

NATIONAL COMMUNITY DETOXIFICATION

Benzodiazepine Guidelines





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1. Introduction

These guidelines were developed from the Community Detoxification Protocols (Ana Liffey Drug Project, 2011) which were reviewed and amended in 2015. The purpose of these guidelines is to advise on the detoxification of service users in a community setting. The recommendations contained in these guidelines were developed by an expert multi-disciplinary team from within the addiction sector while also taking into consideration the available literature. This document provides support for the treatment of service users who are undergoing detoxification for benzodiazepine dependence. These guidelines are intended to be read by those involved in providing psychosocial and medical support for detoxification in a non-residential treatment setting. These guidelines outline the minimum medical and psychosocial supports which should be provided to an individual engaging in Community Detoxification.

1.1 Aims

These guidelines aim to:

- reduce variation in practice and improve the quality of treatment decisions;
- provide professionals with structure and support to improve treatment outcomes;
- ensure that community-based detoxes have a medical and psychosocial support structure;
- educate health care professionals on the accessibility of community based detoxification;
- deliver a convenient treatment option to service users in all areas of the country.



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2. What is Community Detoxification?

Community Detoxification supports service users to reduce or stop their use of methadone, benzodiazepines or Z hypnotics through an organised process involving key workers and GPs within their community. It can be accessed as an alternative option to inpatient residential detoxification, or as a necessary step towards meeting entry requirements for residential treatment. There are three distinct Community Detoxification Guideline documents for: methadone; benzodiazepines; and Z hypnotics. While commonalities in the minimum standards of supports exist, there are important differences in the provision of detoxification options that are addressed in the guidelines, including: entry and exit criteria; detoxification schedules; and withdrawal symptoms. This document contains the benzodiazepine guidelines.

These guidelines have been developed by an expert Steering Committee consisting of leaders in addiction services from the medical, community/voluntary and research fields. The Community Detoxification Guidelines have been developed in line with:

- the QuADS Organisational Standards (Ana Liffey Drug Project and Health Service Executive, 2014);
- the National Drugs Strategy (*interim*) 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009);
- the Introduction of the Opioid Treatment Protocol (Farrell & Barry, 2010);
- the National Drugs Rehabilitation Framework (Doyle & Ivanovic, 2010);
- the National Protocols and Common Assessment Guidelines: to Accompany the National Drugs Rehabilitation Framework (National Drugs Rehabilitation Implementation Committee, 2011).

2.1 Community Detoxification Steering Committee

The following were responsible for the development of the guidelines:

Dr Ide Delargy (ICGP)

Dr Austin O'Carroll (Safetynet)

Dr Des Crowley (HSE)

Dr Joanne Fenton (Access team)

Dr Suzi Lyons (HRB)

Ruaidhri McAuliffe (UISCE)

Tony Duffin (Ana Liffey Drug Project)

Brian Friel (Peter McVerry Trust)

2.2 Professional liability

The Community Detoxification Guidelines are a set of guidelines to assist professionals to support service users through a community-based detoxification. It is the responsibility of the organisations involved to ensure that staff providing Community Detoxification are competent in their role and trained in relapse prevention and care planning. Additional insurance is not required for the provision of Community Detoxification. This work should be included in the service's current insurance policies.

The Community Detoxification Steering Committee and the organisations associated with the development and production of the Community Detoxification Guidelines do not accept responsibility for any harm to service users undergoing Community Detoxification while working in line with these guidelines.

2.3 Uses and limitations of these guidelines

Community Detoxification is a structured detoxification process in a non-residential setting. These guidelines do not make recommendations for crisis detoxification, residential treatment or detoxification within a prison setting. Furthermore, these guidelines do not make recommendations for the detoxification of non-listed substances such as alcohol or the detoxification of pregnant women. Community Detoxification should be readily available to service users seeking treatment. To ensure service users's safety, there are medical contraindications which may exclude certain service users from accessing Community Detoxification. An individual's suitability to participate in Community Detoxification is determined on an individual basis by the GP involved.

2.3.1 A step towards residential detoxification

Community Detoxification can be used to assist service users reducing or stopping their use of methadone, benzodiazepines or Z hypnotics in order to meet the entry requirements of residential treatment facilities.

2.4 Community-based services

The Introduction of the Opioid Treatment Protocol (Farrell & Barry, 2010) recommends that all service users should be offered detoxification as a treatment option and acknowledges that there is a role for community-based services in providing potential key working supports in relation to all treatment options. Further recommendations state that the establishment of stronger links between general practice, pharmacy and community drug projects are desirable.

2.4.1 History and rationale for the Community Detoxification Protocols

The Community Detoxification Protocols were developed in the North Inner City Drugs Task Force Area in Dublin, in response to a gap in treatment options for service users wishing to reduce or cease their methadone or benzodiazepine use. This issue was identified in *'We're People Too'* (O'Reilly, Reaper & Redmond, 2005) and through anecdotal evidence from service users who reported that Community Detoxification options were not available to them. In these instances, service users reported feeling disempowered from their treatment and frustrated that they had limited pathways to address their issues or attain their goals. Through initial consultations, doctors prescribing methadone raised concerns that service users who engaged in a community-based detoxification without adequate preparation or support were at considerable risk of overdose and fatal overdose. GPs also highlighted that they had limited consultation times and were not in a position to provide the necessary psychosocial supports required for safer detoxification in the community.

In 2007, the Ana Liffey Drug Project and Community Detoxification Steering Committee responded to this issue. The concerns of service users, doctors and drug services guided

the formation of an initial interagency steering group to progress the idea of formalised Community Detoxification Protocols. The protocols aimed to outline a clear process for how service users would be assessed as appropriate for a Community Detoxification and how GPs and key workers could coordinate to provide effective supports while managing the risk of relapse and overdose. Following an 18 month implementation period, the pilot was evaluated under the direction of the Steering Group.

2.4.2 North Inner City Drugs Task Force Community Detoxification Evaluation

The protocols and pilot scheme were launched in April 2007, and evaluated in early 2009. The evaluation, which included service users, key workers and GPs, revealed a predominantly positive experience of the pilot scheme.

The main findings were:

- 16 out of 29 service users had an initial introductory meeting.
- Out of these 16, 7 had successfully completed the Community Detoxification and 7 were still engaged. Only 2 disengaged once a GP had become involved in the process.
- 4 of the 29 service users disengaged at the key working phase.
- 4 of the 29 service users received another service such as maintenance or aftercare.
- Referrals were split between: self-referral (48%); community/voluntary (31%); and medical services (17%).
- Detox requests were similarly split between opiates related (55%, $n=16$) and benzodiazepine related (45%, $n=13$).
- Service users reported a positive experience overall; all of them said they would recommend the process to a friend.

2.5 National Pilot

In response to a number of referrals from outside Dublin's North Inner City and growing interest in the initiative, a national pilot scheme was proposed to, and approved by, the Steering Committee. A number of geographical areas were prioritised for inclusion in the National Pilot Scheme in autumn 2011.

2.5.1 Updated guidelines

Building on the experience of the pilot scheme, the Community Detoxification Protocols (Ana Liffey Drug Project, 2011) were reviewed by the Ana Liffey Drug Project in 2015. The current guidelines were developed from the Community Detoxification Protocols and provide updated information on Community Detoxification. The new guidelines are now available to services nationally. By building on experience, these guidelines aim to improve service delivery and ensure the best possible practice.

