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Nursing in an Intravenous Heroin Prescription Treatment

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In opioid substitution treatment, nursing builds and provides the primary and main therapeutic relationship and care with patients. Despite its essential contribution to the treatment of drug-dependent patients, nursing in substitution treatment tends to be overlooked. Also, little is known about their work in heroin substitution in particular. The aim of this article is to describe the nursing actions provided in the care of patients in the PEPSA (experimental drug prescription program in Andalusia, Spain) trial, mainly concerned with patients receiving intravenous diacetylmorphine. The study was conducted in the Centre for diacetylmorphine prescription within the context of a heroin clinical trial, Virgen de las Nieves University Hospital, Granada, Spain.

The nursing team was responsible for overall care for the patient, focusing on his/her needs. Care provided to each patient was individualized, with verbal communication being the main tool to facilitate a two-way exchange of information between the patient and the nurse providing care. The protocol for nursing performance comprised the administration and supervision of the treatment and other actions aimed at reducing harm, encouraging healthy habits, monitoring the patient and counseling. The general process included: admission of the patient; assessment of his/her general health status; delivery of the treatment; and assessment of the patient’s response receiving injected diacetylmorphine. The care of patients who are addicted to drugs provided calls for a relationship that ensure seamless care. This relationship should be aimed at fostering and maintaining therapeutic communication. This relationship involves nurses providing empathy, active listening, assertiveness, acceptance, respect, offering consistent information and avoiding a judgmental approach. In this trial, the nurses attempted to motivate change, detecting and providing positive reinforcement of any changes made, while always respecting the patient’s choices. The fundamental aim was harm reduction, which involves reducing any adverse consequences arising from the use of drugs, without necessarily reducing the use of drugs.

Keywords Diacetylmorphine, Drug Users, IV, Nurse-Patient Relation, Nurse Role, Opiate Dependence, Supervised Injections, Therapeutic Use

INTRODUCTION AND AIMS

Heroin abuse occurs in almost all countries. Although consumption has tended to level off in Spain over recent years, it is calculated that there are some 150,000 people who are problematic heroin users (Spanish Drug Observatory, 2002). Opiate addiction is a chronic disease (McLellan, Lewis, O’Brien, & Kleber, 2000) and approaches to treating this addiction involve prevention, detoxification (with or without drugs), psychotherapy, substitution treatment (methadone, buprenorphine, etc.), harm-reduction strategies (for example, the distribution of sterilized injection material) and social integration.

From the very beginnings of substitution treatment, nurses have played pivotal roles. In opioid substitution treatment, nurses build the primary and main therapeutic relationship with patients and provide them with care. Indeed, as regards the administration of treatment, nurses are the first line of contact. Yet they also play a therapeutic role. On a daily or weekly basis (depending on the centre’s norms), patients go to take their doses. For some patients, those five minutes will be their only contact with a nurse for that day or week (or even more). This reality makes the nurse-patient interaction an excellent opportunity for screening, assisting and identifying the need for referring the patient to appropriate agencies. Opioid addiction treatment requires a multidisciplinary approach, especially with patients who have been addicted over a long term. Nevertheless, professional nurses have a major impact on the outcome of the substitution treatment, as they are the members of the clinical team who

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have the closest contact with patients (Chenitz & Krumenaker, 1987).

Despite its essential contribution to the treatment of patients who are drug-dependent, and probably because of its eminently practical nature, nursing in substitution treatment has tended to be overlooked. Few studies have referred to nurses’ roles in this field. This problem undermines the sharing of knowledge that can lead to improving nursing interventions and strategies for patients who are opioid dependent.

