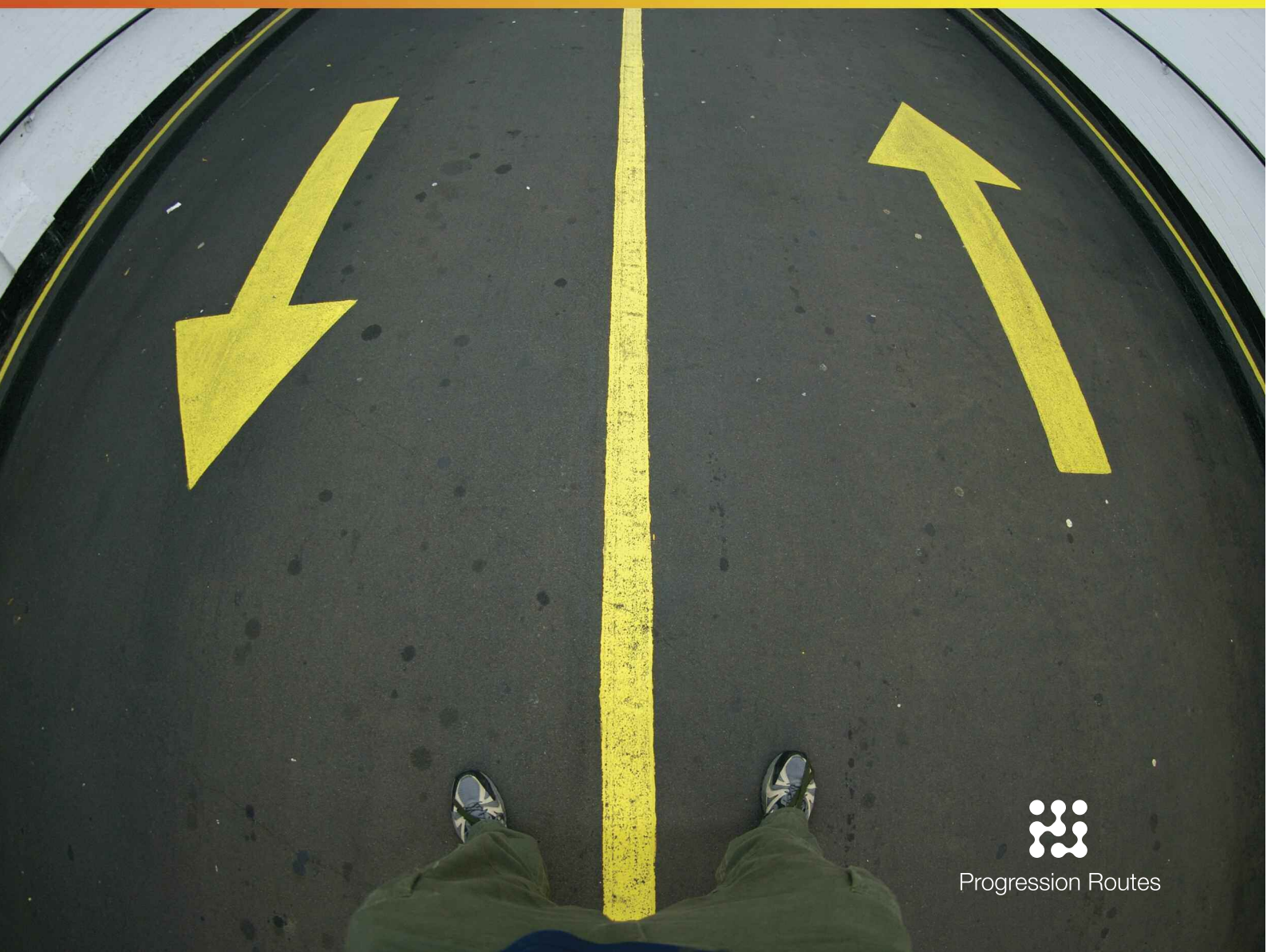
COMMUNITY DETOXIFICATION PROTOCOLS: BENZODIAZEPINES



Progression Routes

COMMUNITY DETOXIFICATION PROTOCOLS: **BENZODIAZEPINES**

Progression Routes

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CHAIRPERSON'S FOREWORD

As Chairperson of the National Community Detoxification Steering Group I would like to express my appreciation to all those involved with the development of these guidelines, in particular Caroline Gardner and Aoife Dermody of Progression Routes who guided us through the process of researching, consulting, writing, reviewing and designing these Community Detoxification Protocols.

The Protocols were originally developed by an expert group in 2007. In response to positive evaluation and implementation, the protocols were reviewed and augmented by an expanded steering group in 2011 which included leaders in addiction services from the medical, community/voluntary and research fields. The input of every member of the steering group since the original draft in 2007 to the redraft in 2011 has been invaluable. It is exciting to see the product of their diligent work in these comprehensive guidelines to outpatient detoxification. The steering group in 2011 are:

Dr. Des Crowley (HSE)
Dr. Austin O'Carroll (Safteynet)
Dr. Brion Sweeney (NDTCB)
Dr. Ide Delargy (ICGP)
Dr. Joanne Fenton (Access Team)
Irene Crawley (Voluntary rep, HOPE)
Ruaidhri McAuliffe (UISCE)
Brian Friel (Peter McVerry Trust)
Dr. Suzi Lyons (HRB)
Joe Doyle (HSE)
Tony Duffin (Voluntary rep – Ana Liffey)
Aoife Dermody (PRI)
Caroline Gardner (PRI)

Members of the 2007 - 2009 Steering Group also included Joan Byrne of the SAOL Project and community representative Sonja Dillon.

I wish to highlight two overarching issues confronting our sector which these Community Detoxification Protocols address; firstly, I have never met a person affected by problem substance use who at some point did not want to either reduce or stop the use of their drug of choice. Unfortunately, there are often times when a window of opportunity opens and a person is motivated to take steps towards positive change, but the resources are not available to support them in their goal. These Community Detoxification Protocols help to ensure that health services and community drug services across the country have the tools to collaborate to provide an accessible, timely and practical detoxification option to service users seeking to reduce benzodiazepine use; secondly, over the last three years funding for health and social services in Ireland has been reduced and this is expected to continue for the foreseeable future. The Community Detoxification Protocols present a cost effective way of maximising existing resources in the community/voluntary and statutory sector to ensure a realistic detox option is available for people when they are ready to change.

We look forward, with hope, to a positive impact on the experiences of service users seeking out-patient detoxification, and the work of doctors and key workers who support them through use of the Community Detoxification Protocols.