2.5.2 Changes in these guidelines

The current guidelines provide updated information including:

- guidance for detoxification of Z hypnotics;

- removal of mandatory broker role in the Community Detoxification structure;
- different stages in the detoxification process;
- an initial assessment by the GP to ensure service user suitability;
- acknowledgement of dual diagnosis and mental health symptoms as a factor in the Community Detoxification process;
- provide online information for GPs and key workers.

The changes to the protocols have been made to enhance service delivery, and to emphasise the centrality of the relationship between the service user, key worker and doctor. However, this is not to say that additional supports cannot be implemented. The Steering Committee fully recognises, and wishes to emphasise, the importance of local knowledge and expertise in ensuring successful delivery of services. There is nothing to prevent services mandating an individual or agency locally to promote and / or coordinate the new guidelines.

2.5.3 The Ana Liffey Drug Project

The vision of the Ana Liffey Drug Project is for a society where all people affected by problem substance use are treated with dignity and respect and have access to quality services. The organisation's mission is to work with people affected by problem substance use and the organisations that assist them. Its aim is to reduce harm to service users and society, and to provide opportunities for development of those service users and organisations. Working in partnership, the Ana Liffey Drug Project aims to improve the range of accessible services available to people who use drugs.

2.6 Guideline structure

These guidelines are structured to make Community Detoxification a clear process for professionals. This document is divided into separate chapters with relevant topics included in each.

Chapter 1 and chapter 2 give an introduction and summary of service delivery. This section provides an overall description of the service.

Chapter 3 and 4 present the psychosocial and medical support roles in line with the guidelines. These chapters are relevant to those who are currently, or who intend to, provide support in the area of Community Detoxification.

Chapter 5 provides clinical recommendations for both psychosocial and medical supports.

Chapter 6 includes relevant information relating to substances and Community Detoxification.

2.7 Summary

These guidelines outline the agreed minimum standards for the delivery of Community Detoxification support. The aforementioned standards of care are delivered through

psychosocial and medical supports.

The minimum standards are:

- **Care Planning:** Care planning takes into account all factors that may negatively impact on an individual's capacity to engage in a successful Community Detoxification such as housing or family matters, as well as those which may promote success, such as meaningful use of time and social supports.
- **Relapse prevention:** Structured sessions aim to provide service users with a skills and knowledge base around drug use, harm reduction, risk and relapse.
- **Medical support:** Regular medical appointments are provided to supervise the detoxification. The prescribing GP agrees to engage in communications with the Key Worker, regarding the service user's progress, and in particular, any change to the initial detoxification schedule or care plan.



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3. Delivering Community Detoxification

This section outlines the key components required to deliver Community Detoxification.

Community Detoxification should include:

- A named key worker or health care professional who will provide psychosocial support.
- A prescribing GP who delivers a physical and mental health assessment, medical support and detoxification.

3.1 Psychosocial support

It is the responsibility of the organisations involved to ensure that staff providing Community Detoxification are competent in their role and have the appropriate level of training to cover their work. Key workers are required to be trained in key working, relapse prevention and care planning.

The recommended time which should be allocated by the key worker to support the service user is two hours per week for the first month and one hour per week thereafter. It is acknowledged that some cases may require additional support.

3.2 Medical support

The GP involved with a Community Detoxification will monitor the medical aspects related to detoxification. The GP will work within the scope of the Community Detoxification Guidelines. Their competencies are integral to their professional medical qualification and do not require additional validation through this process. The GP is responsible for establishing who is suitable for Community Detoxification and will provide medical reasons for those deemed unsuitable.

3.3 Professional relationships

These guidelines place emphasis on psychosocial and medical support as part of Community Detoxification. It is recommended that the key worker, prescribing GP and service user develop a reliable relationship from the initiation of the process.

The key worker should communicate proactively with the GP and be informed about the individual's suitability, suggested care plans, detox schedules and changes in arrangements. The key worker should communicate details of the service user's care plan and any major adjustments to the care plan to the prescribing GP, while also keeping the GP updated on any issues which arise during the process. Both the prescribing GP and key worker are expected to be mindful of the mental health of the service user throughout the process and to discuss any issues if they arise.

It is recommended that the key worker accompanies the service user for the initial assessment with the GP and presents the GP with a drug diary and the Key Work Assessment Form (Appendix 3). The purpose of this is for all parties involved to discuss individual suitability, more specifically, what is expected of the service user and what

options are available to them. If this is not possible, the key worker is required to call the GP (in the presence of the service user) to arrange the health assessment with the GP, followed by sending the GP by email the service user's drug diaries and assessment forms, which are to be reviewed as part of the process. With the service user present, the key worker is required to call the GP to discuss the GP assessment outcomes.

3.4 Under 18s

Service users under the age of 18 are required to attend a Tier 3 service if they wish to participate in Community Detoxification. As the detoxification of adolescents can be more complex than that of adults, the appropriate treatment setting for detoxification needs to include a range of medical, psychological and social supports. Tier 3 services have specialist expertise in both adolescent mental health and addiction.

A Tier 3 service must have a multi-disciplinary team with expertise in the following:

- Medical treatment options for addiction disorders (child psychiatrist, psychiatrist registrar or GP).
- Treating comorbid disorders.
- Child protection issues (social worker).
- Outreach (an experienced outreach worker).
- Assessment of developmental issues (child psychiatrist or clinical psychologist).
- Delivering individual or group psychotherapeutic interventions.
- Systemic or family therapy.

It is advised that complex cases are directed towards inpatient treatment facilities.



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4. Community Detoxification Steps

The Community Detoxification process can be divided into the following six phases:

1. The establishment of a key work relationship.
2. Key work preparation for GP health assessment.
3. Health assessment by the prescribing GP.
4. Key work preparation for detoxification.
5. Detoxification.
6. Aftercare / progression to residential treatment.

In order to begin the Community Detoxification process, an individual must have an appropriately trained key worker who is willing to work within the Community Detoxification Guidelines.

4.1 Establishing a key work relationship

Each service user intending to engage in Community Detoxification will require a key worker to prepare them for the process.

If the service user currently has an appropriately trained key worker, he or she can receive Community Detoxification psychosocial support from that individual.

Psychosocial support can be provided by any appropriately trained health professional who can provide assistance with relapse prevention and care planning.

4.2 Key work preparation for GP assessment

The key worker must work with the service user to prepare him / her for the initial meeting with the GP. Preparation for this meeting involves the key worker completing the forms listed in Appendices 1, 2 and 3. The GP health assessment is a physical and mental assessment completed by the prescribing GP to ensure service user suitability.

- When a service user requests a Community Detoxification, it is the role of the key worker to complete the initial forms provided in these guidelines.
- It is necessary for the service user to be informed of the Community Detoxification process and to be made aware that the overall decision of detoxification suitability is decided by the prescribing GP on completion of an assessment.
- Risk management and harm reduction techniques must be explained to, and understood, by the service user. The service user is required to be fully aware of positives and negative aspects of participating in Community Detoxification.
- Once the key worker has completed the required documents with the service user, the prescribing GP can be contacted to schedule an assessment.
- It is essential that the Key Work Assessment Form (Appendix 3) and drug diary are prepared and presented to the prescribing GP as part of the assessment. These forms assist the GP in the process.
- It is recommended that the key worker accompanies the service user to the GP assessment. If the key worker cannot attend, the Key Work Assessment Form and drug diary should be sent to the GP by email.
- On condition that the GP considers the service user is suitable for Community Detoxification, the key worker can then begin preparation for detoxification.

- In the event of the service user not being suitable for Community Detoxification, it is the role of the key worker to assist this individual in finding a different treatment option.