Several studies in the last years have contributed evidence on the effectiveness, security and viability (Rehm et al., 2001), as well as cost-effectiveness (Dijkgraaf et al., 2005) of the prescription of diacetylmorphine on the treatment of long term opioid-dependent persons who do not benefit from treatments. The clinical evidence on co-prescription of injected diacetylmorphine has shown that the patients treated with injected diacetylmorphine have improved their physical health, psycho-social adjustment, consumptions of illicit drugs, risks associated to the intravenous route, and illegal activities (Guttinger, Gschwend, Schulte, Rehm, & Uchtenhagen, 2003; Gutzwiller & Steffen, 2000; Hartnoll et al., 1980; Killias & Uchtenhagen, 1996; Lintzeris et al., 2006; Uchtenhagen et al., 1999; van den Brink et al., 2003). Five countries at the moment prescribe injected diacetylmorphine as a program or in the frame of a clinical trial: United Kingdom, Switzerland, Holland, Germany, Spain and Canada (Fischer et al., 2002; Klous, Van den Brink, Van Ree, & Beijnen, 2005).

The aim of this article is to describe the nursing actions provided in the framework of the PEPSA (experimental drug prescription program in Andalusia; Programa Experimental de estudiofacientes en Andalucía, Spain) trial (March, Oviedo-Joekes, Perea-Milla, Carrasco, & PEPSA Team, in press). The PEPSA trial compared the efficacy of intravenous diacetylmorphine versus oral methadone in the treatment of patients who were severely opioid dependent. The most outstanding aspects of the nurse’s care within the trial, mainly concerned with patients receiving intravenous diacetylmorphine treatment, will be discussed. This article explores the interventions, the attitudes, and features experienced by the nurses in this study of the nurse-patient relationship.

**PATIENTS’ PROFILE**

The participants’ profile is described to give some details about the characteristics of the patients (n = 62) treated by the nurses. There was an extremely high rate of both social and health problems among the patients in the study (Table 1). The socio-demographic features of the participants show that they were people who had been consuming opiates for a long time, and belonged to a group of drug-users clearly on the margin of society. These persons had serious drug-related health problems (physical, mental and social). The average age of users was 37 years, with a mean length of drug-use of almost 20 years; 30% of patients had not abstained from using drugs for even one month.

<table>
<thead>
<tr>
<th>Variable*</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age at start of trial (1)</td>
<td>37.2 (5.5)</td>
</tr>
<tr>
<td>Male</td>
<td>56 (90.3)</td>
</tr>
<tr>
<td>Living*</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>11 (17.7)</td>
</tr>
<tr>
<td>With family</td>
<td>33 (53.2)</td>
</tr>
<tr>
<td>With friends</td>
<td>5 (8.1)</td>
</tr>
<tr>
<td>Homeless</td>
<td>13 (21)</td>
</tr>
<tr>
<td>Employment status*</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>3 (4.8)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>36 (58.1)</td>
</tr>
<tr>
<td>Allowance or Pension</td>
<td>23 (37.1)</td>
</tr>
<tr>
<td>Legal problems*</td>
<td>31 (50)</td>
</tr>
<tr>
<td>Children</td>
<td>11 (17.7)</td>
</tr>
<tr>
<td>Receives support from</td>
<td></td>
</tr>
<tr>
<td>Nobody</td>
<td>20 (32.3)</td>
</tr>
<tr>
<td>Own family</td>
<td>7 (11.3)</td>
</tr>
<tr>
<td>Parents</td>
<td>28 (45.2)</td>
</tr>
<tr>
<td>Friends and colleagues</td>
<td>7 (11.3)</td>
</tr>
<tr>
<td>Associated diseases</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>25 (40.3)</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>2 (3.2)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>58 (93.5)</td>
</tr>
<tr>
<td>Age at first heroin consumption#(1)</td>
<td>18.1 (4.4)</td>
</tr>
<tr>
<td>Average length of opioid addiction (years)#(1)</td>
<td>19.7 (6.4)</td>
</tr>
<tr>
<td>Months of abstinence from opioids#(1)</td>
<td>14.6 (22.4)</td>
</tr>
<tr>
<td>No. of previous methadone treatments#(1)</td>
<td>3.1 (1.5)</td>
</tr>
<tr>
<td>Currently using prescribed methadone*</td>
<td>45 (72.6)</td>
</tr>
<tr>
<td>Has his/her National Identity Card</td>
<td>44 (71)</td>
</tr>
<tr>
<td>Has a health card</td>
<td>36 (58.1)</td>
</tr>
<tr>
<td>Previous history of mental disorder</td>
<td>53 (85.5)</td>
</tr>
<tr>
<td>Has received psychological or psychiatric treatment</td>
<td>27 (43.5)</td>
</tr>
<tr>
<td>Positive toxicology tests*</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>56 (90.3)</td>
</tr>
<tr>
<td>Methadone</td>
<td>53 (85.5)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>53 (85.5)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>3 (4.8)</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>33 (53.2)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>40 (64.5)</td>
</tr>
</tbody>
</table>