Tony Duffin, Director
Ana Liffey Drug Project
19th October 2011

1 OVERVIEW

Community detoxification supports service users to reduce or stop their use of methadone or benzodiazepines through a structured non-residential process involving key workers and prescribing doctors. This outpatient process may be chosen as an alternative to in-patient residential detoxification, or as a necessary step toward meeting entry requirements for residential detox[1].

This resource is targeted at doctors and key workers who are considering supporting a service user through an out-patient community based detox from benzodiazepines.

2 INTRODUCTION

These protocols outline minimum medical and psycho-social supports to be provided to a service user engaging in community detox. The protocols are in line with national strategic documents such as the *Introduction of the Opioid Treatment Protocol* (HSE, 2010), and the *National Drug Rehabilitation Framework* (Doyle & Ivanovic, 2010) as well as international literature on good practice service provision detailed in the Community Detox literature review[2].

It should be noted that these protocols outline agreed minimum standards for the delivery of interagency community detox support. The minimum standards in short are:

- **Interagency care planning:** Care planning takes into account all factors that may negatively impact on a service user's capacity to engage in a successful detox 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, risk and relapse.
- **Medical supports:** Regular medical appointments are provided to supervise the detox. The doctor agrees to engage in interagency communications with the key worker regarding service user progress and in particular, any change to the initial detox schedule or care plan.

In practice, key working services often support service users to incorporate additional elements into the care plan process such as holistic treatments and support groups. Where there is heightened risk to the service user (see section 3.2), additional medical and psycho-social supports should be provided.

The protocols are overseen by an interagency steering group[3] who are responsible for directing the development of the protocols and their implementation and evaluation, as well as responding to issues that arise through the process. There are two distinct community detoxification protocols documents; this one relating to detox from benzodiazepines and the second relating to methadone. While there are commonalities in the minimum standards of supports there are important differences in the provision of detox options which are addressed in these protocols, including: entry and exit criteria, detox schedules, as well as structural issues such as resource constraints and levels of service provision.

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[1] It is advised to check with residential services regarding entry requirements relating to prescribed or unprescribed drug use.

[2] The literature review is available on www.progressionroutes.ie.

[3] The interagency steering group includes: Dr. Des Crowley (HSE), Dr. Austin O'Carroll (Safteynet), Dr. Brion Sweeney (NDTCB), Dr. Ide Delargy (ICGP), Dr. Joanne Fenton (Access Team), Irene Crawley (Voluntary rep, HOPE), Ruaidhri McAuliffe (UISCE), Brian Friel (Peter McVerry Trust), Dr. Suzi Lyons (HRB), Joe Doyle (HSE), Tony Duffin (Voluntary rep – Ana Liffey), Aoife Dermody and Caroline Gardner (PRI).

2.1 History and Rationale for Community Detox 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 in some cases had reported that community detox options were not available to them, and that their doctors had expressed a reluctance to support them to reduce their medication. 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, methadone prescribing doctors raised concerns that service users who engaged in a community based detox without adequate preparation or support were at considerable risk of overdose and fatal overdose. Doctors also highlighted that they had limited consultation times and were not in a position to provide the necessary psycho-social supports required for safer outpatient detoxification.

In 2007 the Progression Routes Initiative, which had been established to address gaps and issues in service provision and to connect national policy with service delivery, responded to this issue. The concerns of service users, doctors and drug services guided the formation of an initial interagency steering group[4] 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 detox and how doctors and key workers could co-ordinate to provide effective supports while managing the risk of relapse and overdose. Following several months of discussions and research it was agreed that the protocols were ready for pilot. Following a year and half of implementation, the pilot was evaluated under the direction of the steering group.

2.2 North Inner City Drugs Task Force Community Detox Pilot Evaluation

The protocols and pilot were launched in April 2007, and evaluated early in 2009. The evaluation which included service users, key workers and doctors revealed a predominantly positive experience of the pilot. The full evaluation is available from www.progressionroutes.ie. The main findings were:

- Sixteen out of 29 service users who had an initial introductory meeting in regard to community detox progressed to a formal detox involving both doctor and key worker.
- Out of this 16, seven had successfully completed the detox and seven were still engaged. Only two disengaged once a doctor had been involved in the process.
- Four of the 29 service users disengaged at the key working phase.
- Four of the 29 contacts received another service such as maintenance or aftercare.
- Referrals were spilt between; self referral (48%), community/voluntary (31%), and medical services (17%).
- Detox requests were similarly spilt between being opiate related (55%, no. 16) and Benzodiazepine related (45%, no.13).
- Service users reported a positive experience overall and all of them said they would recommend the process to a friend.

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[4] Steering Group for North Inner City Pilot 2007- 2010: Dr. Des Crowley (HSE), Dr. Austin O'Carroll (Safteynet), Ruaidhri McAuliffe (UISCE), Joan Bryne (Voluntary rep - SAOL), Tony Duffin (Voluntary rep – Ana Liffey), Sonja Dillon (SOILSE), Caroline Gardner (PRI).

2.3 National Community Detox Pilot

In response to a number of referrals from outside Dublin's North Inner City and growing interest in the initiative, a national pilot was proposed to and approved by the steering group. PRI were invited to present the protocols to local and regional drugs task forces and sub-groups during late spring and early summer 2011. A number of areas were prioritised for involvement in the National Pilot in autumn 2011.

2.3.1 Community Detox National Pilot Evaluation: Under the guidance of the steering group an evaluation of the national roll-out of the community detoxification protocols will be conducted during 2011/2012.

2.3.2 Community Detox Literature Review: A literature review is available on www.progressionroutes.ie. This includes information on the following:

- National context for community detox
- International good practice guidelines for detoxification
- Outpatient and residential detoxification research
- Efficacy of psycho-social supports during and after detoxification
- Mitigating risk factors for overdose during and after detoxification
- Detoxification prescribing

2.4 General Information on the Community Detox Protocols

2.4.1 Resources to Support the Community Detox Protocols

There are resources available to support the roll out of community detox, downloadable from www.progressionroutes.ie, community detox section. These include:

- Service User Information Literature
- Relapse Prevention Resources
- Sample Assessment and Care Plan Forms
- Community Detox Literature Review
- Community Detox North Inner City Pilot Evaluation

2.4.2 Community Detox Professional Liability

- The Community Detox Protocols are a set of guidelines to assist professionals to support service users through an out-patient detoxification. In line with these protocols the local broker (See Appendix B) may provide advice to supporting professionals as to how they may be applied in specific situations.
- It is the responsibility of the organisations involved to ensure that staff providing community detox are competent in their role and have the appropriate level of insurance to cover their work.
- Clinical Governance for doctors: prescribing doctors are responsible for their own clinical governance, or work under the clinical governance structures established within their service.
- Clinical Governance and key working services: where clinical governance is required, e.g. for the treatment of Under 18's, it is the responsibility of the organisation providing the service to

acquire this. The Progression Routes Initiative may be contacted for guidance on establishing a clinical governance framework.