4.3 GP assessment

A GP assessment is required as part of these guidelines to establish the extent of the service users substance use and to examine his / her physical and mental health. This assessment is completed by a prescribing GP who is prepared to work as part of the Community Detoxification Guidelines. The GP provides the medical support involved in detoxification and determines service user suitability to ensure patient safety.

Assessment recommendations:

- It is the role of the prescribing GP to ensure that the service user is suitable for detoxification in a community setting.
- The physical and mental health of the service user needs to be considered before preparation work commences.
- If the service user has mental health concerns, it is at the discretion of the GP to proceed to detoxification.
- If the service user is currently attending a professional for mental health reasons, this individual must be included in the decision-making process with the prescribing GP.
- For the purpose of the assessment, the prescribing GP will be provided with the Key Worker Assessment Form (Appendix 3) and drug diary.

4.4 Medical contraindications to Community Detoxification

Medical contraindications need to be reviewed as part of the service user's suitability to engage in the Community Detoxification process. If a service user is contraindicated as per the criteria below, that person is not automatically excluded from engaging in a Community Detoxification. However, service user suitability for detoxification is the decision of the prescribing GP.

Factors which may mean a service user is not suitable for Community Detoxification are:

- psychosis or severe mental health problems which are currently untreated;
- a history of epileptic seizures while undergoing detoxification;
- major medical illness;
- possible dual addiction, where both addictions are unstable or where a second addiction other than opiates is uncontrolled, for example cocaine, alcohol and benzodiazepines;
- pregnancy.

4.4.1 Community Detoxification and pregnancy

The Community Detoxification Guidelines do not recommend the use of these guidelines for community-based detoxification for pregnant women. This is due to the complexity of the withdrawal and the possible risks to the mother and foetus. It is recommended by the Institute of Obstetricians and Gynaecologists and Health Service Executive (2013) that all pregnant women receive services from specialised or high risk antenatal clinics. If a service user involved in Community Detoxification becomes pregnant, the GP should be

notified to examine the service user in order to advise on the best available services, and to connect with the Drug Liaison Midwife linked to the relevant maternity hospital.

4.4.2 Other factors

Other factors to be considered are:

- The service user's living situation.
- Current relationships.
- Cannabis and alcohol use.
- Unexpected life events.
- Failed attempts at Community Detoxification in the past.

Note: Service users should be assessed on an individual basis with consideration to their personal situation.

The contraindications relative to Community Detoxification are established on an individual basis. Service users with dual addiction, mental health concerns and poly drug use can access Community Detoxification in certain situations.

4.5 Dual addiction

Service users could present for detoxification with an addiction to more than one substance. Dual addiction can be a medical contraindication for detoxification because of the risks associated with poly drug use, such as overdose and death.

When can a service user with dual addiction access Community Detoxification?

The issue of dual addiction as a contraindication to detoxification needs to be established on a case-by-case basis. Dual addiction should be discussed between the prescribing GP and the key worker. In some circumstances, it is possible for the prescribing GP and key worker to arrange a care plan to manage dual addiction before detoxification is agreed.

Factors when considering dual addiction as a medical contraindication:

- There is a possibility that the individual is addicted to one or more substance which could pose a danger during detoxification. The risk of overdose is greatly increased when certain drugs are used in combination.
- Dual addiction, which includes an addiction to cannabis, could represent a contraindication depending on the amount consumed and the effect this has on the service user individually.

Benzodiazepines and methadone

If the service user is using both benzodiazepines and methadone he / she could be suitable for Community Detoxification. In this situation, benzodiazepines should be detoxed first followed by methadone.

Alcohol and other substances

Alcohol use in conjunction with other substances can pose a serious risk of fatal overdose to the service user. There is a higher risk of overdose or fatal overdose during or after detoxification. It is advised that problem drinking should be managed through a care plan prior to engaging in the Community Detoxification process. Alcohol use can lead to impaired judgment and increase the risk of relapse to unprescribed benzodiazepine use leading to overdose and death. Prescribing benzodiazepines to someone who is using alcohol increases that individual's risk of overdose and death. However, decisions on this issue are at the GPs discretion and should be made between the service user and the prescriber. Service users should be fully informed of the heightened risks and consequences of combined benzodiazepine, reduction and alcohol use.

Alcohol use can be managed through complete alcohol detoxification, reduction in use, or other harm reduction or risk management strategies. As with any situation where there is a heightened risk to the service user, additional medical and psychosocial supports should be provided. Based on the severity of the service users alcohol use, the GP or key worker may advise that the service user attend residential treatment to complete an alcohol detoxification programme before being considered suitable for Community Detoxification.

If the service user is already engaged in the detoxification process and concerns arise in relation to the service user's alcohol consumption, the key worker is obliged to inform the GP as soon as possible. This should be managed as with any increased risk during the detoxification process: through additional supports, structured care planning and ongoing interagency communication.

Psychosocial support

The decision regarding whether psychosocial support can assist the individual in overcoming dual addiction should be determined on an individual basis.

Factors which need consideration are:

- The substance involved.
- The length of time the substances are being used.
- The number of substances being consumed.
- Motivation.
- Living situation.
- The dangers which might be associated with dual addiction.

It may be decided that psychosocial support should be directed towards the reduction of other substances before the GP considers the service user is suitable for Community Detoxification. If dual addiction cannot be managed in a community setting the individual should be directed towards an appropriate treatment option.

When is dual addiction a barrier to community detoxification?

- If the prescribing GP / key worker consider it is a risk for the service user.
- If the prescribing GP / key worker consider the severity of dual addiction cannot be overcome by psychosocial support in the community.
- If psychosocial support in the community has been provided and it has not helped the service user overcome the dual addiction.

4.5.1 Poly drug use

Poly drug use is the use of more than one drug or type of drug by an individual — consumed at the same time or sequentially.

When can a service user who is a poly drug user access Community Detoxification?

The risk of overdose is greatly increased when certain drugs are used in combination, particularly opiates (codeine, heroin, and methadone), benzodiazepines, tranquillizers, sleeping tablets, anti-depressants and alcohol. The use of cannabis may not be considered as harmful, but could pose as a contraindication depending on the amount consumed and the effect this has on the service user individually. Poly drug use can be reduced through psychosocial support provided by the key worker before detoxification is recommended.

When is poly drug use a barrier to community detoxification?

Poly drug use can be a medical contraindication depending on the substances used and the risks which these pose to the service user. Psychosocial support should aim at addressing poly drug use with the service user as part of that individual's care plan leading towards detoxification.

4.5.2 Mental health

When should mental health issues not exclude a service user?

A mental health assessment is an essential stage of Community Detoxification. Dual diagnosis is common among the drug-using population. Studies have shown that the occurrence of comorbid mental disorders in service users who use psychoactive substances can be high (European Monitoring Centre for Drugs and Drug Addiction, 2013).

Drug use may cause one or more symptoms of mental health disorders. Symptoms can result directly from drug use or indirectly from the lifestyle and conditions the drug user experiences. Dual diagnosis can also be present with those who have existing mental health disorders and use substances to self-medicate. The area of dual diagnosis can be complicated as symptoms can overlap. The conditions may present at the same time or at different stages of an individual's life.

These guidelines acknowledge that service users might present for assessment while displaying symptoms of mental health disorders. Service users may experience anxiety disorders, depressive disorders, extreme stress, drug-induced delusions and aggression. These guidelines attempt to provide the best possible guidance in this area for a Community Detoxification.

