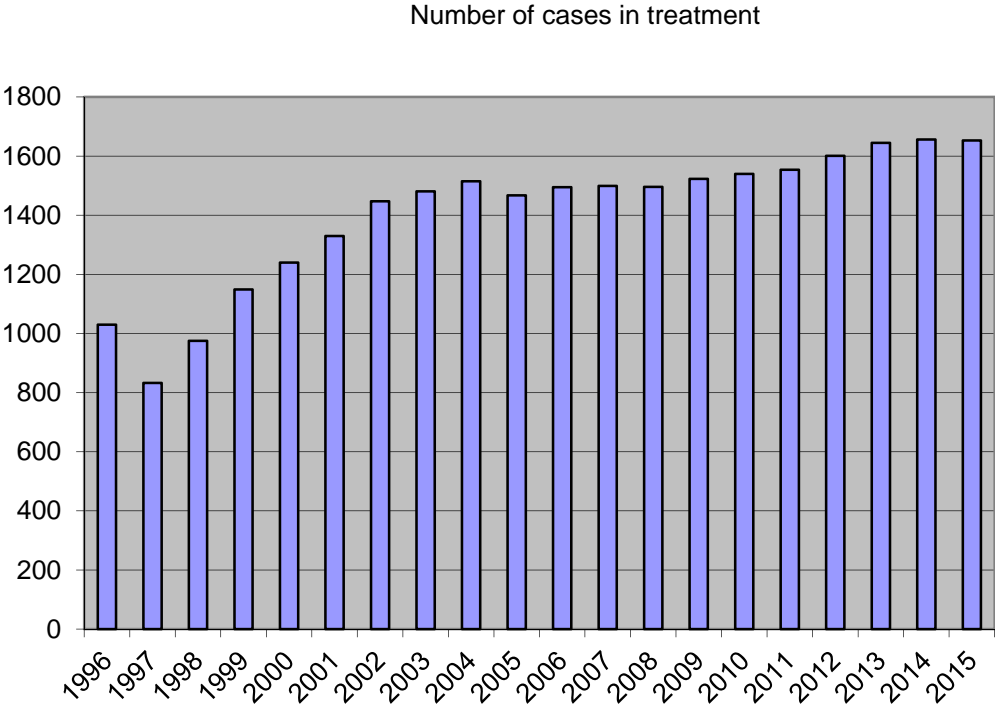
156 admissions and 145 discharges were recorded for the year 2015. Admissions consisted of 101 first-time admissions (56.8%), 24 readmissions to the same facility (28.4%) and 12 admissions due to a transfer (8.4%) from another HAT centre (whereby there may or may not have been a hiatus in connection with this transfer). In eight cases (5.1%), the nature of readmission was unknown. In 11 cases (7.1%), it was not specified whether the patient had been admitted to HAT for the first time or had undergone treatment before.

Of the 1644 cases undergoing heroin-assisted treatment according to the 2015 monitoring database, 741 persons (45.1%) were aged 45–54, 513 (31.2%) were 35–44 years old, 228 (13.9%) were 25–34 years old, and 146 (8.9%) were 55 or older. 16 persons (1%) were younger than 25. The average age of *all* HAT clients undergoing treatment in 2015 was 46 (standard deviation: SD = 7.80), with the median being 47 years and a range from 20 to 78 years. The average age of *first-time* admissions was 38 years (range: 21–57 years). The majority of first-time admissions were men ( $n = 127$ ; 81.9%). The proportion of women was thus 18.1% ( $n = 28$ ). One person's gender was not known.

All information in this report refers to those HAT clients who between 1 January and 31 December 2015 received heroin as part of heroin-assisted treatment for the first time (first-time admissions) or were discharged during this period and whose completed questionnaires reached ISGF no later than 26 January 2016. According to FOPH data, at the end of 2015, 1531 HAT places were approved throughout Switzerland, and 1381 were occupied.

## 2. Progression of patient population

From the start of heroin-assisted treatment in 1994 until 1996, the number of patients undergoing heroin-assisted treatment rose to around 1000. Due to the 1997 moratorium, the number decreased somewhat but then rose again steadily to just under 1500 persons in 2002. From 2008 to 2013, a slight increase in the number of patients is noticeable (figure 1), but this may also have been influenced by occasional non-recorded discharges. The number of patients in 2015 has remained similar to that of previous years.



**Figure 1.** Progression in the number of patients undergoing heroin-assisted treatment. Persons who were discharged and then readmitted in the same year were counted as two cases.

Figure 2 shows the age distribution of HAT patients between 1995 and 2015. Whereas in 1995 78.0% of all HAT patients were under 35 years of age, that number is currently at just over 20.0%. In contrast, however, the proportion of patients aged 45 or over has risen continuously and is approximately 75% in 2015.

