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**Narrator**

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**Interviewer**

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**TB**: I think to put it short what we do here has very much to do with a pragmatic approach. Pragmatism is, in my view, the way to go about it along with the harm reduction approach. We ask ourselves what is useful, not what should be, what would be the best possible aim or goal. We don’t think too much about therapeutic illusions or fantasies, which is very common in medication therapy. Focusing on abstinence and considering that the majority of the patients we are treating here is not going for abstinence at the moment. This has to be respected.

**AS**: By abstinence what do you mean?

**TB**: From any substance. All of the substances. The abused substance has been alcohol. I think that is one of the problems in alcohol therapy. Historically, it is based on abstinence and that is why it doesn’t work that well. That is why it is not that successful. Quite a few of our patients, I would say the majority, don’t want to abstain from alcohol. They are rather thinking about reduction or using in a more controlled way. That is a reasonable goal with most of our patients. They resonate with it.

The old pattern of addiction therapy has been to push patients into abstinence. Make them think that they want to go for abstinence. It is like a brainwash. In society it is more of a moral thing, in a way. Abstinence is good and substance use is evil. It has to be wiped out. All these fantasies about substance free societies. It is an illusion. It is a ruse.

**AS**: There are people who can handle substances and there are people who can’t.

**TB**: That is one thing. In political discussions when I try to get this over to politicians they still think that substances are dangerous, which is not true. I know that is a provocative thing to say. The majority of people use any substance in a controlled way. This is the case for heroin, which is unknown. Most of the people out there think that heroin is very dangerous and if you use it once you are hooked. That isn’t true. We know from studies -- in Switzerland there was a study, too -- and studies in the UK, there is a big group of heroin users that have no problem with using it in a controlled way and in a recreational way. This is the case with heroin, alcohol, and cocaine.

There is a minority of people being vulnerable for genetic reasons, growing up in a bad environment that are vulnerable to the action of psychoactive substances in a self medicating way, probably. That’s not their fault. This happens and it is a fact that we cannot avoid. This is about fifteen to twenty percent of regular users with this risk. In my view this is a fact we have to accept. It is part of the solidarity -- we owe it to these people to stand up and help them and not judge them and punish them. We need to try to help them manage their vulnerability as best as possible. This is also possible. That’s another story -- once addicted always addicted, which is not true either. Addiction, or dependency, is a state you can manage.

There are long-term studies, prospective studies for twenty or thirty years that follow people up. This is also the case when we ask our patients in treatment: What did you go through? They tell us they have been abstinent for ten years and they started to use again and they used controllably and then shifted into out of control use again, dependent use, and then they stopped again. This is not a linear development from abstinence into total catastrophe of addiction. We still don’t quite understand the factors contributing to why people stop after ten years of use. We still don’t know. Sometimes we think therapy might have to do with it, but on the other hand --

**AS**: What kind of therapy?

**TB**: Addiction therapy. It might help people come to grips better. Sometimes I think they have decided before they come to therapy that they wanted to change and that’s why they come. We assist in a natural process that they would go through anyways.

**AS**: You reinforce what they already are doing.

**TB**: Yes, what they already want. I’m not quite sure we really contribute. I think what we can do for sure is help to reduce harm. This is for sure.

**AS**: Can you talk about what harm reduction means to you as a physician? I was talking with another historian last night who does HIV and drug stuff and he’s saying that what he has realized is that depending on where you are in the world the word harm reduction has different meanings. Can you describe what harm reduction means for you here in this clinic in Switzerland?

TB: One point is that it is something very individual depending on the individual patient. Each person we assist. It is trying to help this person to use substances in a controlled way, in a way with as least risk as possible. That’s it. This is individual harm reduction.

There is also the political side to harm reduction. We try to involve ourselves into the political process to help get the framework adapted that harm reduction is possible. I think politically there are goals that are not very useful that way. It is not useful to criminalize users. This is causing harm. So, if we tried to engage in harm reduction we have to see that those are adapted. We try to work on that, which is rather difficult at the moment.

**AS**: There is political opposition to harm reduction? What is going on?

**TB**: Switzerland went through a very important process back in the nineties. The situation was that bad. This was the biggest opiate drug scene worldwide. This made Swiss politicians and Swiss society move. That was rocking our system. This made the four-pillar policy possible.

**AS**: Because of the extreme nature of the problem.

**TB**: There was a lot of pressure. Now, we are suffering of the success of this approach because the opiate scene has disappeared. The opiate dependent people are not seen in public anymore. There is no problem perceived. So, politicians and society have forgotten the lessons we learned back in the nineties. No more problems. The questions coming up about why we should continue to pay for treatments. It is a recession and there is not enough money. People are thinking of how to save money. In times like this you start to think about shortage of budgets like this. The first priority is to cut budgets of minority focus.