(*) self reported data; (1) mean and standard deviation (2) Urine samples taken at randomisation. (3) for any disorder.

On average, the patients had been in three methadone treatments in the past, although at the moment of the study, 27.4% reported no current methadone treatment. Of all patients, 40.3% were HIV positive and 93.5% HCV positive. Twenty one per cent of the patients lived on the streets, only 4.8% were employed and half of them had problems with the law. As almost 30% had no government issued identification card, the social team had
to accompany them to obtain one. Also, a considerable number of patients (over 40%) had no health card even though healthcare is a Public System in Spain. Very few of them had ever received psychological or psychiatric treatment (43.5%) since they had become addicts. This finding points to the limited use of the healthcare services made by this group. As for substance abuse, toxicology tests showed that heroin, methadone and cocaine were the main drugs used by the participants.

Nursing Approach

One of the goals of nursing is to promote the health of the person, by focusing attention on responding to personal needs. By identifying such necessities in cooperation with the patient, and respecting his/her choices, quality attention and the protection of self-decision are ensured. Moreover, it is important to motivate people to participate actively in establishing and achieving realistic goals for themselves (Watson, 1988). Thus, care does not address a perceived deviation from good health, but considers the primary dimension of persons, their stage in the lifecycle and the situation before, during and following the care process (Marriner & Raile, 2003).

Nurses participating in the PEPSA intervention team were responsible for overall care for the patient. Care provided to each patient was individualized, focusing on his/her needs. Verbal communication was the main tool to facilitate a two-way exchange of information between the person and the nurse.

The treatment is based on mutual personal respect and the proximity facilitated by the approach used. There is a direct, ongoing relationship where, at certain times, physical contact is unavoidable (i.e., when vital signs are recorded, when handing over medicines, during intravenous administration of the substance, providing emotional support, etc.). Also, empathy, active listening and assertiveness characterized the care and strengthened the direct relationship with the patient.

Protocol for Nursing Performance in the PEPSA

The Centre was open to patients from 9.00 to 12.30 and from 15.30 to 17.45 hours. The medication was dispensed to the patients once a day in the only oral Methadone Group (no take home), and twice a day—morning and afternoon—in the diacetylmorphine Group (intravenous diacetylmorphine). A complementary dose of oral methadone (take home), was also given to members of this group to take later in the evening.

The protocol for nursing performance comprised the administration and supervision of the treatment and other actions aimed at reducing harm, encouraging healthy habits, monitoring the patient and counseling (Table 2). The general process included: admission of the patient; assessment of his/her general health status; delivery of treatment (methadone or diacetylmorphine); and assessment of the person’s response to the treatment if the patient received diacetylmorphine (oral methadone did not require this observation).