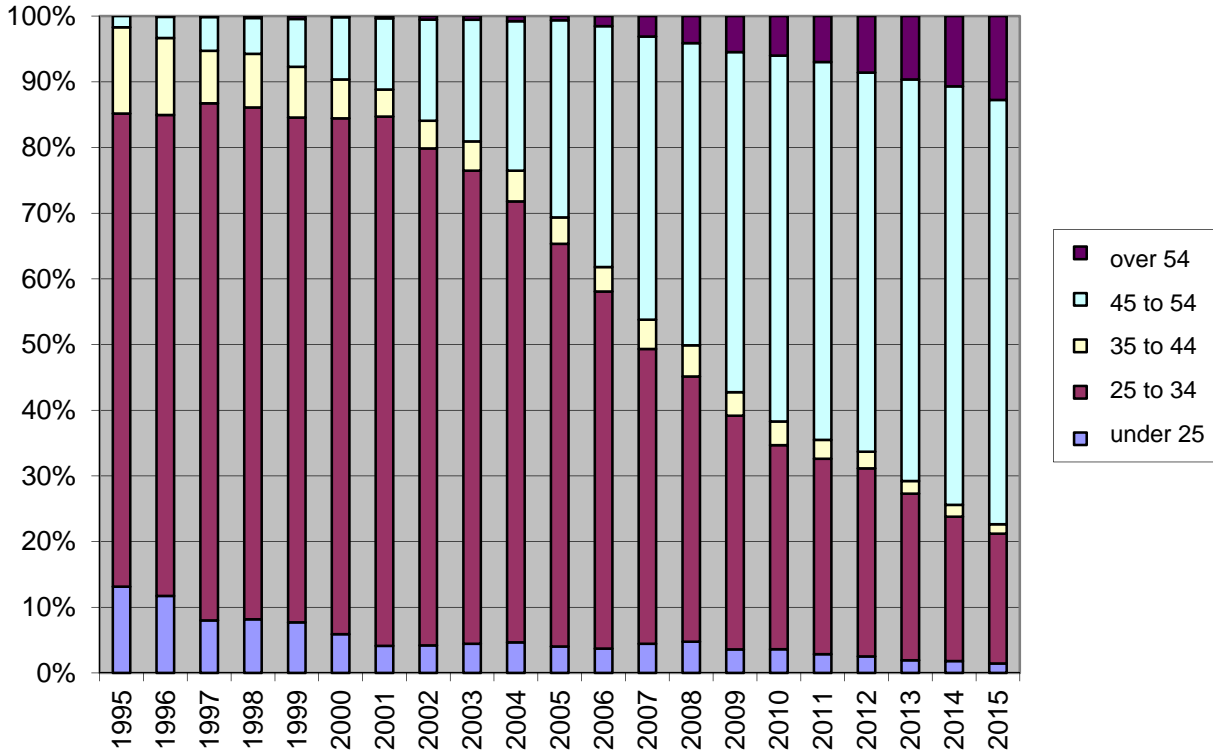


Figure 2. Age distribution of all HAT patients between 1995 and 2015.

The following graph shows the probability (Y axis) of a HAT patient remaining in treatment for at least a specific treatment duration (X axis). It illustrates, for example, that patients have a 0.4 (40.0%) probability of remaining in HAT for four years or longer. Patients have a 0.2 (20.0%) probability of remaining in treatment for at least 15 years.