**AS**: How many patients do you serve here in a year or a day?

**TB**: It is about two thousand patients. We are running four outpatient clinics. We employ a staff of about one hundred and twenty people. Nine hundred are in substitution treatment, opiate [unclear] treatment, which was our starting point. We were founded shortly before the needle park closed -- was shut down. We started with low threshold opiate substitution -- methadone treatment at that time. That was twenty-five years ago. Now, we have evolved into being active in the whole field of addiction medicine. All substances.

**AS**: You’re model went from opiates to everything? We have the exact opposite.

**TB**: We transferred our harm reduction approach into the whole of addiction treatment. I’m very proud of that. I’m working hard to push this approach. I think we are getting on in the addiction medicine field. They start to slowly understand this approach. But, not all of them have.

**AS**: Even here?

**TB**: Yes, even here.

**AT**: As a therapist you need a personal kind of evolution into that, too. I remember in the beginning when I was more like, “Okay, it is doable. I can do this. I can be abstinent.” Over time you can think, “It’s just not going to happen.”

**TB**: You’ve got to become and accept things. Accept the patient. Accept the people that come to treatment. It is about respect and taking them as they are. In many addiction treatment programs this still isn’t the case. Still very much like abstinence oriented and not trying to understand about the values of this person. It is about the aim of treatment that will be abstinence. It’s just not perceiving the person as a human being with values and individual goals. That is the point about individualized treatment. It isn’t general goals, it tailoring treatment to the needs of the individual patient. That is one very important part of this harm reduction approach. Accepting that some people have their own concepts -- whatever! I’m not the one to judge who is right and who is wrong. Why they use substances. I’m just trying to help them to make the best of it.

**AS**: Would you mind giving me some background on your career? How did you into psychiatry and addiction medicine?

**TB**: Well, I started as a psychiatrist. When I was in my internship at that time I was forced, because there were vacancies, into the addiction world. I was forced to work there. This is a stigmatized field. Psychiatry is stigmatized in the first place, and then within psychiatry addiction is stigmatized again.

**AS**: Why is psychiatry stigmatized?

**TB**: First of all it isn’t paid well. We are amongst the lowest income group in medicine.

**AT**: Child psychiatrists are lower.

**TB**: So we are low.

**AS**: I’m glad I asked.

**TB**: I know surgeons are ten-fold. That is one point. The other point is the perception that it’s a frustrating job with no results.

**AS**: Because you are dealing with mental illness.

**TB**: No sufficient results. All of that stuff. That is the same in addiction therapy as well. They are lying; it’s not working, and whatever. This is the result of the wrong approach. If you are going into treatment with somebody and you expect them to do something they don’t actually want no wonder it doesn’t work! This has to be frustrating. We try to advocate for --

**AS**: That is a great point. It is the approach.

**TB**: We battle with resistance forever and feel bad and frustrated -- both the patient and the doctor. If you choose to find the right approach and just try to meet these people where they are and invite them into a therapeutic process that’s a collaborative process. I don’t know what is right for this individual guy. This is interesting for me as well to find with every single patient what is important for him or her. What should the goal be? And to develop options. This is interesting and not frustrating at all.

**AS**: Go back to how you got forced into it.

**TB**: I started to find out that the patients there were people as well. They were interesting. I like working with people anyways. I got fascinated with seeing how stigmatized they were and how much they stigmatized themselves. This was such a treat for me. And seeing how much could be improved and done, or how badly the system was working. From then on I was hooked. I was fascinated by how much could be done.

**AS**: For the better.

**TB**: For the better. There is so much that should be and could be improved. There is incredible potential to help and to make things better and create a better society as well. I am still intrigued. I am still fighting and working for this.

**AS**: How long have you been here?

**TB**: I started to work here in ‘97. This is the twentieth year now.

**AS**: You said you talk to politicians. Can you describe your job here and what you do outside of dealing with patients?

**TB**: Arud [Centers for Addiction Medicine] has always been a political organization as well, a pressure group. This is because we are a private charity. We don’t have to obey any government regulations. Most of my colleagues are working in state clinics and they cannot speak up. They have to be careful about that. We try to use this as an asset.

**AS**: Do you collect information from them?

**TB**: Part of my work is to network and try to get specialists and Society of Addiction Medicine to organize that. To get the specialists together to lobby for improvement of policy. We work with the state authorities.

**AS**: If you are a private charity do you get government assistance?

**TB**: No. We actually function like a private practice.

**AS**: When you were talking about the government trying to cut funding you meant for state-run agencies.

**TB**: We have the four pillars, we have consumption rooms, and we have stuff like that. We talk about cutting budgets of these places. In society we have fifty five percent of Swiss people now that think substitution treatment shouldn’t be covered by insurance anymore because it is their fault.

