

OVERVIEW OF PROTOCOLS

THIS DOCUMENT OUTLINES PROTOCOLS TO GUIDE THE PROVISION AND SUPERVISION OF COMMUNITY / OUTPATIENT DETOX, INVOLVING BOTH COMMUNITY AND VOLUNTARY DRUG PROJECTS AND TREATMENT SERVICES IN A CO-ORDINATED AND FORMALISED WAY. THESE PROTOCOLS ADDRESS BOTH METHADONE AND BENZODIAZEPINE DETOX.

It should be noted that detox itself brings risks of intolerance and overdose, and requires careful clinical assessment as well as cohesive social supports and a clear care plan. These protocols have been established with the intention of ensuring that sufficient services are in place to ensure clients are appropriately supported and have clear and accurate information regarding treatment options.

Best practice in the U.K states that for community detox to be effective 'clear referral criteria and entry points'¹ need to be established in policy. In the Irish / local context the advantages of clear and consistent systems for clients to request and engage in outpatient detox may be beneficial in further establishing community detox as a formalised progression pathway. The Scottish experience also highlights the need for integrated care management and the need for the involvement of multiple agencies in a co-ordinated manner. U.K guidelines also recommend that clients 'should play an active role in the monitoring of their own health and healthcare'².

This document, which has been developed with the input of local medical and drugs services³, outlines working protocols for how all parties can engage in a formalised community detox system. The aim of the protocols is to ensure that service users and service providers have clarity around the best practice provision of community detox. The protocols also aim to ensure that service users are empowered to choose what treatment option is most suitable for them by providing clear information and effective supports.

¹ *Guide 5 – Community Detox*. 'Effective Interventions Unit, Substance Misuse Division, Scottish Executive' <http://www.scotland.gov.uk/Resource/Doc/47251/0013312.pdf>

² 'For community detoxification this might include self-rating scales for anxiety and withdrawal symptoms and a chart for clients to monitor their own sleep pattern' (ibid).

³ Including input from; Dr Des Crowley; GP Co-ordinator - HSE, Dr Brian Sweeney; Senior Consultant Psychiatrist / Clinical Director of Northern Area Addiction Services, Joan Byrne; Director - SAOL, Dr Austin O'Carroll; Prescribing GP, Brendan McKiernan; Director - KELTOI, Gerry McAleenan; Director - SOILSE, Ruaidhri McAuliffe; Co-ordinator - UISCE, Tony Duffin; Director - Ana Liffey, Stuart Fraser; Director - Lantern Project.

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¹ A case manager in this instance is defined as someone with sufficient time to care plan and follow up on care plans, experience shows that this requires time to be set aside of 1 – 3 hours per person. The case manager should have sufficient experience or qualifications in one of the following

disciplines; counselling, addiction, social work, social care etc. This role could also be undertaken by a key worker, if this is agreed by the care plan team.

1 DETOX PROCESS: METHADONE

1.1 Initial Engagement

Clients will be made aware of this system by their doctor, case manager / key worker either from treatment agencies or community / voluntary projects². The requirements, supports, roles and responsibilities of all parties will be fully explained if the client is interested in community detox. At this point the client will need to sign a Consent Form for information to be shared between the various parties (appendix i) and the case manager or doctor will need to go through the Client Information Form (appendix ii) which outlines the risks of relapse and overdose associated with detox and the need for relapse prevention and aftercare planning .

1.2 Assessment

Once a client would like to avail of the detox the following will be assessed:

- a** If the client has a record of one month's clean urines (provided weekly) a case manager meeting will be established. The case meeting will involve the service user, case manager and doctor responsible for prescribing methadone. Where deemed necessary by all parties, others (professional or family members) should be invited to attend. The purpose of this meeting is to: overview the process so all are aware of their role throughout the detox process; discuss relapse dangers; agree a communication strategy; and provide a forum to discuss any issues and answer questions as these arise. Once the four clean urinalysis results are available, all parties will aim to meet in the subsequent 10 working days.
- b** If the client does not have a recent clean urinalysis history, the case manager/key worker will need to make immediate contact with appropriate staff in the treatment agency so they are aware that four consecutive weeks of urinalysis results will be required for engagement in outpatient detox. Clean urines are defined as clear of opiates, and illicit use of prescription drugs.