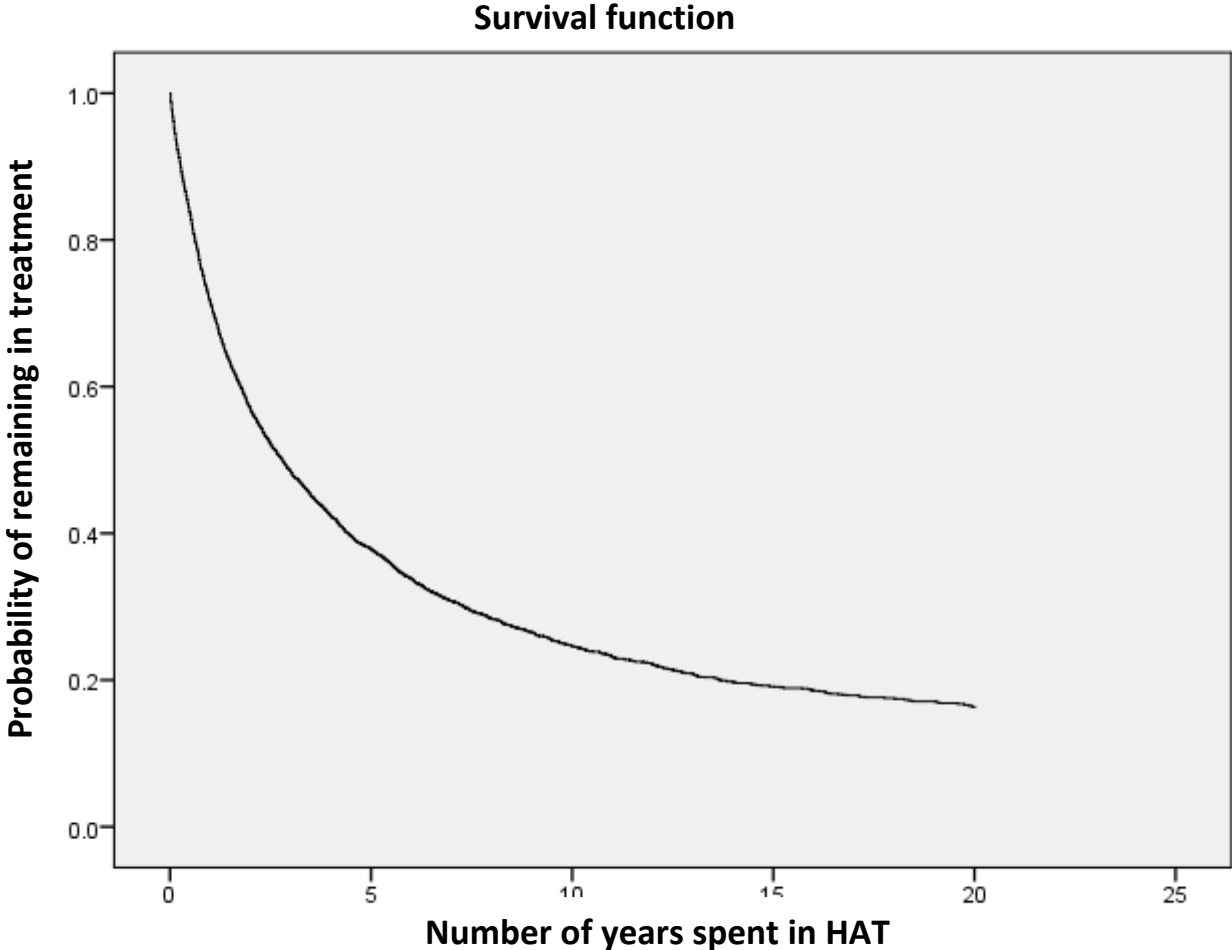


Figure 3. Probability of a patient remaining in HAT.

### 3. Treatment history

Almost all the persons newly admitted in 2015 indicated that they had previously undergone treatment as a result of drug problems ( $n^1 = 84$  out of 88, 95.5%), followed by treatments for medication-related problems ( $12/88 = 13.6\%$ ), alcohol problems ( $9/88 = 10.2\%$ ), addictive behaviour ( $4/88 = 4.5\%$ ) and tobacco use ( $2/88 = 2.3\%$ ). These figures do not differ significantly from those of the two previous years (see table 1).

<sup>1</sup> The number (n) indicates the number of persons in a subgroup (here: of all the persons newly entering treatment and who provided information about their history, 84 persons had previously undergone treatment due to drug problems).

**Table 1.** Treatment experience by substance (multiple answers possible). Valid data/missing data 2013–2014: 165/61; 2015: 88/13.

Earlier treatments	2013–2014		2015	
	n	%	n	%
Drug problems	153	92.7	84	95.5
Alcohol problems	23	13.9	9	10.2
Medication problems	29	17.6	12	13.6
Tobacco use	6	3.6	2	2.3
Addictive behaviour	11	6.7	4	4.5

Substitution treatments were named most frequently, as in previous years (table 2). As for the “Withdrawal” category, it should be noted that since 2013 respondents are only asked about professionally supervised withdrawals, whereas previously any types of withdrawals were taken into account.

**Table 2.** Treatment experience of first-time admissions to HAT (multiple answers possible). Valid data/missing data 2005–2008: 432/99; 2009–2012: 490/19; 2013–2014: 165/61; 2015: 83/18.

Earlier treatments	2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%
Substitution treatment	391	90.5	424	86.5	149	90.3	79	95.2
Inpatient treatment	230	53.2	252	51.4	88	53.3	36	43.4
Withdrawal	343	79.4	345	70.4	111	67.3	60	72.2
Other treatments	34	7.9	55	11.2	26	15.8	8	9.6

Regarding the HAT mediation conduit, 40.5% of new admissions in 2015 stated that no entity or specialist was involved but that they had entered treatment as a result of their own initiative, friends, employers or family. On the other hand, 20.2% of clients had been referred to HAT by a facility specialised in the treatment of addiction (table 3).

**Table 3.** HAT mediation conduits. Valid data/missing data 2013–2014: 165/61; 2015: 84/17.

Mediation conduit	2013–2014		2015	
	n	%	n	%
Conviction/measure/judicial authority/police	6	3.6	4	4.8
Medical practice	15	9.1	10	11.9
Other facility specialised in the treatment of addiction	29	17.6	17	20.2
Other healthcare, medical or social services	12	7.3	13	15.5
No professional entity or specialist involved	77	46.7	34	40.5
Other	26	15.7	6	7.1
Total	165	100	84	100

## 4. Socio-demographic data

Of the new admissions in 2015, 68 persons (76.4%) had Swiss nationality. This percentage is only negligibly lower than in previous years (2005–2008: 85.0%; 2009–2012: 79.7%; 2013–2014: 78.6%).

Almost four fifths of new admissions were single (n = 72, 80.9%), three people were married (3.4%), ten divorced (11.2%), and one person was widowed (1.1%).

41.2% of the persons who were admitted to HAT for the first time in 2015 were living on their own at the time of admission to treatment. Between 10% and 20% each lived with their family of origin or with their partner and/or with a child/children. Five persons (5.6%) lived with friends (shared accommodation); 24.7% had spent the 30 days prior to admission in custody, in a therapeutic setting or in hospital (table 4).



**Table 4.** Whom have you been living with in the past 30 days? Valid data/missing data 2000–2004: 735/335; 2005–2008: 427/109; 2009–2012: 468/49; 2013–2014: 165/61; 2015: 85/16.