**AS**: There has already been a swing back.

**TB**: Yes. There has always been a majority of Swiss people remembering the experience from the nineties where the success was so obvious of the low-threshold harm reduction oriented therapy. The acceptance was high. There was sixty-five or seventy percent pro-substitution treatment. Now it has shifted.

**AS**: Do you think part of that is the general swing towards the right that we’ve been seeing?

**TB**: It is this neoliberalism thing.

**AS**: It is not just that the problem of heroin addiction is being controlled.

**TB**: Like saying that obese people should pay more for health insurance because they eat too much and that creates problems and causes costs and they have to cover themselves. This is the discussion, which is absolutely useless in my view because this is not their personal decision that they choose to use heroin and are fully responsible for it and they cover all the costs. That is not the way it goes. That’s a discussion in the health treatment system: thinking how we can cut costs. Make the people pay themselves.

**AS**: What about the disease model of addiction? We are still talking about this in the United States.

**TB**: Yes, I know. Nora Volkow is really strong on that.

**AS**: The surgeon general just came out with that. In our society it is still a new concept. I’m wondering if yours is different.

**TB**: The disease model has been useful, I think, as a first step to fight stigma. Then it shifted from moral to a disease. Now I think we are stuck with the disease model and it is not that useful in my view.

**AS**: How does it fit into this? If you are diseased you have to do what someone tells you to do to get better.

**TB**: Yeah. It is not just fate. I think there are factors contributing to dependent behavior and risk factors might add up in a syndrome that looks like a disease. It is not something we have a pill to cure. It is much more complex and there are so many other factors contributing, also societal factors. I think there are societies that cause vulnerability and make people use substances in a problematic way. It is not the individual’s fault. There are so many ways to manage this behavior. It is not just fate and nothing to be done about it. You cannot just take the medicine and see how it develops. I’m not so happy with the disease model because it deprives the individual of their autonomy, in a way.

**AS**: It creates a dependency.

**TB**: It is a habit that there is nothing to be done about and that is not true.

**AS**: A typical addiction doctor in the US would explain it as similar to diabetes. It is a way to frame it because we do care about diabetics.

**TB**: I think it is good in the discussion about stigmatization because diabetes is not as stigmatized. If you make the analogy that is good.

**AS**: Heart disease is another one that they use.

**TB**: Talking about diabetes there are many things to manage besides taking pills. It is about a healthy lifestyle and living another type of lifestyle, maybe. There are many things the individual can do, and that is the case. In general in psychiatry we deal with chronic conditions. It is not so much about healing or making it disappear. It is more about managing something; managing yourself.

Also talking about schizophrenia for example. We have no right to push schizophrenic patients to medicate with neuroleptics, for example. That is their point to decide whether they want to use medication or not. To decide if medication might help them on their way as one factor or not. It is not the silver bullet. It is just one possibility to assist. This might work for some and others it might not.

**AS**: Is that how schizophrenics are treated here in general?

**AT**: Psychopharmacology is probably the cornerstone of the treatment; you can’t get around it.

**TB**: There are clinics where the patients are pretty much forced to take the medication, which in my view is not the right thing to do.

**AS**: Even if they were going to self-harm?

**TB**: People have the rights to self-harm. In my position I try to inform them as best I can of the possible risks. If they still continue to self-harm I think I have to go along with this. That doesn’t mean I am happy with it. I am still, as a professional identity, I don’t approve this, but I accept their way. I think life is dangerous. Everything is dangerous in life. If we wanted to avoid all dangers we couldn’t live. Taking substances is dangerous, driving a car is dangerous, and it is how much danger you want to take that is an individual decision. I think in my view it is free will. I don’t think society -- as long as you harm only yourself, we don’t have that much of a right to interfere. That’s my individual opinion.

**AS**: Would you say your opinion is an outlier?

**TB**: No, I think there is an argument now in general about how much interference of the state is acceptable. That is a public health discussion. How much should the government make their citizens behave in a certain way? There is no right or wrong to that. That is a norm you have to decide on.

**AS**: Do you see people here -- patients, is that what you call them here?

**TB**: Patient, clients.

**AS**: How many would you say have a co-occurring mental health issue?

**TB**: Practically all. That is who we have here that come to treatment. The ones we see here in treatment. There are so many studies in that as well, that co-occurring psychiatric diseases is three to four -- not only one. That has to do with our system of diagnosis, the DSM. You end up having quite a few disorders. There are so many co-occurring disorders. Schizophrenia is about ten percent of the population we treat here. In the general population it is about one percent, so it is ten fold. We see about thirty to thirty-five percent with ADHD. The general population is about four percent. About forty to fifty percent with depressive and panic disorders, or personality disorders. Those are just the psychiatric disorders. Disorders like infections, hepatitis C, HIV, liver diseases.

