The Clinical Detail of Working with the Supervised Heroin Team in the UK

Rob van der Waal

Contents

- Setting
- Prescribing practices
- Injecting practice
- Risk management
- Goals
- Reflections

Supervised Clinics at SlaM

- 2005-2009 – RIOTT trial, one clinic open 7 days a week – two sessions
- 2010 - 2016 – 'Hub and Spoke' model
  - Hub: open 7 days a week, two sessions a day, Capacity - 40 clients
  - Spoke (x2): open 5 days a week – one session, Capacity – 10 clients
- Injecting room procedures by 2 RN's

Heroin Assisted Treatment

- Diamorphine ampoules for injection (pharmaceutical heroin)
  - (supervised at all stages)

and

- Methadone mixture or
- *Modified Release Oral Morphine tablets (MXL)*
  - (supervised initially or as long as is clinically required)

Titration

1. Trial period at clinic – increase methadone (e.g. to 60mg), followed by
2. Introduction of additional low dose of diamorphine (e.g. 50mg), then
3. Gradual increase of diamorphine (e.g. by 20-30mg every 2/3 days), in conjunction with
4. Gradual increase of methadone if indicated (e.g. 10mg weekly), until
5. An optimal and well tolerated dose of both is established (in general within 4 weeks)

Optimal Dosing Example

- Option A: Diamorphine 200mg am
  Diamorphine 200mg pm
  Methadone oral 80mg

- Option B: Diamorphine 200mg day
  Methadone oral 90mg

- Option C: Methadone oral 100mg

Flexible dosing

- No take home doses of injectables
- Converting Injectable to Oral (partially or completely)
  - If clients can’t attend
  - To provide choice
  - To provide pathway to Oral
- Option B (once daily injection)
- Option C (no injection)

Reduction

- If part of a mutually agreed care plan following stabilisation
  1. Gradual diamorphine/injecting reduction
  2. Optional methadone reduction if requested and clinically responsible/appropriate
- Alternatively can be due to clinical risk
  - Can involve immediate cessation of injecting and a return to oral opioids

MXL
(modified release oral morphine)

- Some clients expressed an aversion to or reluctance to increase methadone to optimal levels, but
- Were amenable to (optimal doses of) MXL
- MXL appeared to enable clients to reduce injecting frequency and/or reduction of prescribed diamorphine
- (Bond et al, 2011)

Injecting practice

- Washing of hands, cleaning of sites before and after injection
- Inspection of sites- No use of inflamed/damaged veins and sites
- IV- Only peripheral veins in arms, legs allowed
- IM - Most of our clients had poor veins and therefore adapted to intramuscular injections
- No groin injecting (Zador et al, 2008)
- Development of injecting plan

Risk management

- Brief observation before and after each dose
- Monitoring of vital signs at induction, at dose increments and when clinically indicated
- On the spot Breathalyser testing for alcohol use/UDS dipstick for benzodiazepines use
- Regular testing for street heroin (Paterson et al, 2005)
- Dose reductions, time outs, return to OST