TABLE 2

Protocol of nursing actions in the Andalusian Heroin Prescription Trial

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Admission of the patient: (1 or 2 minutes)</td>
</tr>
<tr>
<td>2)</td>
<td>Assessment of general health status: (3 or 4 minutes)</td>
</tr>
<tr>
<td>3)</td>
<td>Administration of treatment: (between 2 and 15 minutes)</td>
</tr>
<tr>
<td>4)</td>
<td>Assessment of the response to treatment: (Experimental Group) (20 minutes)</td>
</tr>
<tr>
<td>Other actions</td>
<td></td>
</tr>
<tr>
<td>1)</td>
<td>Education for Health: Individual, or in workshops (healthy life habits, infectious diseases or drug use with less risk).</td>
</tr>
<tr>
<td>2)</td>
<td>Distribution of condoms and injection set; and needle exchange.</td>
</tr>
<tr>
<td>3)</td>
<td>Intervention with injection technique.</td>
</tr>
<tr>
<td>4)</td>
<td>Monitoring the general condition of the patient to detect any possible need for intervention.</td>
</tr>
</tbody>
</table>

On arrival at the Centre, the patient received individualized, personal treatment, i.e., he/she was called by his/her name or nick-name if he/she had one and agreed for this to be used. Each patient was given a daily general health assessment. The first part of the assessment, for both groups, was carried out prior to the person receiving any prescribed treatment and once he/she had
responded to questions included in a nursing data collection protocol. This entailed recording vital signs, mainly blood pressure and heart rate, plus any possible signs or symptoms of alcohol- or drug-induced intoxication, or Opiate Abstinence Syndrome (OAS) symptoms. The patient was asked to speak about the substances he/she might have consumed just before arriving at the Centre. An alcohol test was performed when considered necessary (in the case of obvious signs of alcohol-induced intoxication or if the patient declared that he/she consumes alcohol). Finally, a brief assessment of the persons’ nutrition, rest and hygiene was performed.

Dispensing of treatment was different for each group as the Methadone Group received only oral therapy while the diacetylmorphine Group received both oral and parenteral treatment. An example of the intervention for each group is displayed in Tables 3 and 4. In the Experimental Group, patients had to attend the Centre twice a day. Three nurses were involved in their care. First, one nurse admitted the patient at the waiting room and assessed his/her status using the data collection protocol mentioned above. The patient then waited for a ten-minute safety period prior to administration of any treatment. This enabled any possible previous intoxication from outside consumption of toxic substances (alcohol, benzodiazepines or cocaine, etc.) to be assessed as well as preventing any intoxication after the injection, thus ensuring the safe dispensation and administration of diacetylmorphine. This waiting period also proved useful to address a different type of situation or problem, namely arguments amongst patients over their turns for care or any preferences for being seen by a specific healthcare professional. If a patient was intoxicated, he/she had to wait for thirty minutes. If this state persisted, treatment was postponed until the next administration. When deciding on this postponement, given that the patient would not receive diacetylmorphine immediately, nurses needed to be aware of how to care for the patient’s reaction.

The nurse in the control room, where the treatment was prepared, was in charge of preparing the medication for each patient and giving it to him/her to administer. The diacetylmorphine came prepared from the hospital pharmacy in a light-protected bag with a 100 mg/ml solution. The nurse aseptically extracted the dose prescribed by the physician and gave it to the patient in a syringe, with cotton wool and a dressing. The nurse also handed out any concomitant medication. The tourniquet was for individual use and each patient had his/her own identified in the injection room.

The nurse in the injection room was always present while each patient injected him/herself. This nurse could give advice

### TABLE 3
Nursing Development Control Group Patient

| General Assessment: | Attends for treatment. The patient says he has had breakfast before coming to the Centre and has slept well. He does not present the Opiate Abstinence Syndrome and has no sign or symptom of intoxication. He has phlebitis on the back of both hands. There are two abscesses on the right forearm which are being dressed at the Centre and which look alright, although they still have sero-sanguineous discharge. |
| Outside consumption: | The patient admitted to the injection of two doses of heroin and cocaine (speed-ball) yesterday. |
| Other actions: | He has brought a needle to exchange for clean injecting material; he is given two injection sets. He is informed how to perform appropriate aseptic measures during and after injection. This aspect is emphasized because the patient himself says that he only uses an alcohol swab “sometimes”. The relationship between abscesses and the lack of hygiene and cleanliness during consumption outside the Centre is pointed out to the patient. |