**AS**: When a person comes in seeking treatment for addiction are they evaluated for other things right away? Is that integrated in a way?

**TB**: they come here with a substance problem because we are an addiction clinic. Our job then is to try to check them for other disorders, which isn’t that easy in the beginning because they don’t want to see a shrink. They come for a substance disorder, and if you start asking them about psychiatric problems that might be hard for them. That is our job to try to involve them into disciplinary approach. We work in a very integrated way in psychiatry: internal medicine, we have social work. We try to offer everything under one roof because [unclear] are so frequent in our experience I can understand. It is very difficult if you have to see three or four doctors for all the different disorders you have to treat all together in one place. And then we try to prioritize and treat the disorder that is most impairing at the moment for the patient; the problem the patient wants to work on. We try to motivate them to get a sense of their other disorders and motivate them to get into treatment there as well, but we cannot force them.

**AT**: It is very modest -- the scope that you can actually engage them to work on. There are low levels of resources then the goals are going to be small.

**AS**: The resources in the person?

**TB**: Yeah. You have to adapt therapy to the resources of the client or the patient. It is a very important process to try to identify how much this person can do, what he wants to do, and focus on that and not try to make them understand that they should do this. It is important to inform them and offer them information and education, but they have to make the decision. To go along with their decision. That is very important.

**AT**: I find myself trying to tone down the expectations of patients. They come in and are already burdened with all the expectations gathered from the environment they are living in. I say, “No, you can’t do that. We have to take this step by step.” “Yeah, but I want this.” “No, this is what you can do. Then we will see where it goes.”

**TB**: That is the problem. The extrinsic motivation is so strong. We try to evocate that motivation. It is the only motor that really works. As you said, very often if we see the patients the first time they are in a crisis. What is their first idea when they go through a difficult time in their life? I have to stop using. Then they think that is the solution because that is what they hear from all over: it is bad that you use and you should stop. When they have a hard time when they try to stop -- that that’s the idea -- then everything is okay. If you try to analyze this, if you take your time and talk this through with a patient then they start to realize there is not a single problem to resolve just by stopping the use of a substance. In contrary, it might even make problems bigger. Many of our patients it is the way they structure their lives, their routine. No alternative at the moment. You shouldn’t take it away because nothing is left. That is not a good place to be. We try to explain this to our patients that we have to find alternatives. Before we cut down or take away, it is a much better position to have alternatives already than to decide to reduce or take the substance use away. Never do that without alternatives.

**AS**: Obviously then you wouldn’t require someone to detox?

**TB**: No, it is useless. We have patients here that have been through twenty, thirty, forty times. How many more treatments of that kind do you want to go through? Every time you go for one or two weeks and then you relapse and prove to yourself that you cannot do it. You’ve failed again and you are a failure. What is the use of this approach? It is not really useful. Sometimes people say we are against abstinence, which is not true at all. I think abstinence is a state: it can be good, useful; it depends for who and what situation. It is not per say good or bad. It depends on the context.

**AS**: What would you say to someone who said that if they stopped using something like heroin or meth and they see drinking beer as triggering that desire -- I know people who have quit and then they think they can have a beer -- and within forty-eight hours they are using meth again. How would that be managed in this environment? Because that person would say that they should never have a beer again.

**TB**: That is our job to work with triggers. I think education is very important to explain the mechanisms of what is happening. I think that is pretty important. People feel less of a victim and it becomes something they can do because there is something happening. There are different approaches to understanding that you can control triggers. This is possible. The earlier that you detect the starting point -- the triggers won’t just go away. The more awareness you develop inside to realize when this starts low. The earlier you intervene the better you can manage. That is what we work on with our patients. That is pretty successful.

**AS**: I have been interviewing some people in long term recovery who are also in addiction treatment who are moving towards this model that you are espousing that is more individualized. A couple of them have said that they haven’t used anything for twenty years and now they have decided that if they want to have a glass of champagne or a glass of wine with dinner they do it, but how hard it was to go from the idea that if you ever touch it again you are an addict. One man told me -- he runs a methadone clinic and would be very in line with what you are saying -- he said when he told his friends from AA [Alcoholics Anonymous] they said he was never really an addict.