- Neither the local broker nor the individuals and organisations associated with the development and production of the Community Detox protocols accept responsibility for any harm to service users or professionals while working in line with these protocols.

2.4.3 Differences in Approach: Methadone and Benzodiazepine Detox

While many features of a benzodiazepine detox and a methadone detox are similar, the community detox process differs for each in the following ways.

EXIT POINTS:

Exit points (the dose at which the service user ceases reduction) differ. Methadone detox may be paused or suspended and a maintenance dose prescribed, whereas the aim under the Benzodiazepine Protocols is 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/when appropriate. Careful evaluation is needed in the case of service users with previous psychiatric issues or who were previously on a benzodiazepine prescription. (See also point 3.1 & 3.2). Additional specialist community mental health supports should be enlisted where appropriate

ENTRY REQUIREMENTS:

Entry requirements aim to ensure, as much as possible, that a service user is adequately prepared, supported and motivated. Urinalysis will provide information on opiate use, but in the case of benzodiazepines, current use cannot be so easily measured. In each instance, the professional opinion of the key worker and doctor, based on their observation 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 detox.

Please note that further general information about community detox is available in the FAQ section.

3 BENZODIAZEPINE DETOXIFICATION PROTOCOLS

This section details steps in the community detox process: assessing suitability, meeting entry requirements, and the detoxification process itself. It is important to note that where the protocols are being used it is presumed that all parties are working in line with these protocols. Any divergence from the process outlined in these protocols should be discussed in a three way meeting between the service user, key worker and doctor, and the local broker should be notified.

3.1 Community Detox Suitability

When considering ceasing benzodiazepine use, a service user is encouraged to consider their options. Available options currently include (but may not be limited to):

- Residential in-patient detox
- Detox arrangement with the prescriber with informal psycho-social support or no external psycho-social support
- Self-detox.

For some service users, none of these is a practical or accessible option. In the case of self-detox, there are considerable risks involved. Supported community detox can provide a viable alternative. Community based detox may suit a service user who wishes to cease benzodiazepine use and who:

- Needs to reduce or cease their current intake to meet residential rehabilitation entry requirements; some in-patient facilities require candidates be benzodiazepine free. Specific entry requirements should be sought from facilities prior to referral.
- Does not wish to avail of in-patient detox, possibly due to childcare or work commitments.
- Is not considered appropriate for referral to inpatient detox.
- Feels that residential waiting lists are too long and wishes to take a proactive approach.

3.2 Relative contraindications

If one or more of the following factors is present, the potential for detox should be discussed in a three-way meeting between the service user, doctor and key worker. If a service user is contraindicated as per criteria below, they are not automatically precluded from engaging in a community detox. Options such as residential treatment or additional support in the care planning process should be considered.

- Severe mental health problems which are currently untreated.
- 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).
- Active ongoing treatment for Hepatitis C.
- Pregnancy.

A doctor may decline to detox a service user in their care if they feel that detox would, at this time, pose significant risk to the health or life of the patient. Where this occurs the doctor should:

- Give a clear explanation to the service user for this decision.
- Identify risks associated with the contraindicating factor so the service user can work towards satisfying criteria for beginning the detox. This may include managing other substance use, extending the preparatory phase, attending to health issues or any other supports put in place.
- Agree a time-frame for review of the decision with all parties.

In the unusual circumstance that a community detox is medically contraindicated:

- This should be clearly explained to the service user.
- Other more appropriate options should be considered, such as residential detoxification.

Concerns regarding someone's suitability for referral to detox, or to start a detox are not unusual. The FAQ section provides clarity on some common issues that arise.

3.3 Community Detox and Under 18s

Under 18s in general do better in treatment when the parents/guardians are actively involved. However, this is not always possible and the law is not explicit on the issue of consent in relation to treatment provision. Services considering providing community detox to a person under 18 years of age should have established procedures for gaining parental/guardian consent and policies and procedures in line with relevant legislative frameworks agreed in consultation with their clinical governance provider. Where parental consent is not forthcoming, the issue becomes more complex, and local governance procedures should be followed closely. Further information on this is available in the QuADS Support Project library in the *Service Provision to Under 18's Policy* [5]. Please note that a specific consent form for working with people under 18 years of age is available from Progression Routes.

3.4 Benzodiazepine Detox Entry Requirements

The requirements to enter benzodiazepine detox are to:

- Provide minimum 14 consecutive days' drug diaries (see Appendix D) for the period immediately leading up to initiation of detox.
- Follow doctor's advice regarding reduction to entry dose level of unprescribed benzodiazepine use.
- Attend a minimum of four sessions covering relapse prevention and care planning and have completed an interagency care plan. While these sessions can take place over a minimum of two weeks leading up to the detox, ongoing weekly sessions should take place until the service user is ready and meets the other entry requirements.
- Present to the key worker and doctor as unaffected[6] and fully able to engage in the process.

Other relevant information regarding detox entry:

- Once entry requirements have been met, the doctor should be informed, and sent a copy of the drug diaries and care plan.
- The key worker should notify the doctor of any delays, changes in care plan or changes in circumstance that may affect initiation of the detox.
- If the service user is not meeting entry requirements, initiation of the detox should be postponed until the criteria have been met.
- If the service user misses an appointment with the doctor or key worker without reason or rescheduling, then the other professional will be contacted. If there is an issue or concern then the service user will be invited to a three way meeting to discuss what additional supports may be required. Such a meeting may be called by the doctor or key worker and at a time and location convenient to all.

Note: This section should be read in conjunction with Section 3.5, below.

3.5 Four Steps of Community Detox: Benzodiazepines

- Section 4 & Appendix A contain further information on the role of broker, key worker and doctor.
- All forms not included as appendices are available from www.progressionroutes.ie, unless otherwise indicated.

[5] Downloadable at: http://www.progressionroutes.ie/index.php?page=quads-support-project

[6] Unaffected refers to a professional observational assessment that the service user is not illicitly using drugs other than the drug from which they are being detoxed and is not presenting under the influence of alcohol.

Step 1 – Brokering the Doctor and Key Worker

OVERVIEW:
Every service user who requests a community detox requires a doctor and a key worker who understand the process and can undertake the roles as described in these protocols. It is the broker's job to negotiate involvement and support professionals in these roles.

TOOLS:
Community Detox Participation Agreement.
Service User Risk Information & Agreement.