In all cases the client's presentation will also be considered in the decision as to whether the detox process is appropriate at the current time. In the case of suspected unprescribed benzodiazepine use where clients are also on prescribed medication, presentation will be an important factor in determining whether benzodiazepine levels need to be tested. Presentation will also be a determining factor as to whether alcohol testing is required; problematic drinking will need to be addressed before the client can be clinically detoxed from methadone.

The client's presentation will also be taken into consideration in cases where their previous four weeks urinalysis results are not 100% compliant. If the client has the full support of both medical staff and the case manager, clients will be able to begin the detox in these special circumstances.

If, in exceptional circumstances, the client has the full support of both medical staff and the case manager, the client will be able to begin the community detox without the four required clean urinalysis results

² This would be trialled in the NICDTF area, this catchment area includes the following services; SAOL Project, Ana Liffey Project, Dublin AIDS Alliance, Chrysalis Drugs Project, Talbot Centre, HOPE project, FLASC, SNUG

Counselling Service, PACE, North West Training and Development Project, Gateway Project, UISCE.

2 DETOX PROCESS: BENZODIAZEPINE

The aim of this system is to detox totally from benzodiazepines, rather than being maintained at a lower amount; clients need to be clearly informed of this. To indicate necessary levels of commitment¹ a client will need to attend four care planning appointments with a 1-2-1 worker (counsellor or drugs addiction worker). These appointments can be spread over 2 – 6 weeks and have three purposes:

- i) Ensure client commitment, through completion of weekly drug diaries.
- ii) Provide necessary supports and care planning
- iii) Establish relapse prevention / aftercare plan.

Once the client has completed four care planning meetings there will be a case meeting between the client, case manager and doctor. If anyone has reservations about the appropriateness of starting the detox this will be discussed and recorded at this point and the next step agreed.

The result of all detox case meetings will be a clear plan for future engagement. If the client does not have the requisite four clean urinalysis results or if there are questions over presentation and/or attendance, a clear plan for future engagement will be agreed between the three parties.

3 CASE MANAGER RESPONSIBILITIES:

The Case Manager² has responsibility for, and by engaging in the process agrees to:

- ✦ Meet with the client to review detox suitability as outlined in the protocols. Contact will need to be made with the treatment agency or doctor, by phone or in a meeting, to confirm their involvement and ability to fulfil their role.
- ✦ Ensure that either they or the doctor has gone through the client information sheets, the client needs to sign these to confirm this has been done.
- ✦ Work with the client for the period of the detox and for a minimum aftercare period of 6 months.³

¹ Client commitment needs to be established to ensure that there is a genuine desire to reduce benzodiazepine use. This is a response to medical concerns that clients may request an increase in prescribed medication in order to stabilise un-prescribed use, but without intending to detoxify, which would lead to greater benzodiazepine use in the long term.

² Where the case management is transferred to another agency the new agency must agree to comply with the protocols as set out in this document. If this is not possible the original case manager will maintain

working with the client for the period in question.

³ A case manager is defined as a worker who has primary responsibility for the clients Care Plan. Where a client has a case manager who is not trained in addiction services, it will need to be agreed that the community detox support work can be undertaken by a professional with experience in 1-2-1 addiction and support work. Within the context of the interagency protocols this worker may be referred to as the key worker.

- ✦ Work with the client to identify issues that may endanger the success of a detox. Using a care plan approach, the issues to be looked at include (although are not limited to):
 - Housing
 - Health
 - Welfare/Finance
 - Family and Children
 - Courts and Justice
- ✦ Where appropriate, and as identified in the care plan, to assist the client in dealing with issues that might endanger their detox or refer on as necessary. Where there is a referral the case manager will need to monitor that the referral service has been able to respond to the need adequately.
- ✦ Complete a Relapse Prevention Plan and an Aftercare Plan with the client. This may require anything from two to several sessions. Plan Guidelines are appended.
- ✦ In the case of a benzodiazepine detox, the case manager needs to work through weekly drug diaries over 4 discreet sessions in a minimum time of 2 weeks.
- ✦ Undertake to contact the treatment agency if and (as soon as) they become aware of any problems/issues with the detox process.
- ✦ Emphasise the benefits of the experience of the detox to date. If clients wish to stop or pause their detox before the scheduled time.