**TB**: I am having a problem with this twelve-step approach because it is too --

**AS**: Does it have a place here?

**TB**: It has a place, but not as much in the US.

**AS**: By here I meant in Switzerland.

**TB**: There are AA groups. I have patients that are in AA groups. There are patients that really like it there and it helps them. I’m not against that at all. There are some pretty good AA groups here that are not that dogmatic, more flexible in a way. They accept the use of substances. They work with people who are still using. I don’t know. It depends on the individual patient. For some patients it is too dogmatic. Then it is stigmatizing again because it makes them feel bad if they use substances.

**AS**: Your model is more helping someone early on in the process figure out what they can handle and what they can’t handle versus a twenty year time period and then saying, “I think I could have a glass of wine.” I just think of the intensity of that decision after all that time and then having people who were close to you say that you were never an addict when that person’s life had fallen apart. It just seems healthier.

**TB**: This all or nothing approach isn’t really helpful. I am trying to advocate the continuing of possible goals and states. This is not you are either abstinent or an addict. There are all different shades in between.

**AT**: How can you achieve a manageable balance?

**AS**: Where you are in control of your life and happy.

**TB**: The degree of control. Even control is not an all or nothing thing. There are different degrees of control. We try to help our patients to improve control, whatever that means. With one patient that might be to reduce their beer consumption from seven liters a day to five liters. It is still an improvement. For others it might mean they only drink on Sunday once a week, or whatever.

**AS**: They come up with that and try it out.

**TB**: It is our job to help them find their own goals and what works for them. That starts anew with every patient. There is no recipe that I could offer that would say this is the way you have to go. I think that is what the patients here appreciate about it. Feeling accepted and respected and realizing that we listen to them and we depend on their view.

**AS**: How long do people usually seek services here? Aside from methadone.

**TB**: Methadone is another point. Saying opioid addiction is a chronic disease. I think it is a chronic disease that we have here in treatment because they were not for their own faults sort of entrenched. That is a result of the political and societal conditions we have had. They were forced into this marginalized lifestyle. They were made chronic. They are so impaired, not by the action of the substance of heroin, but of the side effects of illegal lifestyle and these horrible years they went through. That impairment makes their condition chronic. That is my view on that. There are famous surgeons that have been living with opiate addiction and have been going through a very successful career because they had no problem providing themselves with clean morphine.

I think heroin addiction is not this hopeless chronic disease, per say. There are other factors contributing to this. That is a misconception of it. We treat the effects of the bad conditions they were living under, the impairment of this lifestyle. This is a group -- some of them have been having treatment now for twenty-five years already and they might continue until the end of their life. There is a very small number in that group of people recovering, in a way. Recovery is another term that can be understood in many ways. Recovery in the UK and in the States as well, I think, has been hijacked as a term for abstinence, which is not the idea of it. Recovery means to get to terms with something and to be able to live a normal life with the substance or without, whatever you choose. It is about integration and being part of society with or without substances doesn’t really make a difference there. It is the degree of control.

There is this group that is in our treatment for long term, opiate addicted people. If, for example, with alcohol or cocaine we see people come to treatment for a period of time and then they go ahead with their life, get to terms with it, and they might come back after five years and get another treatment. That is the pattern we see. Some we might not see anymore.

**AS**: Do people come for group therapy or is this more one on one?

**TB**: Swiss patients are going for one on one. They hate groups. I love groups and I think groups are very helpful. We have started so many groups and they all ended up with one or two or no people. I think we are in the luxurious position that we can offer one to one treatment. There are other countries like Germany that have fewer resources. The treatment system depends much more on group approaches because of resources. Here we still have enough funds to finance one to one treatment. That is what they go for. Also, because self becomes stigmatization and not wanting to have other people know they use, or whatever.

That is another thing I am not really happy about. Our patients are not really ready or up to political involvement. We have this in the UK, for example. We have user unions and advocacy groups. There is nothing here. We do that for our patients and sometimes I feel a little bit sick of it. I voice for the patients who won’t speak up.

**AS**: We have had that issue with Alcoholic Anonymous because they want to stay anonymous; they are safe in that space. Lately there are more people who are coming out to say what is happening, parents who will speak out, and advocacy. We are actually getting legislation change because we are speaking up.

**TB**: It is very important. This is what makes politicians move. Somebody has to step up. Somebody who has a problem. If I come up and say, “I have patients who have a problem” that is not the same.

**AS**: That is how we got Narcan to be more available. We have a law called the Good Samaritan Law so that someone will call when there is a person that is overdosing rather than just drop them or leave. It was a group of mothers who lost their children who then lobbied the legislators. Whether they were teary or not they made a huge impression and it was an incredible vote, almost unanimous.

**TB**: That is very important, but it is really hard to hear. Sometimes I think it might be our fault because we have been very active from the start and we are used to this. I think we should have pushed them more from the beginning or evolved our patients more from the beginning to the whole political process as well.