PROCESS:

1 Refer: The key worker, service user or doctor can make referrals to the broker.

2 Engage:
- As required, the broker will contact the doctor and key worker to explain the community detox process and convey all relevant information. If useful an information meeting can be arranged.
- It will be communicated that professionals are not obliged to engage in the process.
- Where engaging a new key working service, the manager will be informed of the process and requested to sign a *Community Detox Participation Agreement* which outlines roles and competencies.
- Where a doctor has reservations regarding provision of community detox, the steps outlined in point 6.2 should be followed.

3 Inform:
- The broker will meet with the service user and key worker to outline the process and answer questions, highlighting entry criteria and other treatment options such as residential detoxification.
- The broker will make clear in the initial meeting that the community detox service cannot be guaranteed, as it is dependent on the participation of a doctor which must be negotiated on a case by case basis.

4 Agree:
- The broker, key worker and service user will discuss the risks associated with detox detailed in Form 1: *Service User Risk Information and Agreement* (see Appendix C). This form should be signed by the service user.
- A copy should be retained by the broker, service user and key worker, and a copy forwarded to the doctor.

5 Confirm:

The broker will ensure that the doctor and key worker each have:
- Contact information for one another and for the broker.
- A copy of the signed *Service User Risk Information and Agreement*.
- A copy of the Community Detox Protocols.
- Suggested next steps.

6 Where a key worker and doctor have a previous working relationship the broker will not need to facilitate communication between them as per point 5 in this section.

Step 2 – Preparation

OVERVIEW:

The service user and key worker begin key working sessions prior to the doctor beginning dose reduction. This is to support the service user to meet entry criteria by establishing or reviewing the care plan and to begin relapse prevention work.

TOOLS:

Drug Diaries
Assessment and Care Plan forms[7]
Relapse Prevention Resources[8]

PROCESS:

1 **Risk:** The risk of withdrawal, seizures and overdose during detoxification will be discussed with the service user by both doctor and key worker.
2 **Entry Criteria:** Entry criteria will be met as per section 3.4.
3 **Relapse prevention and care planning:** The key worker and service user will spend a ***minimum of one hour per week doing relapse prevention and care planning***. Where need is identified, this is frequently 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 **Barriers to detox:** If the service user is presenting as affected, or there are other risk factors present then:
   - This should be discussed, preferably in a three way meeting, between key worker, doctor and service user. The meeting can be called by any party. Where such a meeting is not possible, concerns can be dealt with in a conversation by phone between the doctor and key worker, and in person between the service user and each of the supporting professionals.
   - Time for preparation for detox should be extended as appropriate.
5 **Beginning the detox:**
   - Once entry criteria have been met, the drug diaries & care plan should be forwarded to the doctor, which should trigger the start of the detox. This care plan should be delivered by fax, post or in a one to one handover, as appropriate. If the service user brings a copy of their care plan to their appointment with the doctor, then the key worker should contact the doctor to inform of this arrangement.
   - Once the doctor is agreeable to begin the detox, they will inform the key worker and provide information on the detoxification schedule to be used.

[7] Forms or templates usually used by the service or in the local area, for such purpose. If such templates are not available please contact Progression Routes for guidance.

[8] See Glossary

Step 3 – Detoxification

Overview:
This stage involves the service user reducing medication in line with a schedule agreed with the doctor. The key worker continues to provide care planning support and relapse prevention throughout the detoxification period.

Tools:
Assessment and Care Plan Forms
Relapse Prevention Resources

Process:

1 Following receipt of the drug diaries and once the doctor is agreeable to begin the detox, they will inform the key worker. It is useful if the doctor makes the detox schedule available to both the key worker and service user.

2 To assess entry dose and inform the detox schedule, doctors should calculate the average dose over at least three days as reported in the drug diaries. The table in Appendix A should be used to translate usage into equivalent diazepam[2] to enable the starting dosage and reduction levels to be calculated.

3 The doctor will meet with the service user every two weeks, although appointments will be provided more or less frequently depending on a factors relating to the service user's stability, at the discretion of the doctor.

4 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 detox (indicated by consistent attendance at meetings and engagement with care plan, absence of behaviour which indicates mismanagement of drugs, etc) a move to less frequent dispensing may be used as an incentive to continued progress.
- The service user is showing commitment to detox (as indicated above) and has extraneous commitments such as work or family which would be facilitated by less frequent dispensing

5 The key worker and service user will continue a minimum of weekly meetings which will include relapse prevention work and care planning. Key workers should continue to highlight risks to service users.

6 Where there is an issue or concern perceived by the key worker, doctor or service user regarding risk of relapse or capacity to adhere to the detox, then the service user will be invited, preferably in a three way meeting, to discuss what additional supports are required and how the care plan and/or detox schedule should be adapted.

7 Where a service user misses an appointment, the key worker and doctor should endeavour to make contact with the service user to highlight risks.

8 If the service user misses two appointments with the doctor or key worker without reason or rescheduling, then:
- The other professional will be contacted.
- A discussion will be scheduled as per point 6 above.
- Ongoing non-attendance will be treated as disengagement as per section 3.6.

Further information on managing risk during a detox can be found in the FAQ

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[2] 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 etc.

Detoxification Guidelines for Doctors

- Decisions about dose and reduction should be made between the doctor and the patient in a collaborative and flexible manner. Where rigid schedules are imposed, outcomes may be compromised.
- Where withdrawal symptoms are unmanageable, guidance is to avoid increasing dose, but remain static until symptoms at current dose become manageable.
- Please see Appendix A: Benzodiazepine Conversion Chart for approximate equivalence of various benzodiazepines and 'Z' drugs to diazepam.

Time Frame for Detox

- 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 and goals.
- Detoxification should be consistent, steady, and in response to service user tolerance, withdrawal symptoms and comfort of pace.
- Generally literature promotes longer detoxification periods involving slow dose reduction; guidance is that detox schedules should be considered as a matter of months rather than of weeks.
- Faster detoxification and experiences of uncomfortable withdrawal symptoms due to dose reduction are associated with relapse.
- The minimum psycho-social supports outlined in these protocols have been developed to support service users through longer detoxification. The protocols are not suitable for detox under a shorter time-frame (for example less than six weeks).
- In some circumstances doctors may agree to provide a shorter detox to their patients. Where this occurs, more intensive psycho-social and medical supports should be in place. The principles of interagency work enshrined in these protocols may be useful in the provision of such.
- If a shorter detox 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 doctor.
- If a service user feels under pressure to complete a detox 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 doctor/key worker to negotiate a more suitable timeframe with the residential provider, and ensure that the out-patient detox is done as safely as possible.
- These protocols do not cover ultra-rapid detoxification under anaesthetic.

Sample Benzodiazepine Schedules

DETOX SCHEDULE – OPTION 1

Source: *Department of Health (England) and the devolved administrations (2007). Drug Misuse and Dependence: UK Guidelines on Clinical Management.*

- 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.