If an individual worker moves jobs, then it is the agency's responsibility to ensure the case management role is maintained with a new staff member, or that the client is referred on to an agency that can fulfil this role.

4 CLIENT'S RESPONSIBILITIES:

A client wishing to undertake a community detox will need to;

- ✦ Indicate motivation and show a willingness to engage regularly and reliably with their case manager and treatment agency.
- ✦ Maintain their stability on their prescribed medication. For a methadone detox, the client's urines should not indicate any illicit substance use for at least one month prior to commencing the detox programme. In the case of benzodiazepines, the client will need to present as stable to both case manager and doctor, and engage in meeting regularly with their worker, as well as completing at least two weeks of drug diaries (spread over four individual sessions). Exceptions to this will need to be agreed by both case manager and doctor.
- ✦ Agree to attend whatever review meetings may be set up by the case manager or treatment agency, provided these take into account the client's timetable, i.e. childcare, work commitments etc.
- ✦ To inform the case manager or treatment agency if they want to stop the detox at any time.
- ✦ To inform the case manager or treatment agency immediately if they have had a relapse or slip. This does not preclude them from availing of detox in the future.

5 TREATMENT AGENCY/ DOCTOR RESPONSIBILITIES:

The treatment agency and/or doctor has responsibility for, and by engaging in the process agrees to:

- ✦ In order for the clients pre-detox drug status to be established, weekly urines samples need to be taken, so that the client has a minimum of four clean urines over the period of four consecutive weeks.
- ✦ Meet with the client to review detox suitability as outlined in the protocols. Contact will need to be made with the case manager by phone or in a meeting to confirm their involvement and ability to fulfil their role.
- ✦ Establish in joint consultation with the client a personal detox schedule that takes into consideration the specific needs of the client.
- ✦ Educate clients on the risk of relapse, including overdose. This needs to be re-iterated at all stages of the treatment process by appropriate personnel. The doctor will need to ensure that either they or the case manager have gone through the client information sheets with the client. The client needs to sign these to confirm this has been done.
- ✦ Undertake to contact the case manager as soon as they become aware of any problems/issues with the detox process.
- ✦ Ensure weekly urine collection during the period of detox.
- ✦ Closely medically supervise and have at least weekly contact with the client. Where this appointment can not be made to ensure another qualified medical professional can take the session in lieu.
- ✦ If patients stop their detox before the scheduled time it is important for the treatment agency personnel to emphasise the benefits of the experience of the detox to date.

6 EXAMPLE DETOX SCHEDULE METHADONE

An example detox schedule for clients is –

- ✦ From any starting point to reduce methadone intake by 5 mls per week until the clients reaches 50mls.
- ✦ To continue medication at 50 mls for a period of a month.
- ✦ To reduce medication by 3 – 5 mls per week until client reaches 20 mls. (A Suboxon detox may be also be utilised)
- ✦ To continue medication at 20 mls for a period of a month. At this point efforts will be made to transfer the client to a community pharmacy if they are not already receiving prescriptions through this system.
- ✦ To reduce medication by 3 mls per week until client reaches 10 mls, to continue medication at 10mls for 1 month.
- ✦ The reduction from 10 mls to no medication could take a number of courses including (1) buprenorphine or lofexidine detox, as these are available (2) continued community detox as above (3) in-patient detox for remaining reductions.

If a client wishes to exit the detox system at any point they can do this by contacting their case manager/key worker or doctor/medical personnel (who will in turn inform other involved parties). The client can take up the detox schedule any time within the next 3 months although after this point the contract will need to be renegotiated.

7 DETOX SCHEDULE - BENZODIAZEPINES

Please refer to the department of Health and Children document – *'Benzodiazepines, Good Practice Guidelines for Clinicians'* which can be downloaded at www.dohc.ie/publications/pdf/benzo2.pdf see appendix 2, pages 21 – 25.