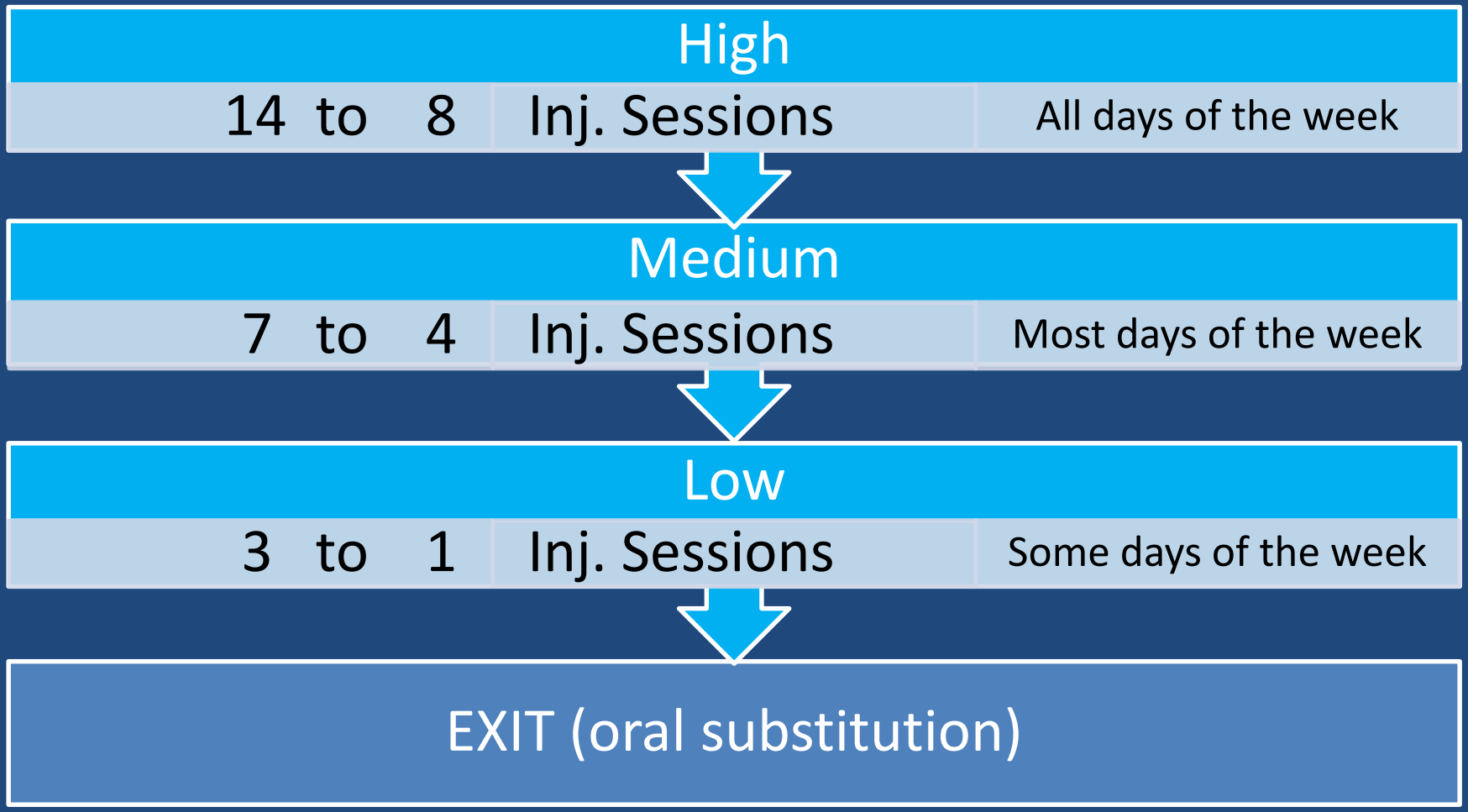
Short term goals

- Focus on 100% attendance of sessions
- Increase prescribed meds to optimal levels
- Cessation of street heroin use
- Stop HAT incompatible use of alcohol and benzodiazepines
- Develop sustainable injecting routine (e.g. IM injecting with site rotation)

Medium – Long term goals

- Reduce/stop all street drug use
- Reduction of injecting dose and/or attendance
- Return to oral substitution? Or long term (reduced) injectable maintenance?

SlaM HAT Model



Reflections

- HAT can keep patients engaged in highly structured treatment
- Model can help clients to progress to low frequency or return to standard oral substitution treatment
- However others expressed no desire to reduce or come off injectables (but stopped street heroin use)
- And not all do well (e.g. continued use of street heroin, alcohol/benzodiazepine use, non attendance, etc.)

Reflections

- Should HAT be time-limited?
- Or not time-limited but depend on progress?
- What is progress?
  - Return to OST?
  - Cessation of street heroin use?

References

- Zador D, Lintzeris N, van der Waal R, Miller P, Metrebian N, Strang J, (2008) The Fine Line between Harm Reduction and Harm Production – Development of a Clinical Policy on Femoral (Groin) Injecting. Eur Addict Res 2008;14:213-218
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- Paterson S, Lintzeris N, Mitchell TB, Cordero R, Nestor L, Strang J , (2005) Validation of techniques to detect illicit heroin use in patients prescribed pharmaceutical heroin for the management of opioid dependence, Addiction, vol./is. 100/12(1832-1839)