Community Detoxification requires:

- A Key Work Assessment Form (Appendix 3). This form collects information relating to symptoms and is presented to the GP in order for an assessment to be conducted.
- A GP assessment to ensure patient suitability.
- Observations by the key worker and GP of the service user's mental health status throughout preparation, detoxification and aftercare and communication of any possible risks regarding the service user's health.
- Acknowledgment that mental health concerns may be present and consideration

of the best options for the service user. Mental health treatment could be introduced as part of the care plans for certain service users.

- Inclusion of mental health professionals if they are working with the service user. The mental health professional should be involved in the decision-making process with the GP.

The most appropriate treatment setting for the service user will be determined by the outcomes of the GP assessment, combined with the professional judgement of the GP and key worker. A service user may need to access mental health treatment before meeting the Community Detoxification requirements. By completing a mental health assessment, service users can be linked in with other services, if appropriate.

Important considerations regarding service users with dual diagnosis:

- The level of risk involved for the service user in the community.
- The service user's capacity to take prescribed medication.
- If services are available, a multidisciplinary team can be involved in the process.

What mental health symptoms should be contraindications?

During the initial Community Detoxification key work session, the Key Work Assessment Form should be completed and presented to the GP in order for an assessment to be conducted. This form records information relating to symptoms of severe mental illness.

The GP can use the standard method of assessing mental health issues and also review the Key Worker Assessment Form. During this assessment the GP shall examine the service user for currently untreated severe mental health issues and psychosis. It is recommended that current and untreated severe mental illness and psychosis should exclude a service user from Community Detoxification.

Signs and symptoms of severe mental health issues and psychosis may include:

- Detachment from reality
- Hallucinations
- Delusions
- Confused and disturbed thoughts
- A lack of insight and self-awareness
- Hearing voices
- Paranoia
- Intent to hurt oneself or others

4.6 The choice of setting

How should the appropriate treatment setting for the service user be decided?

It is the role of the GP to decide if Community Detoxification is suitable for a service user.

The GP might consider a service user is unsuitable if they are:

- medically contraindicated;
- experiencing mental health issues which need to be resolved before detoxification;
- currently in an unsuitable environment;
- experiencing difficulties which need addressing before commencing.

In the event of a service user not being suitable for Community Detoxification it is the

role of the key worker to establish an appropriate treatment setting through assessment and care planning in line with the National Drugs Rehabilitation Framework.

The key worker will need to assess the service user's current situation regarding:

- current drug use;
- childcare commitments;
- work and education commitments;
- current living situation;
- expectations from treatment;
- previous treatment and history of withdrawals.

In line with Protocol 3 (Referral between agencies) of the National Drug Rehabilitation Framework, the key worker will need to research treatment facilities and examine:

- requirements for treatment facilities;
- the programmes delivered by the treatment facilities;
- the length of time of the treatment;
- the location of the treatment facility;
- waiting lists;
- any specific supports required for mental health and childcare needs.

It is acknowledged that there may be requirements and waiting lists for residential treatment. The key worker should continue the care plan and support until the service user is accepted to the appropriate facility.



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5. Psychosocial support

It is the responsibility of the organisations involved to ensure that staff providing Community Detoxification are competent in their role and have the appropriate level of training to undertake their work. The key worker will need to be trained in relapse prevention and care planning.

As part of the Community Detoxification Guidelines, psychosocial support is a core component in its delivery to service users. It is necessary that the service user attend key work sessions weekly.

It is recommended that key work sessions of a minimum of two hours per week occur for the first month and one hour per week thereafter. If the service user is failing to attend key work sessions, this issue needs to be brought to the attention of the prescribing doctor.

The role of the key worker is to:

- Adhere to the Community Detoxification Guidelines.
- Ensure the service user is aware of the detoxification process.
- Carry out assessments to identify and prioritise needs for that individual.
- Complete the Key Worker Assessment Form (Appendix 3) and one drug diary to present to the GP for the GP assessment.
- Create, discuss and implement a treatment plan with the service user before, during and after detoxification.
- Regularly review the established care plan.
- Consider risks such as overdose, self-harm and withdrawal symptoms.
- Assess and act upon immediate risk of danger to substance use
- Highlight the risks and positive aspects of detoxification to the service user throughout the detoxification process.
- Inform the service user of risk management techniques.
- Establish cues and triggers of drug use with the individual.
- Develop strategies with the service user to reduce the risk of relapse.
- Proactively communicate with the GP involved in the detoxification process.
- Contact the GP if a service user is not attending key working sessions.
- Communicate to the GP if the service user is having difficulty with the chosen detoxification schedule.
- Inform the GP of any mental health issues or major life events which have occurred for the individual during detoxification.
- Be mindful of changes in the service user's mental health.
- Ensure that service users have access to a wide range of services.



6

6. Key work process

6.1 Preparing for the GP assessment

Overview

When Community Detoxification has been identified as a goal within the service user's care plan, the key worker should meet with the service user to discuss the Community Detoxification process, to complete the necessary forms and to arrange an appointment with the GP for an assessment.

Process

1. The preparation for the GP assessment is an important process where the key worker ensures that the service user is fully informed of the Community Detoxification Guidelines and any other treatment options available.
2. It is the role of the key worker to complete the initial Community Detoxification forms (Appendix 1, 2 and 3) with the service user and to clarify any areas of uncertainty.
3. At this stage it is essential for the key worker to arrange for a GP to provide an assessment.
4. If the service user's GP wishes to provide the detoxification, it is the role of the key worker to make the GP aware of the Community Detoxification Guidelines.
5. It is the role of the key worker to find a GP who will provide a detoxification as outlined within the Community Detoxification Guidelines, if the service user's current GP cannot provide the detoxification.
6. The key worker must complete the Key Worker Assessment Form (Appendix 3) to present to the GP with one drug diary. If the key worker is unable to attend the GP appointment, the forms must be sent by email to the GP. For patient confidentiality reasons, it is recommended that these documents not be sent by fax to the GP's surgery.

Tools:

- ✓ Initial check list, participation agreement (Appendix 1&2)
- ✓ Drug diary
- ✓ Key Work Assessment Form (Appendix 3)

6.2 Preparing for detoxification

Overview

Preparation for detoxification can require a long period of psychosocial support depending on the individual and the substances being used. It is during this period that the service user must reduce substance consumption and focus on improving skills and techniques for addressing the drug use. These guidelines recommend a minimum of four sessions over a two-week period for the preparation stage. For some service users a longer period than the recommended timeframe might be required. The key worker should meet with the service user a minimum of once a week for preparation until the latter is prepared for detoxification.

Process

1. A care plan addressing all areas of the service user's life needs to be completed with the individual. Priority must be given to areas of greatest need before detoxification. This could be housing or mental health concerns, or other issues.
2. Relapse prevention techniques must be completed with the service user.
3. The key worker and service user will spend a minimum of two hours per week for the first month and a one hour per week there after focusing on relapse prevention and care planning. Where a need is identified, these sessions can be conducted twice weekly for the initial few months. The tasks of care planning and relapse prevention should be clearly differentiated, with time being allocated for each.
4. The risk of withdrawal, seizures and overdose during detoxification should be discussed with the service user by the key worker to prepare the individual for detoxification.
5. If the service user is consuming benzodiazepines they may experience poor memory and concentration. In this case, vital work may need to be redone between the key worker and the service user. This may prolong preparation for detoxification.
6. If the service user does not cease poly drug use and is using significant quantities of substances, it is the role of the key worker to address this and discuss the individual's suitability for Community Detoxification with the GP.
7. Additional key work may need to be provided to service users reducing their levels of street drugs. This may take a longer period of time and require extra resources.
8. The TOP form (Appendix 4) is provided in this document to help key workers examine drug consumption.
9. Drug diaries need to be completed throughout the detoxification process. For benzodiazepine detoxes fourteen consecutive days drug diaries must be presented to the doctor to initiate the beginning of detoxification.
10. When the key worker feels the service user is prepared and meets the entry requirements for detoxification the GP will be contacted.
11. For benzodiazepine detoxifications, the drug diaries and care plan should be forwarded to the GP.