### TABLE 4
Nursing Development Experimental Group Patient

<table>
<thead>
<tr>
<th>MORNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTROL ROOM:</td>
</tr>
<tr>
<td>WAITING ROOM:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AFTERNOON</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTROL ROOM:</td>
</tr>
<tr>
<td>WAITING ROOM:</td>
</tr>
<tr>
<td>INJECTION ROOM:</td>
</tr>
</tbody>
</table>

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about the most suitable place to inject, the correct position of
the tourniquet, a change of vein if the one normally used was
inflamed, the recommended technique for both injection and
searching for alternative veins, and how to avoid the practice of
‘booting’ (drawn blood into the syringe and then injected). The
nurse also ensured that clean, aseptic conditions were main-
tained in the room at all times, that the patients washed their
hands before and after administering the injection, that the in-
jection site was duly disinfected, and that the patients collected
all the equipment they had used, etc. This was also the time
when any necessary nursing care relating to the control of the
venous system (e.g., the treatment of cellulites, blood/lymph
seepage, abscesses, etc.) was delivered in an adjoining room
used for dressing changes. Lastly, if any adverse reaction af-
after the injection had happened (such as anaphylactic reactions,
epileptic fits, overdose of opiates or benzodiazepines, or psychi-
atriac emergencies) this reaction was assessed and appropriate
action taken (i.e., use of an oxygen mask, use of antagonists,
etc.).

The nurses acknowledged that patients developed from the
streets their own methods of using injection equipment, of find-
ing veins and injecting. However, attempts were made to im-
prove the patients’ technique by gradually introducing new
habits. The patient was given help on how to improve his/her in-
jection technique and was asked to inject under the supervision
of a nurse, at least twice; advice and help were also given con-
cerning the right way to do the initial injection. If the patient was
still unable to inject him/herself after this help, he/she could ask
the nurse to make a third and last attempt in accordance with
the protocol; if this too failed, an intramuscular injection was
given. An explanation was always given to the patient on how a
damaged, deficient venous system could be improved during the
treatment by respecting certain rules of hygiene and by fol-
lowing an appropriate technique to avoid complications. Given
that some patients continuing using injected drugs in the street,
emphasis was also placed on the relation between cocaine con-
sumption and the recovery of the venous system.

All required interventions were implemented with a physi-
cian in order and in accordance with the emergencies protocol
set by the Centre. If there was no incident, five minutes after
the injection, the patient went to the waiting room where he/she
waited for safety purposes for another 15 minutes before being
allowed to leave the Centre.

In the Control Group, the supervision and support accompa-
nying the medication consisted of dispensing oral methadone
once a day. The patient consumed the methadone in the Centre
(not take it home). Other concomitant medication (i.e., anti-
retrovirals, etc.), was dispensed as described below. As admin-
istration was oral and the patient only attended the Centre once
a day, only one nurse implemented the protocol. The nurse ad-
mitted the patient and assessed his/her status in the same way as
for the diacetylmorphine group, using the data collection pro-
tocol mentioned before: nutrition, rest, hygiene, substance use,
etc. Nevertheless, this was achieved more quickly than in the
Experimental Group, mainly because the patient did not need
any waiting time either before or after medication.

Other Actions

As mentioned previously, apart from delivering and supervis-
ing the administration of the diacetylmorphine doses, the nurses
also had other responsibilities, such as reducing harm, prevent-
ning risk, promoting healthy habits and counseling.

In many patients, hygiene, nutrition or rest were not adequate
for their health. As a result, nurses focused on basic care, such as
encouraging patients to shower and change underwear and outer
clothing, eat at least one nutritious meal a day (with their family
or in a soup kitchen), avoid prolonged siestas, and adopt regular
sleeping hours at night. This advice also took into account the
resources available to each patient; if none were available, the
patient was referred to nearby social resources or to a social
worker at the Centre.