Living: with whom?	2000–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Alone	371	50.5	171	40	194	41.5	73	44.2	35	41.2
With family of origin (parents, parent, etc.)	89	12.1	42	9.8	37	7.9	25	15.2	11	12.9
With partner and/or child/children (married, unmarried, single parent)	149	20.3	105	24.6	95	20.3	23	13.9	9	10.6
With friends or other persons (not related)	65	8.8	23	5.4	27	5.8	11	6.7	5	5.9
Other, including:	61	8.3	86	20.1	115	24.5	33	19.8	25	32.6
<i>In custody</i>	-	-	-	-	8	6.3	6	3.6	5	5.9
<i>In a treatment facility/home</i>	-	-	-	-	18	14.1	7	4.2	15	17.6
<i>In hospital/clinic</i>	-	-	-	-	3	2.3	8	4.8	1	1.2
Total	735	100	427	100	468	100	165	100	85	100

Of the persons newly admitted in 2015, 20 (22.5%) had at least one child. On admission, 62.4% had a stable housing situation (i.e. own apartment, own house, sublet); 10.6% of respondents referred to an unstable housing situation (on the street, hopping, emergency accommodation, hotel, B&B), and 27.1% referred to facilities (table 5).

**Table 5.** How have you been living over the past 30 days? First-time admissions. Valid data/missing data 2000–2004: 723/347; 2005–2008: 428/110; 2009–2012: 470/47; 2013–2014: 160/66; 2015: 85/16.

Housing situation	2000–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Stable housing situation	465	64.3	297	69.4	317	67.4	120	75.0	53	62.4
Unstable housing situation	169	23.4	50	11.7	63	13.4	19	11.9	9	10.6
Other facilities, including:	89	12.3	81	18.9	89	19.2	21	13.1	23	27.1
<i>Custody</i>	-	-	-	-	-	-	5	3.1	5	5.9
<i>In a treatment facility/home/hospital/clinic/other</i>	-	-	-	-	-	-	16	10.0	18	21.2
Total	723	100	428	100	470	100	160	100	85	100

Almost half the persons who were newly admitted in 2015 were living off social security benefits. One third received a pension (Old Age and Survivors Insurance [OASI]/Invalidity Insurance [IV]); 8.0% had an earned income (table 6).

**Table 6.** How have you supported yourself over the past 30 days? Valid data/missing data 2005–2008: 428/108; 2009–2012: 470/47; 2013–2014: 153/73; 2015: 87/14.

Livelihood	2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%
Earned income	50	11.7	63	13.4	20	13.1	7	8.0
Savings	3	0.7	7	1.5	1	0.7	1	1.1
Pension (OASI/IV)	95	22.2	103	21.9	31	20.3	29	33.3
Social security benefits/welfare	217	50.7	237	50.4	82	53.6	41	47.1
Unemployment insurance	14	3.3	12	2.6	6	3.9	2	2.3
Through partner	9	2.1	3	0.6	1	0.7	1	1.1
Through parents/family members/friends	10	2.3	11	2.3	1	0.7	2	2.3
Dealing/minor trafficking	8	1.9	10	2.1	5	3.3	1	1.1
Other illegal income	3	0.7	0	0.0	1	0.7	1	1.1
Prostitution	3	0.7	1	0.2	1	0.7	1	1.1
Daily allowance insurance	-	-	-	-	2	1.3	0	0.0
Other	16	3.7	23	5.0	2	1.3	1	1.1
Total	428	100	470	100	153	100	87	100

In 2015, 15.5% of all first-time admissions were employed (full- or part-time work or odd jobs). The majority were thus either unemployed (engaging in active job search or not; 53.6%) or else not active on the labour market (pensioner, incapacity to work, housewife/house husband; 28.6%) (table 7).

**Table 7.** What was your main employment status during the past 30 days? Valid data/missing data 2000–2004: 743/327; 2005–2008: 432/104; 2009–2012: 457/60; 2013–2014: 154/72; 2015: 84/17.

Employment status	2000–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Full-time work (over 70%)	73	9.8	49	11.3	54	11.8	18	11.7	8	9.5
Part-time work	25	3.4	35	8.1	33	7.2	7	4.5	2	2.4
Odd jobs	33	4.4	9	2.1	7	1.5	3	1.9	3	3.6
In training	2	0.3	3	0.7	3	0.7	-	-	-	-
Unemployed and actively engaged in job search	36	4.8	86	19.9	104	22.8	22	14.3	10	11.9
Unemployed and not actively engaged in job search	-	-	-	-	-	-	48	31.2	35	41.7
Not active on labour market (pensioner, housewife/house husband, OASI/IV) incl.:	373	50.2	214	49.5	161	35.2	44	28.5	24	28.6
<i>Pensioner (pension, OASI, savings)</i>	-	-	-	-	-	-	11	7.1	9	10.7
<i>Incapacity to work (IV/daily allowance)</i>	-	-	-	-	-	-	32	20.8	15	17.9
<i>Housewife/house husband</i>	-	-	-	-	-	-	1	0.6	0	0.0
Other	199	26.8	36	8.3	95	20.8	12	7.8	2	2.4
Total	743	100	432	100	457	100	154	100	84	100

## 5. Substance use

Table 8 shows the average number of days on which first-time HAT patients have used substances during the last 30 days prior to admission. For illicit heroin, the corresponding average figure in 2015 was just under 15 days, for example. Over half (51.5%) of first-time HAT admissions in 2015 stated that they had used illicit heroin on each of the last 30 days. On average, HAT clients used heroin for the first time at the age of 20.