Tools:

- ✓ Drug Diaries
- ✓ Care Plans
- ✓ Relapse Prevention Tools – Worksheets, Role-Play
- ✓ TOP (Treatment Outcomes Profile) form

6.3 Psychosocial support

Overview

The key worker must support the service user throughout the detoxification process.

Process

1. During detoxification the service user should continue weekly meetings with the key worker.
2. The GP and key worker should communicate with each other if any issues (including relapse) arise during the detoxification period.
3. It is essential that the key worker and service user have copies of the detoxification schedule compiled with the GP. A care plan should be created based on this schedule.
4. Throughout detoxification, awareness relating to risk management and relapse prevention should be reinforced.
5. The key worker should continue to complete the TOP form with the service user throughout detoxification.
6. Non-medical management of withdrawal symptoms should be explained to the service user.
7. A detoxification process may need to be paused if the service user is misusing substances or not attending arranged appointments with the key worker or GP.

6.4 Psychosocial support during aftercare

Overview

The key worker and service user should continue to engage in weekly care planning and relapse prevention support sessions for six months following completion of the detoxification process.

Process

1. Aftercare is an important part of the detoxification process due to risks in relation to withdrawal seizures, relapse, and overdose. This can be due to reduced tolerance in the period after someone becomes drug-free.
2. Some service users may choose to enter residential rehabilitation services at this point.
3. Where the service user remains in the community, the key worker will continue to provide key working and care planning supports appropriate to the needs of the service user.
4. Where a barrier exists to continuous provision of these supports, or the service

user wishes to disengage from the key work service, an alternative provision should be made with another appropriate support service where relapse prevention and care planning can be provided.

5. In the event of service user relapse, the key worker should make a referral to medical support.

Tools

- ✓ Care Plans
- ✓ Relapse prevention techniques
- ✓ Harm reduction techniques
- ✓ Information on other appropriate services



7

7. Medical support

The prescribing GPs involved with Community Detoxification will monitor the medical aspects relating to the detoxification. GP's competencies are integral to their professional medical qualification and do not require additional validation through this process. The GP will work within the scope of the Community Detoxification Guidelines regarding detoxification schedules. The GP is responsible for establishing who is suitable for Community Detoxification and shall provide medical reasons to those whom they deem unsuitable.

The GP should be able to undertake the following:

- Adhere to the Community Detoxification Guidelines.
- Examine the Key Worker Assessment Form and drug diaries.
- Complete an assessment to confirm service user suitability to participate in Community Detoxification.
- Create a detoxification schedule agreement with the service user.
- Discuss dose and reduction with the service user in a collaborative and flexible manner.
- Monitor medication concordance.
- Monitor the service user's physical and mental health status throughout detoxification.
- Communicate regularly with the key worker.
- Reassess detoxification if mental or physical health concerns arise.
- Reassess detoxification if the service user is neglecting to attend appointments.



8

8. Medical support process

8.1 GP assessment

Overview

Community Detoxification provides medical supervision by a GP within the community. To assess the service user's suitability, the GP must complete a health assessment. During this assessment, the GP determines if the service user is both physically and mentally suitable for Community Detoxification

Process

1. The GP is presented with the Key Worker Assessment Form (Appendix 3) and a completed drug diary.
2. The GP examines a history of the service user's drug use and medical / treatment history.
3. A record must be kept of all medication which the service user is currently prescribed.
4. The GP can determine if there are any medical or mental health contraindications which might be a risk to the service user.
5. If the GP is unsure of the suitability of the service user, they can consult with the key worker.
6. During the assessment the GP will inform the service user what is expected of him or her to meet the entry requirements for detoxification. A dose reduction care plan can be advised to help the individual meet the recommended entry criteria.
7. If the key worker cannot accompany the service user to the GP assessment, the key worker should contact the GP to inform the GP of the service user's suitability and what is expected of the service user to be accepted to the detoxification stage.
8. If the GP considers the service user is unsuitable for Community Detoxification, the key worker should be provided with specific details of the decision.
9. By informing the key worker of suitability, the GP and key worker can then choose an appropriate detoxification setting.

Tools

- ✓ Key Worker Assessment Form
- ✓ Record of Medication and Illness

8.2 Detoxification

Overview

At this stage the GP begins prescribing and the service user begins to reduce medication in line with a schedule agreed with the GP. The key worker continues to provide care planning support and relapse prevention throughout the detoxification period.

Process

1. Following receipt of the drug diaries, and if the GP is agreeable to begin the

detoxification, the GP is required to inform the key worker of this decision. The GP should make the detoxification schedule available to both the key worker and service user.

2. The GP should meet with the service user every two weeks, although appointments can be provided more frequently, or less frequently, depending on factors relating to the service user's stability. This is at the discretion of the GP.
3. Daily dispensing from the pharmacy should be in place. After a given period of time this may be reconsidered where the service user is showing commitment to detoxification. A move to less frequent dispensing may be used as an incentive to continued progress.
4. If the service user is showing commitment to the detoxification process and has extraneous commitments, such as work or family, this can be facilitated by less frequent dispensing
5. The key worker and service user should continue a minimum of once-weekly meetings.
6. Where there is an issue or concern perceived by the key worker, GP, or service user, regarding risk of relapse, or capacity to adhere to the detoxification schedule, then the service user will be invited to a three way meeting to discuss issues arising.
7. Where a service user misses an appointment, the key worker and GP should endeavour to make contact with the service user in order to highlight risks.
8. If the service user misses two appointments with the GP or key worker without reason or rescheduling, then this should be discussed between the GP and the key worker.

Tools

- ✓ Drug Diaries
- ✓ Detoxification Schedules
- ✓ Conversion Tables



9

9. Disengagement

Disengagement refers to when a service user ceases to engage with the Community Detoxification process.

It is important to note that if a service user cannot meet entry requirements for the detoxification, decides not to begin the detoxification, or does not complete the detoxification process, this should not be considered as a failure by the service user. Efforts should be made by all professionals to highlight the achievements of the individual to date and the lessons learned for the future. As with any treatment option, in some instances Community Detoxification may not be suitable for a particular person at a certain point in time.

9.1 Definition of disengagement

Where the service user has begun detoxification and the GP has begun prescribing, the service user is considered to have disengaged with the process if they:

- do not attend two or more consecutive meetings with the key worker and have not provided reasonable explanation or attempted to make alternative arrangements with the key worker (this also applies during aftercare);
- are perceived by the doctor or key worker to be 'topping up' on their prescribed medication, or otherwise using their prescribed medication inappropriately, and are unwilling or unable to address this behaviour when offered support to do so.

9.2 Outcomes of disengagement

Where a service user has disengaged, the following steps may be taken:

- The key worker and GP should endeavour to make contact with the service user to highlight overdose risk.
- The key worker should attempt to make contact with the service user, and discuss the service user's care plan, adapting it as necessary to suit changing needs or circumstances.
- The GP will encourage the service user to reengage with the latter's key worker and may continue to prescribe until a zero dose is reached in line with the original schedule.
- The GP might cease prescription where it is felt that to continue to prescribe could pose a greater risk to the health of the service user than to cease prescription.