Other duties taken on by the nurses included the distribution
of condoms and injection sets as well as the exchange of used
needles. This was done in both groups on an individual basis
through a brief interview to ascertain the patients’ understand-
ing of and attitudes to risks associated with certain drug-use
practices: sharing or re-using needles, using the compressor,
hygienic measures and others. The goal was to identify changes
in the patients’ method of administration (intravenous to inhala-
tion, or vice versa), and to encourage healthier habits.

When providing care for these patients, the nurses also ac-
nowledged that substance abuse co-exists with other illnesses,
such as sleep disorders, anxiety, depression, HCV or HIV.
For this reason, the patient was also supervised when taking
concomitant medication for physical diseases (anti-retrovirals,
tuberculostatics, antibiotic therapy, anti-inflammatories, anal-
gesics, anti-emetics); psychiatric medication (anti-depressants,
neuroleptics, anxiolytics or hypnotic drugs); and palliative drugs
for side effects from opioids (laxatives, antihistamines or anti-
epileptics). These medications could be prescribed at the Centre
itself or by other health service providers, such as infectious dis-
 ease consultants or a general practitioner. Some patients would
bring their medication collected at other centres for the nurses
to give to them at the PEPSA Centre on a daily basis. When the
medication was about to run out, the nurse reminded the patient
to visit his/her doctor for a prescription renewal.

Finally, in accordance with the protocol, the nurses and the
psychologist organized health education workshops for the pa-
tients. The topics of the workshops included: life styles and
health, sleeping habits, bucco-dental health, nutrition, diseases
associated with the route of drug administration (i.e., intra-
venous, inhaled) and the sort of substance used (i.e., heroin,
cocaine), HIV and AIDS, hepatitis, tuberculosis, sexually trans-
mittted diseases, safer sex, less risky drug use, sexuality, contra-
ception and contraception methods (these latter two workshops
were for women). These workshops were not as popular amongst
the patients as anticipated.
DISCUSSION AND CONCLUSIONS

Nursing care for patients who are addicted to drugs calls for a relationship which ensures seamless care. This relationship should be aimed at fostering and maintaining therapeutic communication based on skills of empathy, active listening, assertiveness, acceptance, respect, consistent information, and a non-judgmental approach (Chenitz, 1989). Communication is the fundamental basis for nursing activities, especially in the nurse-patient relationship, because it enables the continuity of attention and, at the same time, the establishment of personal relations that influence recovery and the quality of healthcare by prioritizing the patient’s welfare. As observed by Watson (1988), it is important to recognize the phenomenological field of the person, i.e., of the totality of the person’s experiences, accepting that negative feelings may be expressed, and that value judgments should not be made about the person.

One aim of nursing care is to help the patient him/herself pinpoint behaviors that could possibly be altered, and to help in discovering his/her own ability to change. As a result, nurses attempt to motivate change, to detect and provide positive reinforcement of any changes made, while always respecting the patient’s choices, and promoting the restoration of his/her independence (Wesley, 1997). In this trial, the fundamental aim was to work at reducing harm, which involves reducing any adverse consequences arising from the use of drugs, without necessarily reducing the use of drugs (Armstrong, Feigenbaum, Savage, & Vourakis, 2006).

Attention was also paid to the attitudes and beliefs held by experts treating drug addicted people, given that certain studies show that punishment-based attitudes are associated with very limited therapeutic outcomes (Caplehorn, Hartel, & Irwig, 1997; Caplehorn, Lumley, Irwig, & Saunders, 1998). The attitudes of healthcare professionals can raise a barrier in harm reduction approaches, particularly when the persons who use drugs become “bad patients” because they are considered dangerous, manipulative, or failing to cooperate in their treatment (Matinson & Hawthorne, 1996). Punishment-based attitudes may make patients lie and become mistrustful, and have no place in the context of a harm reduction policy (Hilton, Thompson, Moore-Dempsey, & Janzen, 2001). Critical, judgmental attitudes can cause any existing therapeutic relationship to break down, leading to the patient turning entirely away from the health service and avoiding any type of action from healthcare professionals. This distancing from therapy can also mean that the patient will only come to the Centre for substance, and will not allow any other type of intervention. As risk reduction aims to respect an individual’s freedom while curbing the negative consequences of consumption, any such activity should attempt to favor the involvement and responsibility of the patients toward attaining the goals set.