DETOX SCHEDULE – OPTION 2

Source: Dr Chris Ford, Kay Roberts & Jean-Claude Barjolin, *Detox Guidance on Prescribing Benzodiazepines to Drug Users in Primary Care.*

- If on between 30-60mgs reduce by 5mgs/fortnightly
- If on between 20-30mgs reduce by 2-5mgs/fortnightly
- If on less than 20mgs reduce by 2 mgs/fortnightly
- When down to 5 mgs reduce by 1 mg every 2 weeks. (can use ½ of 2mg tablet or oral solution of diazepam 2mg/5ml or 5mg/5ml).
- Recommended length approx 6 months.

DETOX SCHEDULE – OPTION 3

Source: DOHC (2002): *Benzodiazepines: Good Practice Guidelines for Clinicians*.

- Replace the drug being used by equivalent doses of diazepam at the rate of one dose per day.
- Reduce by 2mg if daily dose 15mg to 20mg
- Reduce by 1mg if daily dose 10mg to 15mg
- Reduce by 0.5mg if daily dose 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.

Step 4 – Aftercare

Overview:

The key worker and service user continue to engage in weekly care planning and relapse prevention supports for six months following completion of the detox.

Tools:

Assessment and Care Plan Forms

Relapse Prevention Tools

Process:

1. This is an important step in the process due to risks in relation to withdrawal seizures, relapse, overdose due to reduced tolerance and death 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 there is a barrier to continuous provision of these supports, or the service user wishes to disengage from the key working service the broker will be contacted and an appropriate alternative provision made with another appropriate support service where relapse prevention and care planning can be provided.
5. In the case of service user relapse, the key worker should make an immediate referral to medical support.

3.6 Disengagement

Disengagement refers to when a service user ceases to engage with either professional after having begun step 3: Detoxification.

It is important to note that if a service user cannot meet entry requirements for the detox, decides not to begin the detox, or does not complete their detox process, this should not be considered as a failure for the service user. Efforts should be made by all professionals to highlight the achievements of the individual to date and the lessons learnt for the future. As with any treatment option, in some instances community detox may not be suitable for a particular person at a particular point in time. Experience from the pilot phase suggests that service users who were not previously availing of support continue to engage and avail of support from the key working agency even where they do not continue past Step 2: Preparation.

3.6.1 Definition of Disengagement in Relation to Community Detox

Where the service user has begun step 3: Detoxification, and the doctor 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 step 4: 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.

3.6.2 Outcomes of Disengagement

Where a service user has disengaged:

- The key worker and doctor 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 doctor will encourage the service user to reengage with their key worker and may:
  - o Continue to prescribe until a zero dose is reached in line with the original schedule, or
  - o Cease prescription where they it is felt that to continue to prescribe could pose a greater risk to the health of the service user than to cease prescription.

3.6.3 Re-engagement / Requests for a Second Detox

Due to the high risks associated with detox, a service user presenting following disengagement or relapse should be referred back to medical supports as quickly as possible.

Decisions regarding prioritisation, re-entry dose and subsequent detox are based on clinical assessments made by the prescribing doctor and 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.

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[9] Competencies are based on relevant sections of DANOS (Skills for Health, 2007, 2008)

Re-engagement may be facilitated once commitment to the process and appropriate preparation has been evidenced as per the entry criteria to a community detox outlined in these protocols.

Additional requirements or a prolonged period of preparation may be identified as necessary by the service user, doctor or key worker. The care plan should clearly address any issues that impacted on the service user's previous disengagement.

4 REQUIRED COMPETENCIES FOR PROFESSIONALS INVOLVED

Each role within the community detox process has required competencies[10]. In the case of the broker and key worker these competencies will be ascertained through an agreed and recognized governance structure. For further information on the brokering process, and the role of the broker, please see Appendix B: Guide to the Role of the Broker

4.1 Broker

The Community Detox Steering Group in communication with the local/regional Drugs Task Force, Treatment and Rehabilitation Sub-Group of same, or another suitable interagency group, will agree an appropriately qualified and experienced person / organisation to undertake this role. The broker requires competencies to undertake the following:

- Apply the Community Detox Protocols in difficult and varied situations.
- Present the protocols to various stakeholders in an accessible and comprehensive manner.
- Develop joint working agreements and practices and review their effectiveness.
- Develop and sustain effective working relationships with staff in other agencies.
- Promote the development of substance misuse services in the local area.
- Promote effective communication for and about individuals.
- Facilitate meetings.
- Receive, analyse, process and store information.
- Contribute to the development of organisational policy and practice.
- Contribute to effective evaluation of the initiative.

4.2 Key worker

The management of the key worker's employing agency will sign a *Community Detox Participation Agreement* prior to any service user being supported in a community detox by their service. This agreement will outline required competencies of the key worker as well as the responsibilities of the organisation. The key worker should be able to undertake the following:

- Apply the Community Detox Protocols.
- Carry out assessment to identify and prioritise needs.
- Contribute to care planning and review.

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[10] Competencies are based on relevant sections of DANOS (Skills for Health, 2007, 2008)

- Support individuals through detoxification programmes with particular attention to applied relapse prevention.
- Support individuals who are substance users.
- Assess and act upon immediate risk of danger to substance users.
- Participate in inter-disciplinary team working to support individuals.
- Carry out comprehensive substance misuse assessment.
- Counsel individuals about their substance use using recognised theoretical models.
- Help individuals address their substance use through an action plan.
- Use information to take critical decisions.
- Promote effective communication for and about individuals.
- Feedback information to the local broker as required.

4.3 Doctor

Competencies are integral to their professional medical qualification and do not require additional validation through this process.

5 MANAGING INTERAGENCY DIFFICULTIES

At any point during the process the broker can be contacted for informal advice by the key worker, doctor or indeed the service user. This can pre-empt interagency difficulties in many cases. The following steps outline the process for resolving interagency conflict, if this should arise. The vast majority of issues should be resolvable at either point one or two:

1 The doctor or key worker should try to resolve the issue with the other professional on a one-to-one basis by phone-call, email or letter. In the case of key workers, they should seek the support of their line manager in an instance where they are unsure of how to apply the protocols or when they require advice regarding the best way to proceed. The broker can be contacted for informal advice as indicated above. If the issue is not resolved satisfactorily and in a timely manner through one to one communications then;

2 The broker should be informed. The broker's role in relation to issues arising is to assist professionals to apply the protocols.

3 If issues fall outside the protocols or the broker cannot support a satisfactory result for all involved, the advice of a member of the steering group will be sought.