8 CONTRAINDICATIONS

The following contraindications may mean that the detox would be inappropriate for the client at this time. These issues will need to be discussed with the GP.

- + History of epilepsy seizures while undergoing detoxification
- + Possible dual addiction, where both addictions are unstable or where a second addiction other than opiates is uncontrolled, (for example cocaine, alcohol and benzodiazepines).
- + Severe mental health problems which are currently untreated,
- + Major medical illness,
- + Active treatment for Hepatitis C ongoing
- + Pregnancy

9 MONITORING OF PROTOCOLS

To ensure that the protocols are workable and match client requirements, a steering group will monitor these over a trial period of at least 18 months. If you, or a service user you know, have experienced any issues or problems in accessing a community detox, please contact: Caroline Gardner, Progression Routes Co-ordinator at progressionroutes@saolproject.ie or call 8553391

10 AFTERCARE AND RELAPSE PREVENTION

10.1 Information session

Before beginning the community detox, the client needs to sign a form stating that they have read and understand all aspects of the protocols, as listed below. The case manager / key worker will need to read through this sheet and make sure that the client has thought about and understands each point. This form is in addition to the confidentiality form that needs to be signed by the client.

10.2 Care Plan and Relapse Prevention Plan

Most workers will be well versed in working through Relapse Prevention Plans and Care Plans. To assist with this guidelines have been provided in appendix iiiii.

Care planning and follow up support will need to be ongoing, outcomes must be recorded and the plan will need to be reviewed frequently. The relapse prevention plan can take anything from two sessions to several.

A tool that may be useful in this work is the SAOL COCAINE RELAPSE PREVENTION WORKSHEETS, which, while designed for cocaine, can be applied effectively to any substance mis-use. These can be downloaded from: www.saolproject.ie/cocaineresources.htm

i) CLIENT CONFIDENTIALITY FORM – COMMUNITY DETOX PILOT

AGREEMENT TO SHARE YOUR INFORMATION

WE WOULD LIKE YOUR PERMISSION TO COLLECT AND SHARE INFORMATION BETWEEN YOUR CASE MANAGER/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.

As some of the information that agencies hold about you is sensitive, they must follow the principles of the Data Protection Act. These principles ensure that the information which 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

I AGREE THAT PERSONAL INFORMATION ABOUT ME MAY BE SHARED WITH OTHER AGENCIES AND WITH OTHER PROFESSIONALS. THIS DOCUMENT IS ONLY VALID FOR 6 MONTHS AND NEEDS TO BE RENEWED AFTER THAT.

Signature of service user

Date of signing this agreement

YOU CAN CHANGE YOUR MIND AT ANY TIME BY CONTACTING ONE OF THE WORKERS INVOLVED IN YOUR CARE. THIS WILL BE RECORDED ON YOUR FILE AND LOGGED ONTO THIS ORIGINAL CONSENT FORM.

Date consent withdrawn

Signature of worker

ii) CLIENT INFORMATION SHEET AND CONSENT FORM

BEFORE BEGINNING A DETOX IT IS IMPORTANT TO KNOW THAT IT CAN INCREASE THE RISK OF RELAPSE. MORE PEOPLE DIE OF AN OVERDOSE WHILE THEY ARE DOING OR WHEN THEY HAVE COMPLETED A DETOX (AND HAVE USED AGAIN) THAN WHEN THEY USE HEROIN WHILE ON METHADONE MAINTENANCE. WHAT THIS MEANS IS THAT PEOPLE WHO ARE THINKING ABOUT A DETOX NEED TO BE SURE THAT THEY ARE REALLY READY TO COMMIT TO WORKING WITH THE SERVICES, AND KEEP THEM INFORMED OF ANY ISSUES WHICH MAY PUT THEM IN DANGER OF USING AGAIN. IF SOMEONE USES HEROIN AFTER A PERIOD OF NOT USING, THEN THE CHANCES OF OVERDOSE ARE HIGH. FOR EXAMPLE, IT'S RECOMMENDED THAT WHEN PEOPLE COME OUT OF PRISON, THEY TRY A TEST DOSE FIRST AS THEIR TOLERANCE WILL HAVE DECREASED.