During the study, the reality that patients tends to underestimate the extent of their non-prescribed drug use or even deny consumption, was noted. This reality was shown when patient’s response did not coincide with the results of the toxicology and the alcohol tests. In general, the patients’ drug use entailed mainly the consumption of cocaine, benzodiazepine and/or alcohol. The situation was different, however, for the use of cannabis or heroin in the street, where there was less reticence in admitting this consumption. This could be due to the fact that they do not consider their use of cannabis as a problematic one. Also, given that they are in a heroin prescription Centre, this probably allows them to admit the use of heroin without difficulty (it should be noted that the experimental group did not use almost at all heroin in the street, and the control group assumed it “normal” to continue using heroin in the street). When a patient omits or muddles information, the healthcare professional may feel frustrated. This reaction may occur if the patient’s action is seen as a failure in therapy (loss of the patient’s trust in him/her, or seeing outside consumption as a failure of the intervention); there may also be a feeling that “the nurse’s trust has been betrayed.” In situations of this kind, the nurse may feel discouraged or might consider he/she has the right to take revenge. Over and above any consequent actions, either in line with the rules of the Centre or aims of the treatment, it is essential that the nurse does not take such situations personally, as this could compromise professional objectivity and opportunities to take action may be lost.

By showing respect and not criticizing or recriminating outside consumption of substances, nurses can contribute towards achieving medium- and short-term objectives on an individual basis. Those objectives could entail, for instance, encouraging attitudes and skills on the part of the patient related to the use of aseptic measures for consumption outside the Centre, or trying to change from injections to inhaling, amongst others.

Intravenous injection provided the nurse a privileged access to the patient’s body. The work of physical care and helping with the injection meant that the nurses could discuss with the patient everything related to outside drug use, techniques and abilities acquired, his/her behavior in different circumstances, and other issues. Moreover, this curative access, massage or examination of the patient’s body that is so frequently ill-treated by the patient him/herself allowed nurses to consider with the patient the real significance of the injection, thus helping to alter inappropriate attitudes and behavior in consuming (Marset, 2005).

The contact and daily routine with these patients afforded many moments of closeness during the clinical trial. The fact that nurses witnessed first hand both the injection of the substance and effects on the patient provided exceptional insight into the ritual of injection; a ritual that had ceased to occur carelessly in the street, at home or in a car, and instead is now being performed in a purpose-made centre with hygienic tools and measures in place. The ritual of taking drugs thus becomes merely taking a medication. This concept is more or less consciously assimilated by each patient. Both during and after injection, nurses should be respectful and patient; there should also be a moment of silence after the dose has been administered, trying not to disturb the patient during his/her moment of pleasure, or flash.
During these moments, situations may occur in which, as well as providing purely technical attention, nurses may become aware of a need to provide emotional and spiritual attention. Healthcare involves both the nurse and patient experiencing a sublime personal transaction (Watson, 1988). Patients express both positive and negative feelings before, during and even after the injection. These feelings may be related to previous or current realities, family or social relations, health condition, etc. The nurse accepts these emotions allowing a development of a relation of help and confidence, in the creation of a supportive surrounding and recognizing value of sensibility toward oneself and others (Watson, 1988).