9.3 Re-engagement/requests for a second detoxification

Due to the high risks associated with detoxification, a service user presenting after disengagement, or relapse, should be referred back to medical supports as soon as possible. Decisions regarding prioritisation, re-entry dose and subsequent detoxification are based on assessments made by the prescribing GP. These will vary from case to case. Factors such as whether the service user is (or was in receipt of) a prescription for benzodiazepines, will be taken into account.

Re-engagement may be facilitated once commitment to the process and appropriate preparation has been evidenced as per the entry criteria to a Community Detoxification in accordance with the Community Detoxification Guidelines. Additional requirements, or a prolonged period of preparation, may be identified as necessary by the service user, GP or key worker. The care plan should clearly address any issues that precipitated the service user's previous disengagement.



10

10. Benzodiazepines

10.1 Definition

Benzodiazepines are defined as a large family of drugs used as hypnotics, anxiolytics, tranquillizers, anticonvulsants, pre-medication, and for intravenous sedation. They differ in their duration of action, metabolites and lipid solubility. They are commonly prescribed in the treatment of anxiety and insomnia. Guidelines recommend they be prescribed for a maximum of 2-4 weeks as benzodiazepines are recognised as being highly addictive.

10.2 Benzodiazepine detoxification

This section outlines steps in the Community Detoxification process: assessing suitability; meeting entry requirements; and the detoxification process itself. It is important to note that where the guidelines are being used it is presumed that all parties are working in line with these guidelines.

10.3 Before benzodiazepine detoxification

The following should be considered before commencing detoxification:

- The service user needs to have shown motivation towards some control of his / her benzodiazepine use and wants to reduce and his / her use of other substances.
- Service users could be misusing opioids and benzodiazepines. If the service user requests a Community Detoxification for both opioids and benzodiazepines, the individual must be stable on a prescribed amount of methadone and complete the benzodiazepine detoxification first.
- Preparation for detoxification can extend over a long period of time depending on the individual.
- Benzodiazepine detoxes are more complicated than opioid detoxes - due to the side effects and multiple withdrawal symptoms - therefore more psychosocial support may be required.
- Benzodiazepine detoxification can cause multiple withdrawal symptoms such as restlessness, anxiety and insomnia.
- Service users may experience impaired memory and concentration, therefore professionals could be required to repeat information and work which has been previously completed.
- Benzodiazepines cause emotional blunting for individuals. During detoxification the emotions which have been repressed could re-emerge.
- Long term benzodiazepine use can cause depression. This is usually resolved between six months to a year after use stops.
- Benzodiazepine use can exacerbate existing depression and cause suicidal tendencies in those experiencing depression.
- Service users may be consuming a large amount of street benzodiazepines. Key work might need to support the service user in reducing their street dose before detoxification can begin.
- Depending on the individual, preparation for benzodiazepine detox may require a long period of time.
- Psychosocial support may be required to resolve poly drug use before detox preparation can begin.
- The service user is required to complete his / her detoxification to a zero dose.
- The consumption of alcohol and other substances during a benzodiazepine

detoxification can cause a fatal overdose.

- Six months aftercare must be agreed to with the key worker or another service post detoxification.

10.4 Entry Requirements

Entry requirements aim to ensure, as much as possible, that a service user is adequately prepared, supported and motivated for detoxification. Urinalysis will provide information on opiate use, but in the case of benzodiazepines and Z hypnotics, current use cannot be measured easily. In each instance, the professional opinion of the key worker and GP, based on their assessment of the service user, will play a considerable role in assessing whether or not the service user meets the entry criteria and is ready to undergo detoxification.

The following requirements should be met prior to detoxification:

- Provide a minimum fourteen consecutive days' drug diaries for the period immediately leading up to initiation of detoxification.
- Attendance at a minimum of four sessions covering relapse prevention and care planning and completion of an interagency care plan. While these sessions can take place over a minimum of two weeks leading up to the detoxification process, ongoing weekly sessions should take place until the service user is ready and meets all entry requirements.
- Ability to participate in key work and engage in appointments. It is acknowledged that service users may present affected. Key work and appointments should only be cancelled if the service user is unable to participate.
- The service user must be consuming 40mg or less of benzodiazepines to begin a Community Detoxification programme within the recommendations of the guidelines.

10.5 Risks during and after benzodiazepine detoxification

1. Benzodiazepine/ benzodiazepine-like drug detoxification increases the risk of overdose and seizures

Benzodiazepine detoxification increases the risk of overdose and fatal overdose. During and after detoxification, an individual's tolerance diminishes. If a relapse occurs, the service user is at a much higher risk of overdose than during use. Where benzodiazepine use is stopped suddenly, there is an increased risk of seizures occurring. The safest way to undertake the benzodiazepine detoxification process is by means of gradual dose reduction under medical supervision.

2. Poly drug use increases the risk of overdose

The use of any drug carries a risk of overdose. This risk is greatly increased when certain drugs are used in combination, particularly opiates (codeine, heroin, methadone), benzodiazepine, tranquillizers, sleeping tablets, anti-depressants and alcohol.

3. Injecting benzodiazepines is dangerous

Benzodiazepine tablets can be crushed and injected. This can lead to an increased risk of vein damage, infection and overdose.

4. Sharing injecting or snorting equipment increases the risk of acquiring HIV and other blood-borne viruses

When the service user undergoes detoxification, that person may no longer carry his or her own works or other equipment. If the user relapses there may be a higher risk of having to share equipment than when using regularly.

10.6 Areas to plan for during and after detoxification

1. Cravings

Craving for drugs can continue for a while or can occur unexpectedly. Through relapse prevention, it is the role of the key worker to help the service user plan to deal with expected and unexpected cravings.

2. Stress

Often people who have used drugs for a number of years respond to stressful situations by taking drugs.

3. Confidence after completion

When the service user finishes the detoxification process, there remains a serious risk of relapse. Often this can be the most difficult time for people. Developing and following an aftercare plan with the key worker, which includes care plan supports and relapse prevention, can help the service user move on safely and manage risk after finishing the detoxification.

4. Relationships

While most people around the service user will hopefully be a source of support, some people in their immediate circle may not. As part of the care plan, the key worker is required to help the service user to plan how to deal with these issues.

5. Loneliness

Major lifestyle changes can mean that people feel isolated or lonely. An important part of care planning can be for the service user to work with the key worker and find meaningful ways to fill the spaces in the day and establish new social networks.

10.7 Exit points

Exit points will differ between guidelines. Methadone detoxification may be paused or suspended and a maintenance dose prescribed, whereas the aim under the benzodiazepine and Z hypnotic guidelines are to reduce to a zero dose. There may be situations where prescribers support a service user to remain on a low dose of benzodiazepines with a view to further reduction if or when appropriate.



11

11. Schedules, conversion table and detoxification

11.1 Detoxification guidelines for GPs

Decisions about dose and reduction should be made between the GP and the service user in a collaborative and flexible manner. Where rigid schedules are imposed, outcomes may be compromised.

Below are benzodiazepine guideline schedules that may support doctors in planning a client-specific detoxification.

11.2 Schedules

Detoxification schedule: Option 1

Reduction of one-eighth (between one-tenth and one-quarter) of the daily dose every fortnight.

Initially reduce by 2 – 2.5 mg and if withdrawal symptoms occur, then the dose can be maintained until symptoms improve.

High doses: Faster rate of reduction from high dose to therapeutic dose, for example by half over six weeks.

Source: Department of Health (England) and the devolved administrations (2007).