**AS**: There is still quite a bit of stigma still. It isn’t that you have overcome stigma. It is that you have overcome a different treatment model.

**TB**: Yes. There is lots of stigma still. We try to work very closely with general practitioners because I think they see a lot of people that have substance problems but don’t come for substance problems and go for other reasons. I think they have a very important role in screening and prevention and trying to make people realize or understand about risks of drug and substance use. There as well the stigmatization is so strong. General practitioners say they don’t want to deal with it. It is like opening Pandora’s box: “Oh, no. That’s too much. I don’t want to know about that.” That’s a problem.

**AS**: We have the same problem. Is there medical school training around addiction?

**TB**: We have started to improve. There is a new concept now for medical students. The Society for Addiction medicine has been invited to contribute to this program and it is getting better. I think we are learning from Canada. Canada is pretty ahead in that way. The medical students there already have quite a bit of addiction medicine -- because it is so frequent. It is underrated. I think medical students should already practice and get experience working with people with substance use problems. That’s what they emphasize in these courses too: that they should self reflect on their stand on substance use.

**AT**: Using a lot of Ritalin to be able to study enough to pass.

**TB**: It starts with your own understanding and perception of the problem or the phenomenon. To get a normal approach to that. There is still a lot to do.

With general practitioners sometimes I think this is a really hard job. They are still very much in this paternalistic way of understanding medicine. The expert: “I tell my patients what they have to do. If they don’t listen I tell them harder, and then even harder. If they still don’t listen I throw them out of the treatment. I don’t want to see them anymore because they don’t want it.”

**AT**: The other ones you also don’t hear about a lot. I know a lot of general practitioners that have a really good approach to addiction. They are really good. They are the people that people go to, too.

**TB**: The ones I am talking about I would say are the old generation. It is coming to an end now. The ones that are in their sixties now. They have just grown up in another way. The younger practitioners think differently, but still aren’t educated well enough in that field. There is a big lack of knowledge.

**AS**: The thing I’ve heard is they ask what they would take out and remove from course time because it is so packed. What would they not teach?

**TB**: What we really work a lot with is the motivational interviewing approach. That is an approach that has been done a lot in the alcohol therapy field. Miller and Rollnick back in the sixties. That was so helpful. This is now getting adopted all over medicine working with chronic diseases. It works with intrinsic motivation: trying to make people want to change for their own sake. This approach is so helpful working with people with obesity, or diabetes, or HIV, or whatever. They have to manage the long lasting condition where they have to have a motivation to do something and be active to manage their health. This approach I think should be already taught with medical students because it is an attitude.

**AS**: Do you use that here?

**TB**: Yes, we do. Understanding that you have to advocate intrinsic motivation and that therapy wouldn’t work otherwise. You should forget about treating people if you don’t know what they really want. That’s where therapy starts. This sounds pretty trivial, but so many doctors don’t really talk with their patients about what they want: “Do you really want to take those pills?” for example. On behalf of adherence. Only half of the pills prescribed are really taken. That is also a result of that. Nobody really cares about what the patients actually think.

There is this shift going on in medicine at the moment -- slowly, but it is -- that we understand that patients are human beings as well and we do a job together with them. It is not just us saying what they have to do. There is also the Internet and all that stuff contributing to that because patients inform themselves. They are getting out of their role as a victim and getting more active, which is good.

I think those are the most important points of our approach. Ever since Arud was founded -- it has been twenty-five years now -- we have always been growing. I think this is also a good thing to see. I think this is because we offer a treatment that fits. We still have a long way to go and we will continue to grow because there are still so many people out there not coming into treatment because they don’t find a treatment that fits. They don’t want to hear, “You should stop again. There is no other way. You are bad.” Feeling that their doctor is frustrated and they don’t want to talk about it because they are just supposed to stop. All of that. There is still quite a potential for us to grow. That is what we have always been true to. We never say we are full. If all our therapists are busy then we just employ new therapists.

**AS**: You don’t turn someone away?

**TB**: No, never. I really believe in low threshold treatment. You have to use the window of opportunity. Whenever someone has the feeling that they need assistance you should be ready to offer this within twenty-four hours. That’s what we can do.

**AS**: There are some people starting to do that in Minneapolis.

**TB**: I think all this waiting is terrible.

**AS**: Many of our children are dying because they aren’t getting in at that moment, especially young people. You finally somehow twisted their arm and then you have to wait ten days.

**TB**: In the UK and in Scotland I have been several times to assist them. They are about to open a heroin assistance treatment now, but it has taken three years of lobbying and sharing our experiences with them. Up there they have a waiting list of up to six weeks for someone with opioid addiction to get admitted to agonist treatment. This is just impossible. That’s not the way. Here anybody can just walk in and within twenty minutes is in treatment.