1 DETOX CAN INCREASE THE CHANCE OF OVERDOSE

Before beginning a detox it is important to know that it can increase the risk of relapse. More people die of an overdose when they are doing or have completed a detox (and have used again) than when they are on methadone maintenance and use heroin. What this means is that people who are thinking about a detox need to be sure that they are really ready to commit to working with the services and keep them informed of any issues which may endanger them of using again. If someone uses heroin after a period of not using then the chances of overdose are high. For example it's recommended that when people come out of prison that they try a test dose first as their tolerance has decreased

2 THE NEED FOR INFORMATION SHARING AND KEEPING EVERYONE UP-TO-DATE

To make sure that you have the best chance of a successful detox and that you are not in danger of relapse then you need to commit to keeping your case manager or key worker and your doctors aware of any issues that may affect your detox and drug stability. You will also need to sign a confidentiality form which means that you give your permission for the people involved in your detox plan to pass on information to each other. The best way to keep everyone informed is to keep your scheduled meetings with your doctor and key worker.

3 THE NEED FOR AN AFTERCARE PLAN AND PROPER SUPPORTS

It is important that you have made plans as to how you will be supported after your detox. Often this can be the most difficult time for people for some of the following reasons;

- Big lifestyle changes can mean that people feel isolated or lonely. You need to think how you will fill the spaces in your day and make new social networks now that your routine has changed.
- Craving for drugs can last for a while or can hit you unexpectedly; you will need to plan for how you will deal with expected and unexpected cravings.
- Often people who have used drugs for a number of years have not developed skills to handle stress and so take drugs to deal with difficult situations. You will need to think about how you will handle difficult situations and life stresses without drugs; some people will attend counselling, NA etc, to look at these issues.
- People around you may not want you to detox and may encourage you to use, you need to plan how you will deal with them.

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

I HAVE READ THIS INFORMATION SHEET (OR THE SHEET HAS BEEN READ TO ME) AND I UNDERSTAND THAT I NEED TO KEEP THE DOCTOR AND MY KEY WORKERS INFORMED ABOUT WHAT IS GOING ON FOR ME AND ATTEND REGULAR APPOINTMENTS WITH THEM. I ALSO UNDERSTAND THE RISK OF RELAPSE AND OVERDOSE ASSOCIATED WITH DETOX AND THE NEED TO HAVE AN AFTERCARE PLAN AND FOLLOW THROUGH ON THIS.

Clients Name:

Date:

Signed:

iii) RELAPSE AND AFTERCARE PLAN GUIDELINES

THE CLIENT'S CARE PLAN SHOULD ADDRESS ISSUES SUCH AS EMPLOYMENT, HOUSING, JUSTICE AND HEALTH ISSUES. THE ROLE OF THE RELAPSE AND AFTERCARE PLAN IS TO LOOK AT ISSUES SPECIFICALLY RELATED TO DRUG USE AND DRUG USING BEHAVIOUR. BEFORE A PERSON CONSIDERS DETOX YOU SHOULD DISCUSS THE PERSON'S CARE PLAN WITH THEM, WITH THE AIM OF EXPLORING WHETHER OTHER ISSUES NEED TO BE DEALT WITH BEFORE THEY BEGIN DETOX. THE CASE MANAGER SHOULD USE THE RELAPSE AND CARE PLAN TO MOTIVATE THE CLIENT TO ACHIEVE THE SMALL STEPS REQUIRED TO MOVE THINGS ON.

It is recommended that the SAOL COCAINE RELAPSE PREVENTION WORKSHEETS be referred to as a template for creating a relapse prevention plan, where the worker does not have other relevant resources etc. While these sheets have been designed for cocaine, they can be applied effectively to any substance mis-use and provide a useful template for working through relapse prevention. These can be downloaded from: www.saolproject.ie/cocaineresources.htm

The following check list should also assist you in forming a relapse prevention and aftercare plan with your client.