Detoxification schedule: Option 2

If daily dose is between 30 - 40mg reduce by 5mg fortnightly

If daily dose is between 20 - 30mg reduce by 2 - 5mg fortnightly

If daily dose is less than 20mg reduce by 2 mg fortnightly

When down to 5 mg reduce by 1 mg every 2 weeks. (Can use ½ of 2mg tablet or oral solution of diazepam 2mg / 5ml or 5mg / 5ml).

Recommended programme length approximately 6 months.

Source: Ford, Roberts & Barjolin (2005).

Detoxification schedule: Option 3

Replace the drug being used by equivalent doses of diazepam at the rate of one dose per day.

Reduce by 2mg if the daily dose is 15mg - 20mg

Reduce by 1mg if the daily dose is 10mg -15mg

Reduce by 0.5mg if the daily dose is 5mg

Tailor the dose reduction to patient response, i.e. weekly, fortnightly or monthly. Once patient is at a dosage of 0.5mg daily the dose interval can be increased to every two to three days.

Source: Benzodiazepine Committee (2002).

11.3 Conversion table

Diazepam is regarded as the first-line treatment for benzodiazepine detoxification due to its pharmacological profile which includes intermediate half-life, which is associated with reduced intensity of withdrawal symptoms. In exceptional circumstances, other benzodiazepines may be used for detoxification. However, caution should be exercised in using short-acting benzodiazepines as this can lead to incomplete cover and

complications such as withdrawal seizures.

Table 1 (Benzodiazepine Conversion Table) presents the approximate equivalent doses to 10mg diazepam (Valium). Conversion tables vary throughout literature. The information provided on benzodiazepine conversion can differ between detoxing individuals. All of the drugs listed below are recommended for short-term use only (2-4 weeks maximum).

Benzodiazepines	Approximate Equivalent Oral dosages to 10mg of Diazepam	Half-life (hrs)¹
[active metabolite]		
Alprazolam: (Xanax, Xanor, Tafil)	0.5	
Bromazepam: (Lexotan, Lexomil)	5-6	10-20
Chlordiazepoxide: (Librium)	25	5-30 [36-200]
Clorazepate: (Tranxene)	15	[36-200]
Flunitrazepam: (Rohypnol)	1	18-26 [36-200]
Flurazepam: (Dalmane)	15-30	[40-250]
Lorazepam: (Ativan, Temesta, Tavor)	1	10-20
Lormetazepam: (Noctamid)	1-2	10-12
Nitrazepam: (Mogadon)	10	15-38
Oxazepam: (Serax, Serenid, Serepax, Seresta)	20	4-15
Prazepam: (Centrax, Ly-sanxia)	10-20	[36-200]
Temazepam: (Restoril, Normison, Euhypnos)	20	8-22
Triazolam: (Halcion)	0.5	2
Non-benzodiazepines with similar effects		
Zaleplon: (Sonata)	20	2
Zolpidem: (Ambien, Stilnoct, Stilnox)	20	2
Zopiclone: (Zimovane, Imovane)	15	5-6

Table 1. Benzodiazepine Conversion (Ashton, 2002)

See National Institute for Care and Health Excellence (2015) For examples of switching schedules and other information about conversion and reduction.

Time Frame for Detoxification

The pace at which a service user detoxifies should be decided on a case-by-case basis and should be informed by service user need, motivation to detox and goals. Detoxification should be consistent and in response to service user substance tolerance, withdrawal symptoms and comfort of pace.

In general, literature promotes longer detoxification periods involving slow dose reduction; guidance is that detoxification schedules should be considered as a matter of months rather than of weeks.

Faster detoxification schedules can mean that the service user experiences

uncomfortable withdrawal symptoms due to dose reduction, fast withdrawal is also associated with relapse.

The minimum psychosocial supports outlined in these guidelines have been developed to support service users through longer detoxification. The guidelines are not suitable for detoxification under a shorter time frame (for example less than six weeks).

In rare circumstances GPs may agree to provide a shorter detoxification schedule to their patients. Where this occurs, more intensive psychosocial and medical supports should be in place. The principles of interagency work enshrined in these guidelines may be useful in the provision of such.

If a shorter detoxification schedule is pursued, the increased risk of heightened withdrawal symptoms, relapse and attendant risks should be explained to the service user by the key worker and GP.

If a service user feels under pressure to complete a detoxification process in a faster time period than would be advised, for example in order to meet criteria for accessing a residential treatment facility, attempts should be made by the GP / key worker to negotiate a more suitable timeframe with the residential provider, and ensure that the detoxification is undertaken in as safe a manner as possible.

11.4 Benzodiazepine withdrawal symptoms

Benzodiazepine withdrawal symptoms consist of both psychological and physical symptoms which an individual may experience during detoxification. Withdrawal symptoms increase in proportion to the length of time the benzodiazepines have been used and are worse when a high dose has been consumed. Drug withdrawal responses usually involve the re-emergence of the initial symptom for which the drug was taken. For benzodiazepine users this can mean feelings of anxiety and stress. The Community Detoxification Guidelines recommend a slow withdrawal schedule to reduce the possibility of severe withdrawal symptoms. Not every detoxing individual may experience withdrawal symptoms.

Psychological withdrawal symptoms:

- Excitability
- Insomnia, nightmares and sleep disturbance
- Increased anxiety, panic attacks
- Social phobia
- Depression
- Aggression
- Derealisation
- Depersonalisation
- Poor memory
- Poor concentration
- Obsessions
- Hallucinations
- Intrusive memories
- Paranoid thoughts
- Cravings

Physical withdrawal symptoms:

- Fits
- Headache
- Sweating
- Pain and stiffness
- Fatigue
- Influenza-like symptoms
- Dizziness
- Palpitations
- Weight change
- Appetite change
- Skin rashes
- Hypersensitivity - touch, taste, sound, light
- Dry mouth
- Gastrointestinal symptoms – nausea vomiting, diarrhoea, difficulty swallowing
- Blurred/ double vision
- Over-breathing

Management for benzodiazepine withdrawal symptoms:

- Avoidance of tea, coffee and other stimulants near bed-time
- Drinking herbal teas
- Relaxation music – CD and phone apps
- Adopting anxiety management techniques
- Taking prescribed dose of benzodiazepine at night
- Behavioural therapy – to replace the anxiety-related behaviours with better adapted ones
- Breathing techniques
- Guided imaging – focus on relaxing situations, relaxing music and calming words
- Role-play - experience controlled exposure to stressful and frightening situations
- CBT – individuals learn to understand their thinking patterns
- Acupuncture
- Massage
- Aromatherapy
- Exercise – walking and anything experienced as enjoyable
- Yoga
- Meditation

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Appendix 1

Initial meeting form

Key Worker Initial Checklist

The initial checklist must be completed by a key worker and service user at the first Community Detoxification meeting. The Checklist, Key Worker Assessment Form, Client Credentials Form and a Drug Diary must be completed before a GP is contacted.

To ensure the best possible practice, staff should ensure that service users are fully informed of the Community Detoxification process. Below is a sample checklist and explanatory notes.

Sample Checklist:

1. Explaining Roles	
Outline the role of the key worker and GP throughout the community detox process as well as what commitment is expected from the individual.	
1.1 Key worker	
1.2 GP	
1.3 Service user	
2. The Community Detoxification Process	
Outline the different stages of a benzodiazepine community detoxification.	
2.1 Preparation	
2.2 GP assessment	
2.3 Detox	
2.4 Aftercare	

Appendix 2

Risk information and participation agreement

To be filled out with key worker.

The purpose of this form is to give you information and ask you to sign an agreement on:

1. Risks during and after a Community Detoxification programme and information on how to manage such risks.
2. Your rights regarding confidentiality and sharing your information as needed for the detoxification programme.
3. Future contact regarding your experience of the detoxification programme.