Over one third (34.8%) of first-time HAT admissions in 2015 stated that they had taken methadone once in their lives. What is striking is the major decrease over the years in the average number of days during which methadone was consumed (table 8). This should, however, be interpreted as a methodological distortion rather than as an actual decrease in the use of methadone: in the version of the questionnaire used from 2013 on, respondents were asked to indicate their consumption of illicit (not medically prescribed) methadone; whereas in previous years they had been asked about the consumption of any methadone (i.e. prescribed and non-prescribed).

Almost two thirds (64.2%) of first-time admissions to heroin-assisted treatment in 2015 indicated that they had used hypnotic drugs or sedatives at some point in their lives, in addition to heroin. In the general population, (medically prescribed) hypnotic drugs and sedatives are usually taken by older people. In the case of first-time HAT admissions in 2015, however, no link can be found between consumption of these substances and age.

The average number of days on which alcohol was consumed in 2015 was similar to the preceding years 2013–2014 (table 8). Almost 40% of the clients who were admitted to HAT for the first time in 2015 reported that they had not consumed any alcohol in the past 30 days.

On the other hand, the number of days on which tobacco was smoked declined slightly over the years, which would suggest that proportion of non-smokers among first-time HAT admissions is higher than previously. At the same time, the average number of days when cannabis was used also decreased (table 8).

LSD or hallucinogenic drugs are not widely used by HAT clients; two and one person(s), respectively, reported that they had used LSD or hallucinogenic drugs on at least one day in the past 30 days before entering treatment. As illustrated in table 8, these substances were used on average for less than one day in the past 30 days prior to admission.

Over half (57.3%) of the clients among 2015 first-time admissions reported a disorder as a result of multiple substance use (according to ICD-10). All of them indicated that opioids were the problematic substance. They also mentioned cocaine or cocaine derivatives (64.7%), tobacco (52.3%), sleeping pills and sedatives (49.0%) and/or cannabis (35.3%) as additional problematic substances.

Almost four fifths (78.7%) of first-time admissions to HAT in 2015 indicated that they had taken an illegal substance intravenously before.

**Table 8.** Average use of different substances (number of days in the past 30 days before admission) among first-time HAT admissions for the years 2005–2015. Valid data/missing data 2005–2008: 428/110; 2009–2012: 470/47; 2013–2014: 165/61; 2015: 89/12.

<b>Substance</b>	<b>2005–2008</b>	<b>2009–2012</b>	<b>2013–2014</b>	<b>2015</b>
Alcohol	8.89	8.12	5.66	6.02
Heroin (illegal)	18.25	16.76	16.96	14.75
Methadone (illegal)	13.94	12.88	3.55	2.93
Buprenorphine (illegal)	-	0.00	0.00	0.06
Fentanyl (illegal)	-	0.00	0.00	0.00
Other opioids/opiates	0.34	0.92	0.83	0.92
Cocaine powder	5.97	5.35	5.34	4.19
Crack	0.82	0.55	1.15	1.35
Other types of cocaine	-	0.00	0.00	0.06
Amphetamines	0.02	0.09	0.03	0.03
Methamphetamine	-	0.00	0.17	0.34
MDMA and related substances (Ecstasy)	0.08	0.02	0.01	0.01
Synthetic cathinones	-	0.00	0.00	0.01
Other stimulants (such as non-indicated methylphenidate, modafinil or khat)	0.00	0.00	0.03	0.67
Barbiturates	0.10	0.31	0.08	0.01
Benzodiazepines (not indicated)	5.93	8.99	6.09	6.38
GHB/GBL	-	0.00	0.03	0.09
Other hypnotics and sedatives	1.31	0.74	0.30	1.09
LSD	0.07	0.16	0.01	0.02
Ketamine	-	0.00	0.00	0.01
Other hallucinogens, including mushrooms	0.00	0.06	0.00	0.54
Inhalants/volatile substances	0.00	0.00	0.00	0.00
Cannabinoids	8.06	7.26	5.63	3.30
Tobacco	25.30	23.99	17.07	10.79

## 6. Reasons for discharge

Reasons for discharge from heroin-assisted treatment are the same as 10 years ago. Over half of the persons were transferred to another addiction-specific centre in 2015 as well. Fewer deaths were recorded than in previous years but there were even fewer 10 years ago (table 9 and figure 4). In all, at least 188 HAT clients in heroin-assisted treatment since 2000 have died, including 13 in the year 2015.

**Table 9.** Reasons for discharge for years 2001–2014. Valid data/missing data 2000–2004: 844/343; 2005–2008: 617/134; 2009–2012: 545/61; 2013–2014: 254/72; 2015: 138/7.