4 If needed then the issue will be bought formally to the steering group for a response.

Please note that further information on working relationships can be found in the FAQ

6 FREQUENTLY ASKED QUESTIONS

6.1 General

DOES A DETOX HAVE TO BE MANAGED UNDER THE PROTOCOLS, OR CAN IT BE DONE INFORMALLY WITH THE DOCTOR AND/OR KEY WORKER?

The community detoxification protocols are a good practice guideline for professionals supporting someone through a detox. Where the process begins with a referral to the broker, all professionals would be encouraged to adhere to the process as outlined however, no professional is obliged to work according to the protocols and services may develop an arrangement that suits them.

HOW DOES SOMEONE DO A DETOX FROM METHADONE UNDER THESE PROTOCOLS?

There are a separate set of protocols, the Community Detox Protocols for Methadone available online at www.progressionroutes.ie.

CAN SOMEONE DETOX FROM CODEINE OR ANOTHER OPIATE UNDER THESE PROTOCOLS?

This may be possible. The local broker should be contacted who can seek the advice of the steering group in relation to individual cases.

CAN AN ALCOHOL DETOX BE MANAGED UNDER THESE PROTOCOLS?

No, these protocols do not extend to alcohol detox, although the principles of inter-agency work contained in these protocols may be useful.

6.2 Working Relationships

WHAT IF THE PRESCRIBING DOCTOR/GP DOES NOT WISH TO BE INVOLVED IN THE PROTOCOLS?

The response to this question depends on whether the service user is a) being prescribed benzodiazepines or b) not on a prescription for benzodiazepines

a) When a service user is being *prescribed* benzodiazepines and their doctor initially does not wish to support them through a community detox, the following steps should be taken:
   1. The broker should seek to engage the doctor in writing, outlining the community detox process, the entry criteria, the supports available and the steps undertaken by the service user thus far.
   2. The broker should also request from the doctor a reason for declining detox, and any recommended steps the service user could take to satisfy entry criteria for a detox or additional criteria identified by the doctor.
   3. If the doctor is still not willing to provide a community detox under the protocols the broker will contact a relevant member of the steering group for advice on how the issue can be moved on.

   At any point if the service user is not satisfied with the process, they can be supported in using the standard HSE Complaints Policy 'Your Service Your Say'[11].

b) Where the service user is *not on a benzodiazepine prescription previously* but is taking unprescribed benzodiazepines, doctors can provide invaluable support to patients seeking to address this issue. However a doctor is under no obligation to initiate prescription for the purpose of detox. Where the patient is currently on a methadone prescription and attending the clinic/surgery on a regular basis,

provision of a benzodiazepine detoxification should incur little additional drain on resources in terms of the prescriber's time.

WHAT IF I DISAGREE WITH A DECISION THAT HAS BEEN MADE BY THE DOCTOR OR KEY WORKER, OR FEEL S/HE IS NOT ACTING IN ACCORDANCE WITH THE PROTOCOLS?
See Section 5

6.3 Substance use, Medication and Entry criteria

WHAT IF THE SERVICE USER IS DRINKING PROBLEMATICALLY?

- Dual addiction is considered a relative contraindication to detoxification under these protocols (see section 3.2) and it is advised that problem drinking should be managed through a care plan prior to engaging in the Community Detox.
- Alcohol use can lead to impaired judgement and increase the risk of relapse to unprescribed benzodiazepine use, overdose and death. Prescribing benzodiazepines to someone who is using alcohol increases their risk of overdose and death; however, decisions on this issue are at the prescriber's 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 and alcohol use.
- Alcohol 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 psycho-social supports should be provided.
- If the service user is already engaged in the detox and concerns arise as to their alcohol consumption the key worker is obliged to inform the prescribing doctor as soon as possible. This should be managed as for any increased risk during the detoxification process: through additional supports, structured care planning and on-going interagency communication.

WHAT IF THE SERVICE USER IS USING DRUGS THAT DON'T SHOW IN URINALYSIS?
Other problematic drug use that could increase the risk of overdose must be managed first prior to the person engaging in a detox. Key worker and doctor assessments will be necessary in this regard.

6.4 Managing Risk during the Detox

THE SERVICE USER HAS EXPERIENCED A TRAUMATIC LIFE EVENT THAT MAY AFFECT THEIR CAPACITY TO COMMIT TO THEIR DETOX. WHAT HAPPENS NOW?

- Any such situation should be risk assessed and managed. If there are concerns that there could be an increased risk of overdose, the option of pausing or postponing the detox should be broached with the service user.
- Where the service user is keen to go ahead and confident of their ability to adhere to the detox plan, risk management strategies such as relapse prevention should be intensified, and the doctor may be kept informed about the service user's circumstances.
- Generally, where urgent support is needed for the service user by another service (for example, accommodation /medical) the key worker or doctor should write to the service and highlight the risk that is posed to the individual in terms of overdose, seeking flexibility in prioritising the service user in this instance. Referral to professionally trained and accredited counsellors/psychotherapists and psychiatrists should be sought as appropriate.

- If the service user is or becomes very unstable in terms of their accommodation then securing stable accommodation should be prioritised. Homelessness should be considered as a significant risk factor although it does not in itself preclude someone's involvement in community detox.

6.5 Disengagement and Relapse

WHAT HAPPENS IF THE SERVICE USER RELAPSES AFTER COMPLETING THE DETOX?
See section 3.6.

7 GLOSSARY

7.1 Broker

The broker provides support to professionals working under the Community Detox Protocols: see Appendix B for further information.

7.2 Care Plan

A care plan is a documented agreement of a plan of action between the service user and service provider based on SMART (Specific, Measurable, Agreed, Realistic and Time-bound) objectives. A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the service user and the service provider/s. The care plan should explicitly identify the roles of specific individuals (including the service user) and services in the delivery of the care plan. Care plans should be reviewed both routinely and when changes in a service user's circumstances make it necessary.

7.3 Key Worker

The named person assigned to work closely with the service user and provide a range of psycho-social interventions and advocacy for that service user.

7.4 Relapse Prevention

This is an individual or group-based cognitive behavioral approach. A relapse prevention programme usually includes the following: identifying high-risk situations and triggers for craving; developing strategies to limit exposure to high-risk situations; developing skills to manage cravings and other painful emotions without using drugs; learning to cope with lapses; learning how to recognise, challenge and manage unhelpful or dysfunctional thoughts about drug misuse; developing an emergency plan for coping with high-risk situations when other skills are not working; learning to recognise how one is 'setting oneself up' to use drugs; generating pleasurable sober activities and relationships, improving quality of life and attaining a lifestyle balance (Wanigaratne, 2003; Department of Health (England) and the devolved administrations, 2007). *For further information on relapse prevention and resources, please contact Progression Routes, or see the Community Detox literature review at www.progression-routes.ie*

APPENDIX A: BENZODIAZEPINE CONVERSION TABLE[12]

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, etc. For further reference, please see the Community Detox literature review, available at www.progressionroutes.ie.