**AS**: That’s what you call low threshold. You don’t have to prove anything.

**TB**: Yes. The only thing you have to do is take a urine specimen to prove there are opioids in the system.

**AS**: Is that the only time you would do a UA [urine analysis]?

**TB**: Yes. We shouldn’t start opioid treatment if someone is intolerant. That would be dangerous. Sometimes you have people coming in and saying they need substitution treatment. I had one patient that was a schizophrenic just pretending to be an opiate dependent. Then you can only tell with the urine analysis. If there are no opioids in the urine then you won’t start treatment. That is the only condition. Then we start right away.

In opiate assisted agonist treatment what is very important is the individualization to be able to use as many different substances as possible. We started off with methadone in the nineties and that was all there was around. Now we know that, as with any other medication, there are different individual side effects. People tolerate substances differently. Now we use methadone, buprenorphine, slow-release morphine, and heroin, the original substance. That is the very important thing to be able to do. It is long-term treatment and it is about quality of life. You have to find the substance that fits best for the individual patient. That might be methadone, that might be heroin, that might be morphine. In my perspective it is very important. It is amazing to see how life can change for a patient who has been on methadone for twenty years because it was the only thing around and now changing to slow release morphine. We have had patients that say, “This is like a new life. I feel so much better.” Others have the same experience with Buprenorphine. I think it is really important to give them a choice. There is no medical indication for what substance is best for what patient. They have to find out what is the best for them.

What we really aren’t happy with in Switzerland is the state of heroin treatment. We are still very much restricted by law.

**AT**: I was just going to ask I mean morphine, buprenorphine, and methadone can be obtained through pretty much every pharmacy.

**TB**: That is regular treatment.

**AT**: Do you think heroin should be that available?

**TB**: Absolutely. There is no problem with that. We have twenty-three years of experience with heroin treatment. We run the largest heroin clinic in Switzerland. We have about two hundred and twenty people in heroin treatment and we have been doing this for twenty-three years. It works exactly as any other agonist treatment. The only thing when we started heroin treatment in ‘94 one hundred percent of users were using intravenously. This is an international, European trend. There are less and less people injecting, which is good.

**AS**: How do they get heroin treatment? Is that injected as well?

**TB**: It can be. We offer injectable heroin. The majority of patients now have shifted to oral avenues.

**AT**: That was my question. I have noticed some of my patients have started to get oral heroin. How does that make sense? My understanding of the pharmacology of heroin is that it very quickly gets transformed into morphine. Does any of that reach the brain in the form of heroin?

**TB**: Yes. I was so amazed, but the ones who get the oral heroin tablets use it nasally. There the onset of action is a bit faster.

**AS**: It isn’t a tablet?

**TB**: It is a tablet, but they crush it and snort it. I don’t have anything against that because snorting it is still much more safe than injecting. We are very happy with this trend. Only twenty-five of our patients do injection only with the heroin treatment. Forty-five percent have shifted totally to tablets. I think this type of tablet based heroin treatment could be transferred to regular treatment. Any general practitioner could give these tablets away. Nothing speaks against that.

**AT**: I am a little wary about injectable heroin because I think there is a risk of doctors becoming dependent.

**TB**: Well, we have to live with that risk. I think the injectable heroin is another story. The onset is so fast that it can be dangerous. That is why injecting is still supervised here. They have to inject on the premises.

**AT**: In case they overdose accidentally.

**TB**: If they have used alcohol or benzodiazepines before and they inject the onset is so fast that you can end up having an overdose within two minutes.

**AS**: Are people asked if they are on benzos and alcohol before they get injected?

**TB**: We know them, and we know which ones are risky guys and use a lot of other substances as well. That’s manageable. We have never had anyone die in twenty-three years. Nobody died on the premises. The only thing that can happen is they breathe less or they stop breathing for a while and you have to assist everything and they come back again. It’s not really dangerous as long as you know how to proceed.

Anyways, with the heroin tablets we restrict the take home dose to two days. People with heroin treatment on tablets have to show up at least three times a week. Considering that this is a long-term treatment that should enable people to live autonomously and integrate into society and have a job and have a family life. How can you do that having to show up three times a week at the treatment center? Traveling there. It is just not the thing to do.

**AS**: Do you think they should have access to more tablets?

**TB**: This is counterproductive. The aim of those treatments is to help people reintegrate in society and live a regular life. Having these restrictions makes it impossible to engage in a regular lifestyle.