Reason for discharge	2000–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Scheduled end of treatment without transfer to an addiction-specific centre	27	3.2	35	5.7	26	5.1	2	0.8	19	13.8
Scheduled end of treatment with transfer to an addiction-specific centre	400	47.4	260	42.1	288	52.8	141	55.5	68	49.3
Hospitalisation	19	2.3	17	2.8	10	1.8	4	1.6	1	0.7
Termination/exclusion	131	15.5	64	10.4	44	8.1	26	10.2	17	12.3
Loss of contact	104	12.3	27	4.4	12	2.2	8	3.1	2	1.4
Change of residence	50	5.9	32	5.2	23	4.2	5	2.0	3	2.2
Incarceration	50	5.9	28	4.5	18	3.3	9	3.5	8	5.8
Death	45	5.3	33	5.3	59	10.8	38	15.0	13	9.3
Other reasons	18	2.1	121	19.8	63	11.6	21	8.3	7	4.9
Total	844	100	617	100	545	100	254	100	138	100

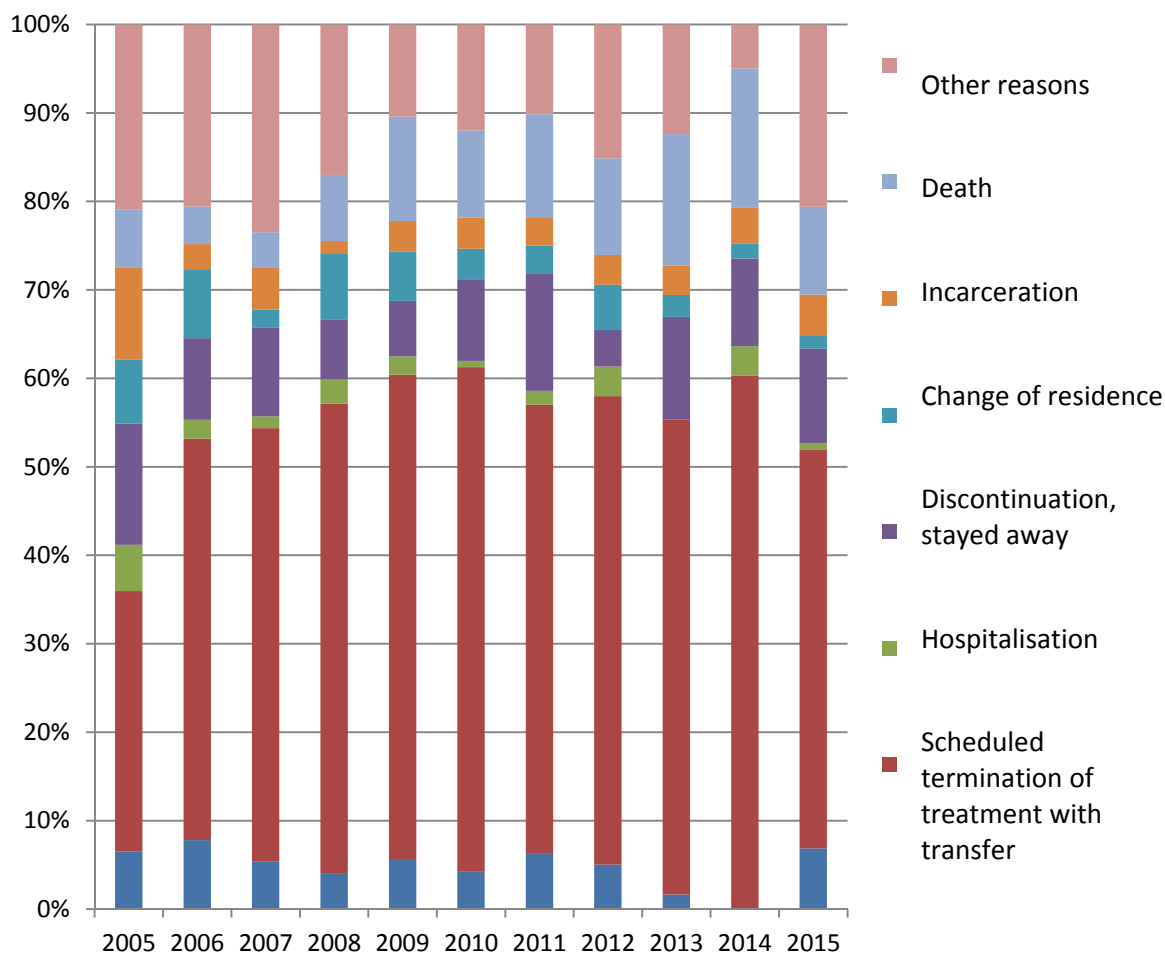


Figure 4. Reasons for discharge for years 2005–2015.

## 7. Hepatitis and HIV

The evaluation of hepatitis and HIV data considered all cases where either test results or data on vaccination status were available. Persons were thus included who had never been tested for hepatitis A or B but who stated that they had decided on, or were refusing, vaccination.

The hepatitis test results available to us do not allow differentiation between an acute and a chronic disease. Since a chronic disease is much more likely than an acute disease, all persons who tested positive for hepatitis pathogens were categorised as having a chronic infection. It might therefore be possible that, among the persons listed as having a chronic infection, there are some who are currently going through an acute phase of the disease and who might recover completely. It is also important to note that an infection is detectable only within a few weeks after exposure and that test results can be wrong. But since this would involve no more than a handful of cases, such possible exceptions are not included in the evaluation. If no hepatitis test was done on admission, older tests were evaluated – and it is possible that the hepatitis status has changed in the meantime. The actual prevalence may thus be slightly higher than indicated here.