In this table, the approximate equivalent doses to 10mg diazepam (Valium) are given[13]. These equivalents do not agree with those used by some authors and may vary between 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	6-12
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, Lysanxia)	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

[12] This table is based on research and clinical experience of Professor C Heather Ashton (2002).

[13] For examples of switching schedules and other information about conversion and reduction see the NHS Clinical Knowledge series at: http://www.cks.nhs.uk/benzodiazepine_and_z_drug_withdrawal/management/scenario_benzodiazepine_and_z_drug_withdrawal/switching_to_diazepam/additional_information#-371759.

1 Half-life: time taken for blood concentration to fall to half its peak value after a single dose. Half-life of active metabolite shown in square brackets. This time may vary considerably between individuals.
2 Non-benzodiazepines are chemically different from benzodiazepines but have the same effects on the body and act by the same mechanisms.
3 The elimination half life of diazepam and chlordiazepoxide as well as other long half-life benzodiazepines is longer in the elderly (Salzman, 2004) and those with an impaired liver (Delcò et al, 2005).

APPENDIX B: GUIDE TO THE ROLE OF THE BROKER

Overview

Each local or regional area that implements the community detoxification protocols must identify a broker. In considering a suitable candidate for the broker role, the following should be considered:

- The broker should be nominated by an inter-agency group in the area such as the Local / Regional Drugs Task Force or Treatment and Rehabilitation Subgroup of same.
- The broker should have full support from their employer organisation to fulfil the role as outlined in the protocols.
- The employer organisation should be in a position to fill the role of the broker should the nominated person be absent from their post due to leave or end of employment.
- The broker should be trained in the broker role and be facilitated to access to on-going centralised support from the steering group of the National Community Detox Pilot, via the broker sub-group, regarding the implementation of the protocols.

The broker provides support to professionals working under the Community Detox Protocols. This is done through:

- Raising awareness of the protocols with individual service providers who have not previously worked under the protocols.
- Providing on-going advice and support to doctors and key-workers who are working under the protocols.
- Supporting resolution of issues as they arise and the referring of issues to the Community Detox Steering Group where necessary.

An important aspect of the broker role is supporting the evaluation of the National Pilot through data collection on the process in their local or regional area.

The broker is the central point of contact in their local areas for service users or referring agents. The broker supports initiation of a detox by identifying and engaging key workers or doctors where they are not already in place and ensuring all parties are clear in relation to the process and their role within it. A goal of the community detox initiative is to support interagency working; the broker requires a good knowledge of local community/voluntary and HSE services and the capacity to support effective interagency work.

The estimated hours involved in this role are ½ day per week, although this is dependent on local demand. It should also be noted that within the first few months additional hours will be required for provision of local information sessions and for the broker to attend training/ information sessions.

Competencies in line with DANOS criteria

The broker must be able to:

- Apply the Community Detox Protocols in difficult and varied situations.
- Present the protocols to various stakeholders in an accessible and comprehensive manner.
- Develop joint working agreements and practices and review their effectiveness.
- Develop and sustain effective working relationships with staff in other agencies.
- Promote the development of substance misuse services in the local area.
- Promote effective communication for and about individuals.
- Facilitate meetings.
- Receive, analyse, process and store information.
- Contribute to the development of organisational policy and practice.
- Contribute to effective evaluation of the initiative.

Role Description

1 To be a first point of contact for community detox in the local area or region

- Respond to any queries within two working days.
- Direct all media enquiries to the Steering Group via the Chairperson of the Steering Group.

2 To promote the Community Detox Protocols in the local area or region

- Facilitate information session with local stakeholders, with the support of the Steering Group.
- Engage local professionals in either key working or doctor roles.
- Provide information sessions to service providers as required, including community/voluntary, statutory and medical service providers.
- Ensure promotional materials are available in appropriate public locations to increase awareness of the initiative among service users, professionals and concerned individuals.

3 To support doctors and key workers to work under the protocols

- Meet with service users and key workers to provide an initial brokering and information session.
- Facilitate brokering meetings with service users and key workers within one week of referral.
- Formally confirm all specific detox details with the relevant professionals.
- Respond to queries and concerns of key workers and doctors working under the protocols and support them to work in line with the protocols.
- Undertake six-weekly check-ins with key workers.

4 To respond to inter-agency challenges as these arise

- Support the agencies involved to respond to issues in accordance with the protocols.
- Utilise the support and advice of the Steering Group in responding to any issues that cannot be resolved through informal and formal support from broker.

5 To participate in the evaluation of the national pilot

- Collect data on cases and interventions using forms provided by the Community Detox Evaluation Sub-Group.
- Store forms containing personal data of service users in line with relevant data protection legislation.

- Submit data for collation to the Steering Group as required.
- Participate in interviews as part of the evaluation.
- Inform the Steering Group if there are any suggestions for improvement in regard to the process or protocols.

6 To avail of on-going support and training

- Attend broker training / information sessions in the initiation phase of the project.
- Attend six-weekly broker sub-group meetings.
- Attend any additional training / information sessions as required by the National Community Detox Steering Group.

For further information on the broker role, or any other aspect of the National Community Detox Pilot please contact Aoife Dermody (aoife.dermody@aldp.ie) *or Caroline Gardner* (pri@aldp.ie) *in Progression Routes Initiative.*

APPENDIX C: SERVICE USER RISK INFORMATION AND AGREEMENT

FORM 1: **SERVICE USER RISK INFORMATION AND AGREEMENT**[14]
TO BE FILLED OUT: At broker meeting with service user and/or key worker
TO BE KEPT BY: Broker, with each party to be given a copy

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 detox and information on how to manage such risks.
2) Your rights regarding confidentiality and sharing your information as needed for the detox.
3) Future contact regarding your experience of the detox.

RISKS

1) METHADONE DETOX INCREASES THE CHANCE OF OVERDOSE

Methadone detox increases risk of overdose. During and after your detox, your tolerance goes down. If you relapse you are at a much higher risk of overdose than when you were using. If you inject on 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 detox are more likely to relapse and thus more likely to overdose or get HIV, Hepatitis B or C in the future.

2) BENZODIAZEPINE / BENZO-LIKE DRUG DETOX INCREASES RISK OF OVERDOSE AND SEIZURES

Where benzo use is stopped suddenly, there is an increased risk of seizures. Gradual dose reduction under medical supervision is the safest way to reduce benzodiazepines.