RISKS

1. Methadone Detoxification Increases the risk of overdose

During and after your detoxification, your tolerance decreases. If you relapse you are at a much higher risk of overdose than when you were using methadone. If you inject during a relapse, you are at a much higher risk of fatal overdose than if you smoke. When compared to those who stay on methadone, people who detoxify are more likely to relapse and thus more likely to overdose or become infected with HIV, Hepatitis B or C in the future.

2. Benzodiazepine / benzodiazepine-like drug detoxification increases the risk of overdose and seizures

Where benzodiazepine use is stopped suddenly, there is an increased risk of seizures occurring. The safest way to undertake the benzodiazepine detoxification process is by means of gradual dose reduction under medical supervision.

3. Poly drug use increases the risk of overdose

The use of any drug carries a risk of overdose. This risk is greatly increased when certain drugs are used in combination, particularly opiates (codeine, heroin, methadone), benzodiazepines, tranquillizers, sleeping tablets, anti-depressants and alcohol

4. Sharing injecting or snorting equipment increases your risk of acquiring HIV and other blood-borne viruses

When you detoxify, you may no longer carry your own works or other equipment with you. If you relapse you may be at a higher risk of having to share equipment than when you were using regularly.

Other things to plan for during and after Detoxification

Cravings

Craving for drugs can last for a while or can be experienced unexpectedly. Through relapse prevention, your key worker will help you plan to deal with expected and unexpected cravings.

Stress

Often people who have used drugs for a number of years respond to stressful situations by taking drugs. Your key worker will help you to develop and strengthen your coping

skills to handle difficult situations and life stresses without drugs. Some people attend counselling or a support group etc to look at these issues.

Confidence after you finish

When you finish a detoxification programme you are still at serious risk of relapse. Often this can be the most difficult time for people. Developing and following an aftercare plan with your key worker, which includes care plan supports and relapse prevention can help you to move on safely and manage risk after you finish the detoxification process.

People around you

Hopefully, while most people around you will be a source of support, some people in your life may not be. Your key worker can help you to plan how to deal with these issues.

Loneliness

Significant lifestyle changes can mean that people feel isolated or lonely. An important part of your care planning can be to work with your key worker in finding meaningful ways to fill the spaces in your day and build new social networks.

Your key worker will talk to you about all of these issues and any other concerns you have regarding relapse. Together you will come up with a relapse prevention / aftercare plan.

Community Detoxification Service User Participation Agreement

To make sure that you have the best chance of a successful detoxification and that you reduce the risk of relapse, your commitment to this Community Detoxification involves:

1. Ensuring you understand the risks involved in undergoing a Community Detoxification Programme.
2. Setting realistic goals for reduction/detoxification.
3. Adhering to your detoxification schedule and working on your care plan.
4. Keeping your scheduled appointments with your doctor and key worker.
5. Telling your key worker and your GP as soon as possible if any issues arise or if you relapse. This is so you can work together through your care plan to manage any difficulties. Sharing information and keeping everyone up-to-date can help prevent relapse and overdose.
6. Continuing through 6 months of care-planning and relapse prevention after you finish
7. Signing this form to give permission for people involved in your detoxification plan to pass on information to each other, and to confirm that you understand the risks involved in undertaking a Community Detoxification programme.

I have read this information sheet (or the sheet has been read to me) and I understand the information as outlined above.

Signature of service user: _____

Date of signing this agreement: _____

Appendix 3

Key Work Assessment Form

Service user name: _____

Phone number: _____

Email address: _____

Postal address: _____

It is required that the Key Work Assessment Form is completed at the initial meeting between the person delivering psychosocial support and the service user. This meeting should be scheduled before the service user presents to the GP for an assessment.

The key worker is required to deliver the initial assessment form to the GP in person or via email. The purpose of the Key Work Assessment Form is to assist the GP in establishing any medical contraindications that may be present to preclude a service user from Community Detoxification.

Section 1 Drug Use

Please record what substance(s) the service user is consuming and in what quantities.

Substance	Weekly consumption
Alcohol	
Alcohol-based solution	
Marijuana	
Benzodiazepines (prescribed and non-prescribed)	
Z Hypnotics (prescribed and non-prescribed)	
Methadone (prescribed and non-prescribed)	
Heroin	
Codeine	
Amphetamines	
Methamphetamines	
MDMA	
Mephedrone (snowblow)	
Crack Cocaine	
Cocaine	
Anti-Depressants	
Other	

Detoxification History

Date/year	Treatment service	Did the individual complete the treatment?

Does the service user have a history of fits or severe withdrawal symptoms in treatment?

Yes No

Section 2 Mental Health

Is the individual experiencing any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Visions |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Fast speech | <input type="checkbox"/> Detachment from reality |
| <input type="checkbox"/> Confused thinking | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Unusual behaviour | <input type="checkbox"/> Abnormal speech |
| <input type="checkbox"/> Ideas of self-harm | <input type="checkbox"/> Ideas of harming others |
| <input type="checkbox"/> Poverty of speech | <input type="checkbox"/> Over-activity |

Other: _____

Is the individual currently attending a professional for mental health purposes?

If yes, please include the name and contact details of this professional:

Is this individual currently on prescribed medication for mental health purposes?

Please give a brief history of the service user's mental health (this is to include treatment, medication, diagnosis, self-harm, suicide:

Section 3 Physical Health

Has the individual any known physical illness or disease?

Is he or she on medication for physical health purposes?

Section 4 Environment

What is the service users living arrangement?

If he or she is currently residing in a hostel, how long is this arrangement likely to continue?

Signatures

Date _____

Key worker signature _____

Service user signature _____

Appendix 4 Treatment Outcomes Profile (TOP) for Community Detoxification

The Treatment Outcomes Profile (TOP) form examines an individual's drug use, health and social functioning over a 28 day period. It is recommended that this form is completed periodically throughout the preparation, detoxification and aftercare stages of the community detoxification process.

Date: _____

Service user name: _____

Key worker name: _____

Treatment Stage: Preparation
 Detoxification
 Aftercare

Section 1: Substance use

Record the average amount on a using day and number of days on which substance used in each of the past four weeks.

Substance	Measurement	Average daily	Week 4	Week 3	Week 2	Week 1	Total Days
			Days (0-7)	Days (0-7)	Days (0-7)	Days (0-7)	(0-28)
Alcohol	Standard drinks						
Heroin	grams						
Methadone (prescribed)	mls						
Methadone (non-prescribed)	mls						
Crack/cocaine	grams						
Amphetamines / Headshop	grams						
Cannabis	spliffs						
Ecstasy	tablets						
Benzodiazepines (prescribed)	tablets						
Benzodiazepines (non-prescribed)	tablets						
Other sedatives (zimmovanes etc)	tablets						
LSD / Acid	tabs						
Other:							

Section 2: Injecting risk behaviour

Record the number of days client injected non-prescribed drugs in the past four weeks (if no, enter zero and proceed to section 3)

	Week 4	Week 3	Week 2	Week 1
a) Number of days injected				
b) Times injected per day				

Please tick if at any point in the past four weeks the client has:

- c) Injected with needle or syringe used by someone else
- d) Injected using a spoon, water or filter used by someone else

Section 3: Health and social functioning

a) Client's rating of psychological health status (e.g. anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good**

b) Client's rating of physical health status (e.g. extent of physical symptoms and being troubled by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good**

c) Record accommodation issues for the past 30 days

- Acute Housing Problem yes no
- At risk of eviction yes no

d) Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 **Good**



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