From 2014 on, the method for ascertaining the status regarding hepatitis was changed. Deviations from previous prevalence levels may therefore have occurred.

## 7.1 Hepatitis A

With hepatitis A, there is only an acute and no chronic disease. The acute phase of the disease begins about four weeks after exposure and generally lasts five weeks until complete recovery. After having gone through the disease or after successful vaccination, there is lifelong immunity against hepatitis A. In Switzerland, about 100 cases of hepatitis A occur annually, mainly after trips to a high-risk area.<sup>2</sup> Most of those affected are young adults, and men contract the disease more frequently than women. This trend was also evident in the case of first-time admissions to heroin-assisted treatment in 2015: 20.8% of the men tested positive for hepatitis A, compared to 5.9% of the women.

Half (50.6%) of 2015 first-time admissions stated that they had previously had a hepatitis A test. There has been a decrease in persons susceptible to hepatitis A, and there is no indication that this decrease was the result of the rephrased questioning. Random fluctuation due to the low number of cases is conceivable, however (table 10).

**Table 10.** Hepatitis A status of all first-time admissions to HAT. Valid data/missing data 2001–2004: 85/970; 2005–2008: 361/170; 2009–2012: 359/150; 2013–2014: 73/92; 2015: 67/34.

Hepatitis A	2001–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Susceptible	31	36.5	123	34.1	138	38.4	39	53.4	35	28.2
Immune (vaccinated or recovered)	45	52.9	191	52.9	180	50.1	26	35.6	17	69.2
No test results, but vaccination decided on	5	5.9	26	7.2	15	4.2	5	6.8	10	0.0
No test results, vaccination refused	4	4.7	21	5.8	26	7.2	3	4.1	5	2.6
Total	85	100	361	100	359	100	73	100	67	100

## 7.2 Hepatitis B

After the acute phase (which usually lasts less than 12 weeks), a person infected by hepatitis B virus either recovers completely, or else her condition becomes chronic. Chronic hepatitis B can last for decades and can cause other liver diseases. A patient who has completely recovered from the disease is immune to hepatitis B for the rest of his life. Vaccination can also provide immunity against hepatitis B. Protection is only provided, however, if the person vaccinated develops a reliably detectable level of anti-HBs after the last dose. Yet follow-up is often neglected.

Prevalence and incidence of hepatitis B have fallen sharply worldwide. In Switzerland, fewer than 100 persons are diagnosed with an acute hepatitis B annually; most of them (75%) are men. The majority of infections (approx. 60%) occur in the 25-to-50 age group.<sup>3</sup>

Over half (56.2%) of first-time admissions in 2015 stated that they had previously had a hepatitis B test. The test results indicate that none of these persons are conclusively suffering from chronic hepatitis B. 34 persons (42.5%) were susceptible, and 21 persons (26.2%) are immune as a result of vaccination (table 11).

<sup>2,3</sup> Diseases and medicine. Federal Office of Public Health FOPH, 21/01/2016, [www.bag.admin.ch](http://www.bag.admin.ch)



**Table 11.** Hepatitis B status of all first-time admissions to HAT. Valid data/missing data 2001–2004: 89/966; 2005–2008: 368/173; 2009–2012: 357/152; 2013–2014: 77/149; 2015: 80/21.

Hepatitis B	2001–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Susceptible	15	16.9	107	29.1	129	40.6	41	53.2	34	42.5
Immune (vaccinated)	39	43.8	147	39.9	148	42.2	24	31.1	21	26.2
Immune (recovered from disease)	7	7.9	20	5.4	8	3.1	5	6.5	9	11.2
Seropositive (unknown status)	7	7.9	23	6.3	10	0	2	2.6	0	0.0
Chronic	10	11.2	15	4.1	13	3.1	0	0.0	0	0.0
No test results, decision for vaccination taken	7	7.9	43	11.7	29	4.7	5	6.5	10	12.5
No test results, vaccination refused	4	4.5	13	3.5	20	6.3	0	0.0	6	7.5
Total	89	100	368	100	357	100	77	100	80	100

## 7.3 Hepatitis C

Like hepatitis B, after an acute phase of hepatitis C, the infected person either recovers completely, or else her condition becomes chronic. Having recovered from hepatitis C does not leave a patient with immunity against the disease, however. Nor is there a vaccination against hepatitis C.

In Switzerland, between 0.7% and 1.0% of the population is infected with the hepatitis C virus, as are approximately 3.0% of the population worldwide, on average. In Switzerland, approximately 50 new cases are reported annually, most of them are men (estimated at approximately 70%). Young adults aged between 20 and 39 are more often affected (approx. 60% to 65% of cases). According to the FOPH report, the majority of newly diagnosed infections are related to intravenous drug use.<sup>3</sup>

74.2% of first-time admissions to HAT in 2015 indicated that they had previously had a hepatitis C test. Of the 58 first-time admissions to HAT whose hepatitis C data were available, 23 (39.6%) were negative. This prevalence is somewhat lower than in previous years.

**Table 12.** Hepatitis C prevalence of all first-time admissions to HAT. Valid data/missing data 2001–2004: 66/989; 2005–2008: 272/259; 2009–2012: 294/215; 2013–2014: 48/178; 2015: 58/43.