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), benzos, tranquillizers, sleeping tablets, anti-depressants and alcohol.

4) SHARING INJECTING OR SNORTING EQUIPMENT INCREASES YOUR RISK OF CATCHING HIV AND OTHER BLOOD BORN VIRUSES

When you detox, 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.

[14] For service users below 18 years of age and their guardians there is a separate consent form available from Progression Routes.

OTHER THINGS TO PLAN FOR *DURING AND AFTER* DETOX

CRAVINGS

Craving for drugs can last for a while or can hit you 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, NA etc., to look at these issues.

CONFIDENCE AFTER YOU FINISH

When you finish a detox, 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 detox.

PEOPLE AROUND YOU

While most people around you will hopefully be a source of support, some people around you may not want you to detox and may encourage you to use. As part of your support, your key worker can help you to plan how to deal with them.

LONELINESS

Big 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 make 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 Detox Service User Participation Agreement

To make sure that you have the best chance of a successful detox and that you reduce the chance of relapse, your commitment to this community detox involves:

1. Ensuring you understand the risks involved in doing a community detox.
2. Setting realistic goals for reduction/detoxification
3. Adhering to your detox schedule and working on your care plan.
4. Keeping your scheduled meetings with your doctor and key worker.
5. Telling your key worker and your doctor as soon as possible if any issues come up 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 six months of care-planning and relapse prevention after you finish.
7. Signing this form to give permission for people involved in your detox plan to pass on information to each other, and to confirm that you understand the risks involved in doing a community detox.

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:

AGREEMENT TO SHARE INFORMATION

We would like your permission to collect and share information between your key worker and your treatment agency, so that we can understand your needs better, improve services and avoid asking you for the same information more than once.

We would also like to use this information anonymously for evaluation of the community detox initiative by the community detox steering group.

As some of the information that agencies hold about you is sensitive, they must follow the principles of Data Protection legislation. These principles ensure that the information services have is:

- Used fairly and legally
- Only used for the purposes for which it was collected
- Adequate, relevant and not excessive
- Correct and up to date
- Kept only for as long as needed
- Processed in accordance with a person's rights
- Stored safely

Agreement to Share

1. I understand that this document is only valid for six months and needs to be renewed after that time.
2. I understand that if I do not wish to have my data used for evaluation purposes I can still undergo a community detox.
3. By ticking this box I confirm that I *do not* wish my data used anonymously for evaluation ☐
4. I understand that I can change my mind at any time and withdraw this consent by informing my key worker.

Signature of service user:

Date of signing this agreement:

Withdrawal of Consent

I confirm that I have withdrawn my consent to have my personal information shared with other agencies.

Signature of service user:

Signature of worker:

Date consent withdrawn:

AGREEMENT FOR FUTURE CONTACT

In order to gather information on the Community Detox and to improve the service in the future, it would be helpful to us if you would provide us with information about your experience of the Community Detox and how you have progressed at some point in the future. For this we need to record your contact details. After you have completed/stopped the detox you may get a phone-call or email from us inviting you to an interview. This does not oblige you to share information, but is simply an agreement that we may attempt to contact you about this.

Agreement for Future Contact

1 I agree that a member of staff acting on behalf of the Community Detox Steering Group may contact me via a phone-call or email for information relating to the Community Detox following my participation in Community Detox.

2 I understand that if I do not wish to agree to this, I can still undergo a community detox programme.

Signature of service user:

Date of signing this agreement:

CONTACT DETAILS

Name:

Phone Number:

Email Address:

APPENDIX D: SAMPLE DRUG DIARIES

DAY & TIME	WHAT DID I USE AND HOW MUCH?	WHAT TRIGGERED ME TO USE?	HOW WAS I FEELING BEFORE I USED?

BY FILLING OUT THIS DRUG DIARY YOU WILL BE ABLE TO SEE PATTERNS IN YOUR DRUG USE. DOING THIS WILL HELP YOU TO BECOME AWARE OF THINGS THAT PUT YOU MOST AT RISK OF RELAPSE.

APPENDIX E: BIBLIOGRAPHY

Please note that a comprehensive literature review and bibliography for the National Community Detox Initiative is contained in the Community Detox Literature Review, which is available from www.progressionroutes.ie

Ashton, H. (2002): Benzodiazepines: How they Work & How to Withdraw (The Ashton Manual). Available at: http://www.benzo.org.uk/manual/index.htm & http://www.benzo.org.uk/bzequiv.htm.

Delcò, F., Tchambaz, L., Schlienger, R., Drewe, J., Krähenbühl, S. (2005). Dose adjustment in patients with liver disease. *Drug Safe* **28** (6): 529–45.

Department of Health and Children (2002): Benzodiazepines: Good Practice Guidelines for Clinicians. Available at: http://www.dohc.ie/publications/benzodiazepines_good_practice_guidelines.html

Department of Health (England) and the devolved administrations (2007): *Drug Misuse and Dependence: UK Guidelines on Clinical Management. London:* Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

Doyle, J. & Ivanovic, J. (2010): National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive.

Ford, C., Roberts K., & Barjolin, JC. (2005): Detox Guidance on Prescribing Benzodiazepines to Drug Users in Primary Care. http://www.exchangesupplies.org/conferences/NDTC/2009_NDTC/presentations/chris_ford_benzo_guidance.doc

HSE (2010): The Introduction of the Opioid Treatment Protocol, HSE: Ireland

HSE: Information leaflet; *Your Service, Your Say.* Available at: http://www.hse.ie/eng/services/ysys/Complaint/Leaflets/Leaflets.html

NHS Clinical Knowledge series: Benzodiazepines and Z Drug Withdrawal Available at: http://www.cks.nhs.uk/benzodiazepine_and_z_drug_withdrawal/management/scenario_benzodiazepine_and_z_drug_withdrawal/switching_to_diazepam/additional_information#-371759.

NIHCE (2007): 'Drug misuse: opioid detoxification' (NICE clinical guideline 52). National Institute for Health and Clinical Excellence, London, UK.

O'Reilly, F., Reaper, E., & Redmond, T. (2005): We're People Too: views of drug users on health services. Dublin

Salzman, C. (2004). Clinical geriatric psychopharmacology (4th ed.). USA: Lippincott Williams & Wilkins.

Skills for Health (2007): DANOS Guidance on Competence and Qualifications 2007. Available at: http://www.southwarkpct.nhs.uk/documents/3423.pdf

Skills for Health (2008): Drugs and Alcohol National Occupational Standards (DANOS) Guide. Available at: http://www.southwarkpct.nhs.uk/documents/3423.pdf

Wanigaratne S (2003): Relapse Prevention in Practice. *The Drug and Alcohol Professional*, 3 (3), 11-18