The pleasure derived from drug use is an aspect which is generally ignored in discussions on drug addiction (O’Malley & Valverde, 2004). The treatment relying on prescribed heroin involves a moment of pleasure for the patient which nurses witnessed. This situation does not generally occur in conventional medicine, when nurses nearly always witness pain and illness. In this trial nurses cared for a patient who was actually experiencing a pleasurable event in front of the nurse. The pleasure is enjoyed after the injection without involving any risk or destructive process. For this reason, the idea behind the nurse’s work, particularly when administering treatment, is aimed at avoiding intoxication. The ritual of the typical injection amongst peers is converted into an act of taking medicine accompanied by a nurse who witnesses the patient during an intimate experience.

Some Limitations of Nursing Work in the PEPSA Trial

During the intravenous heroin prescription trial, many situations and moments for detailed discussion concerning nursing knowledge and skills occurred. Notwithstanding, there were certain flaws in the systematic collection of important nursing data, mainly in recording nursing performance so as to facilitate seamless care. This reality prevents conclusions being drawn about the treatment with these patients and, consequently, only a description of the nurses’ work can be offered. The nurses’ roles throughout the clinical trial focused on protecting and supervising the health of the patient, and collecting any details which might indicate whether the nurses’ interventions were effective. However, the information gathered was limited to explaining the patient’s condition, and did not include the nurses’ actions and approaches to a given situation. Nursing performance should have been recorded to enable later research into this area, offering new ideas which might contribute towards developments and improvements in this field, and make the work of nursing visible. Therefore, it is just as essential for the nurse to record his/her performance as it is to give a thorough assessment of the patient to be treated, so that such interventions can be evaluated, both for the patient as well as for other centres (Mutasa, 2001; Ryrie, Dickson, Robbins, Maclean, & Climpson, 1997).

There is a general sensation of failure regarding the health education workshops. The content of each of the workshops was devised by the nursing team and the psychologist at the Centre, involving both time and effort. However, results were disappointing in the light of the low attendance at most workshops and some workshops that were not attended at all. This lack of interest in the workshops may be due to three main reasons. Firstly, the content had been pre-set by protocol and the interests and needs of the patients had not been assessed when the workshops were actually held. Secondly, the subject matter to be addressed could not be altered, as this had been defined by protocol. Lastly, as patients had a time schedule for receiving their medication, workshop attendance required extra effort on their part. This same circumstance has been emphasized in another study, with a similar profile of patients undergoing treatment with methadone. There, it was stated that it is hard for patients to attend medical appointments, given that picking up methadone from the chemist or purchasing illicit drugs will always have priority for them over an appointment with the nurse (Mistral & Hollingworth, 2001). Therefore, it should be stressed that the needs and demands of the study group for workshops must be examined beforehand so that workshops provide what is important for them and truly meet their needs. At a later stage, other types of material more in line with the initial objectives in the protocol can be introduced. It is also essential to generate a positive environment, concentrating on motivating the patients to change by themselves, rather than determining and introducing changes for them (Ryrie et al., 1997). It is also important not to hold high expectations that patients of this kind will take part in this kind of initiative, as this will only lead to feelings of frustration which affect our relationships with the patient (Mistral & Hollingworth, 2001).

CONCLUSIONS

This project determined that the nurse is a central element in programs where patients receive supervised heroin prescription, in particular, and in other substitution treatments in general.

The nurse’s relationship with patients who are addicted to drugs will have a major impact on the patient’s degree of trust in continuing with his/her treatment. This relationship will largely be based on their attitudes, beliefs and interactions. Success will not merely be determined by the scope of the nurse’s knowledge, but also by the ability to forge effective relationships with patients. Consequently, a combination of both factors will condition the degree of professionalism and, as a result, professional success.

Supervised diacetylmorphine injection, as part of co-prescription of heroin in substitution treatment, is a relative new therapy that only takes place in a few limited countries (most of them in the frame of clinical trials) at this point in time. The significance of the nurse’s role in this therapy stems from their privileged contact with the patient. Nurses are part of an injection ritual that does not involve any risk or destructive process, and became an act of taking a medicine. After extensively reviewing the literature, the authors were unable to locate any articles on the nurse’s role in supervised diacetylmorphine injection.

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REFERENCES