Hepatitis C	2001–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Negative	12	25.8	124	45.6	158	53.7	25	52.1	23	39.6
Recovered	1	1.5	9	3.3	10	3.4	8	16.6	13	22.4
Chronic	48	72.7	139	51.1	126	42.9	15	31.3	22	37.9
Total	66	100	272	100	294	100	48	100	58	100

## 7.4 HIV

84.5% of first-time admissions in 2015 indicated that they had previously had an HIV test. Two persons have never had a test, and one person did not want to answer the question. Table 13 shows HIV prevalence in first-time admissions between 2001 and 2015.

**Table 13.** HIV prevalence of all first-time admissions to HAT. 2001–2004: 96/959; 2005–2008: 361/148; 2009–2012: 380/129; 2013–2014: 149/77; 2015: 72/29.

HIV	2001–2004		2005–2008		2009–2012		2013–2014		2015	
	n	%	n	%	n	%	n	%	n	%
Negative	90	93.8	326	90.3	350	92.1	137	87.8	66	91.6
Positive	6	6.2	35	9.7	30	7.9	12	12.2	6	8.3
Total	96	100	361	100	380	100	149	100	72	100

<sup>3</sup> Diseases and medicine. Federal Office of Public Health FOPH, 21/01/2016, [www.bag.admin.ch](http://www.bag.admin.ch)

## 8. Psychiatric disorders

Prevalences of diagnosed psychiatric disorders according to ICD-10 are listed below. It should be noted that the following results assumed zero missing values for completed questionnaires. If no psychiatric disorder was indicated, it is assumed that there is no disorder. This means that the indicated figures are possibly an underestimation of actual prevalences.

In 2015, 53.8% of discharged clients were diagnosed with – or indicated in the questionnaire – no other psychiatric disorder other than the addiction (table 14). This figure is relatively stable compared to 2013 and 2014. The decrease since 2013 in psychiatric disorders diagnosed at discharge is probably attributable to the questions being rephrased. Now a diagnosis must be specified with the corresponding diagnosis number, whereas earlier a cross next to the particular diagnosis group was sufficient.

**Table 14.** Number of confirmed psychiatric diagnoses of first-time admissions to HAT in the years 2005–2015. Valid data/missing data 2005–2008: 628/41; 2009–2012: 549/191; 2013: 159/0; 2014: 163/0; 2015: 145/0.

Number of diagnoses	2005–2008		2009–2012		2013		2014		2015	
	n	%	n	%	n	%	n	%	n	%
None	222	35.4	171	37.3	91	57.2	82	50.3	78	53.8
One diagnosis	344	54.8	279	50.8	52	32.7	57	35	51	35.2
Two diagnoses	55	8.8	83	15.1	15	9.4	21	12.9	14	9.7
Three diagnoses	7	1.1	14	2.6	1	0.6	3	1.8	2	1.4
Four diagnoses	0	0	2	0.4	0	0	0	0	0	0
Total	628	100	549	100	159	100	163	100	145	100

Over one fifth (22.1%) of discharged persons in 2015 had been diagnosed with a personality or behavioural disorder. A personality disorder is characterised by a persistent, inflexible and maladjusted pattern of perception, thinking, feeling and behaviour which differs significantly from socio-cultural expectations of the environment. Those affected are severely compromised in their ability to cope with everyday life in social and other contexts. By definition, personality disorders start in childhood or at some point during adolescence and early adulthood and then persist. They are not based on any other mental disorder or brain condition. But they may well precede or accompany other disorders.

Besides an opioid dependence (66% of discharged clients in 2015) seven (6.6%) persons stated that their principal diagnosis is problematic use of multiple substances.

Some 18% were diagnosed with an affective disorder, and just under 10% had a schizophrenic, schizotypal or delusional disorder. These prevalences are within the range of normal fluctuations.

**Table 15.** Prevalence of ICD-10 diagnosis groups of first-time admissions to HAT in the years 2005–2015 (multiple answers possible). Valid data/missing data 2005–2008: 623/128; 2009–2012: 542/64; 2013: 159/0; 2014: 163/0; 2015: 145/0.

Diagnosis group	2005–2008		2009–2012		2013		2014		2015	
	n	%	n	%	n	%	n	%	n	%
Organic, including symptomatic, mental disorders	6	1.0	11	2.0	2	1.3	6	3.7	2	1.4
Schizophrenia, schizotypal and delusional disorders	54	8.7	50	9.2	15	9.4	13	8.0	12	8.3
Mood (affective) disorders	118	18.9	123	22.7	29	18.2	25	15.3	26	17.9
Neurotic, stress-related and somatoform disorders	27	4.3	36	6.6	6	3.8	10	6.1	5	3.4
Behavioural syndromes associated with physiological disturbances and physical factors	6	1.0	9	1.7	0	0.0	2	1.2	0	0.0
Disorders of adult personality and behaviour	233	37.4	225	41.5	29	18.2	43	26.4	32	22.1
Mental retardation	2	0.3	5	0.9	0	0.0	0	0.0	3	2.1
Disorders of psychological development	2	0.3	0	0.0	0	0.0	0	0.0	0	0.0
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	25	4.0	36	6.6	4	2.5	9	5.5	5	3.4
Unspecified mental disorder	1	0.2	1	0.2	0	0.0	0	0.0	0	0.0