**AS**: Can people take methadone home?

**TB**: Yes. Ninety percent of the patients we have here are on regular agonist substance treatments. Heroin treatment we can only offer in licensed facilities. That is another clinic of ours on the other side of the river. Ninety percent of the patients we treat here in regular agonist treatment have at least one week of take home, which is no problem. They are in control. Why shouldn’t they? Many of them work; they go for business travels and whatever. They don’t have to come here all the time.

**AS**: But some people do start out that way and have to come here everyday?

**TB**: That’s an exception. If they are in a psychosis or a very deep depression and are suicidal or for psychological reasons are not able to handle take homes. They might lose them or are not in control of dosing them, but that is the exception.

**AS**: It is very different because we police it very heavily in the US.

**TB**: That is useless. That is another way of institutionalization. It is causing harm and impairing patients.

**AS**: There are all kinds of people who hang around who are trying to sell. It brings the culture that they are trying to get away from right there to the place where they are trying to get better. That treatment now is so stigmatized that so many people won’t even say they are on it. They don’t want to go. Many treatment centers will not refer you to methadone. They will only do Suboxone or Vivitrol.

**TB**: I think in the States the general practitioners are only allowed to prescribe buprenorphine.

**AS**: Yes. No methadone. They are only allowed a certain number of patients and they have to go through a DEA [drug enforcement agency].

**AT**: Each one of those substances has advantages and disadvantages over the other. Ultimately it’s got to be the user who decides.

**TB**: And not the state and not the government. It is really an absurd situation. If you look all over the world you have countries, for political reasons, like in the north -- Finland -- has only buprenorphine. That’s a political decision because they thought any other substance was not safe. Same in France. It has improved now. It is still about eighty-five or ninety percent of this agonist treatment is with buprenorphine because the government thinks that it is safer.

**AT**: It is a partial antagonist.

**TB**: Yes. That is also called Indivior, the company that manufactures buprenorphine has been very politically active advocating for buprenorphine and getting quite a lot of government on their side. These are economic reasons.

**AT**: Drug pushers.

**AS**: Thank you, you have been very generous.

[walking around clinic]

**TB**: This is the medical department. This is where we treat Hepatitis C and HIV and other disorders. We see an increasing number of age related comorbid medical disorders. The average age of the opiate dependent cohort is forty-five years. That’s the nineties generation heroin and they are aging. There are hardly any newcomers. Heroin is out. It is a loser drug. We hardly see any young, new heroin users. The epidemic is over. What we see is a cohort of aging heroin users. They are twenty years older than their actual age. They have aged twenty years because of the lifestyle they have been forced to live. This lifestyle made them sick, not the drugs. We treat the results.

This is the lab. This is quite an important machine. It is sort of an ultrasound, but it measures the fibrosis of the liver. That’s very important in treating hepatitis c. This is an issue at the moment all over: hepatitis c treatment is still quite expensive. Gilead, which started the whole thing off, earns billions.

**AS**: They have kept the cost pretty high?

**TB**: Yes, it is about sixty thousand dollars a treatment.

**AS**: Where are they based? For how long?

**TB**: Six weeks. The United States. They didn’t even develop the substances themselves. They bought the patent and now they are making a hell of a lot of money.

We have this problem that sixty percent of the cohort of the opiate dependent population we treat here are infected with Hepatitis C. Also a consequence of the lifestyle and not of the drug. Actually, we should treat them all with this new treatment. It is very effective and has a ninety to ninety-five percent success rate. We should treat them all; that’s how you treat infections like that, but it’s too expensive. The government decided to make limitations on the treatment, so we can only treat them if the fibrosis has progressed to a certain level. They have to be pretty sick to get the treatment. It would be wiser to treat them earlier before they get to that degree. That is why we measure the fibrosis grade to get them into treatment.

**AS**: We had the same thing happen with Narcan. The price went up to two thousand dollars right at the time when all the state governments were allowing more access to it.

**TB**: This is internal medicine here and all of the rest of the premises is psychiatry. We work very close together because all of the patients are comorbid and we are trying to get the treatment to fit the needs of the patient. We have five hundred patients in agonist treatments. That is quite a numbers. That’s why we have computerized systems. We get all the medication per patient for the comorbid disorders. This is the amount for one week because most of them come once a week and get all their medication.

This is a project where we are going to move together the four clinics in Zurich next year to one place. We have centralized the outpatient clinics into one place. We think we can offer more comprehensive and better quality treatment if we are all under one roof. That is going to happen the end of this year.

**AS**: You are open six-thirty a.m. to nine-thirty p.m. six days a week?

**TB**: Seven days a week. Now we think of reducing the service over the weekend because ninety-nine percent of our patients are so stable we don’t have to offer the services. That was important in the beginning back in the nineties when people are still very bad off and they needed much more support. Now it has stabilized.