- 1 Has the client considered their drug use triggers and established practical plans to deal with these as they occur?
- 2 Has your client considered how they will refuse offers of drugs etc? It may be useful to practice these skills with your client.
- 3 Discuss the option of the client accessing on-going counselling to support the change process. You may need to refer the client to appropriate services and check that they are working out for the client.
- 4 Discuss relapse warning signs, these may indicate to a person when they are unconsciously thinking of using again and putting themselves in a situation to make relapse easier. i.e. distancing themselves from support networks and being around people associated with drug use.
- 5 Has the client planned what they will do with their free time? Often boredom is a significant instigator of relapse, as a key worker your input will play an important part in assisting the client to identify and access suitable activities, whether these be social, interest or work and education related.
- 6 Has the client thought about whether they need to change the people they socialise with? If a change in their drug use will mean a change in their social networks then this will need to be considered and planned for. Loneliness and isolation can also play a significant role in someone's relapse. As a key worker you can assist the client to acknowledge and plan for any of these situations and feelings.
- 7 The client and keyworker will need to discuss the supports available and make a plan for which of these will be suitable for the client. These protocols stipulate that the case manager / key worker needs to be available for 1-2-1 work with the client for an aftercare period of 6 months. Arrangements for aftercare need to be discussed and a plan agreed.

iv) INFORMATION SHEET: INPATIENT DETOX FACILITIES

THE FOLLOWING FACILITIES PROVIDE INPATIENT DETOX IN THE DUBLIN REGION.

PETER MCVERRY TRUST THE LANTERN RESIDENTIAL COMMUNITY METHADONE SERVICE

Garristown, Co. Dublin

OFFICE c/o 29 Mountjoy Square, D1
EMAIL cwilliams@pmvtrust.ie
PHONE 8230776
CONTACT Clare Williams (Head of Services).

SERVICE OFFERED:

Target group – drug users wishing to detox from methadone. 6 week residential programme to help methadone users detox and become drug free. Psychosocial/relapse prevention groupwork. Keywork system, with individual support plans and horticultural programme. On site detox in conjunction with GP. Individual counselling. Self and agency referrals. Pre-access and follow-up support from Peter McVerrys Outreach and Tenancy Sustainment.

ADMISSION CRITERIA

- + Over 18
- + In need of residential community detoxification
- + Supported by their Prescriber
- + Dependent on a maximum of 50mls of methadone
- + Prior to admission the client must be free of all benzodiazepines and alcohol.
- + Urinalysis is required before admission for the health and safety of the client.
- + Clients who are not deemed suitable for a community detox programme are
 - Individuals who are pregnant
 - Individuals who have a fit risk
 - Individuals who suffer severe psychiatric illnesses
 - Individuals dependent on alcohol
 - Individuals dependent of benzodiazepines

PRIMARY MODEL USED

Psycho/Social model with outdoor therapeutic horticulture programme.

CATCHMENT AREA

Currently nationwide

GP INVOLVEMENT

Client must be supported by their community prescriber Peter McVerry Trust doctor. Visit's service on weekly basis and assesses all residents and liaises with community prescriber.

AFTERCARE

Majority of residents are referred onto treatment centres. Residential aftercare is available from Peter McVerry Trust post treatment.

CHILDCARE

None available

COSTS:

Currently €84 weekly for food and accommodation.

MERCHANTS QUAY IRELAND HIGH PARK RESIDENTIAL PROGRAMME

Grace Park Road, Drumcondra, D1

EMAIL info@mqi.ie
PHONE 837 7883

SERVICE OFFERED:

High Park Residential Programme provides a 17-week treatment programme for people whose drug use has become problematic. The service aims to support and assist participants to achieve the awareness, skills, and coping strategies to maintain a drug-free life style.

The service is staffed 24 hours a day, 7 days a week and delivers an intensive personal development programme which includes; one-to-one counselling and care planning, therapeutic group-work, addiction and health education workshops, literacy and numeracy education, community activities, life skills development, drama workshops, and complementary therapies e.g. acupuncture and reiki. The service also includes a fully equipped gym and sauna for residents' use.

High Park Residential Programme has single room accommodation for 13 residents at any one time. It retains 5 beds exclusively for female occupancy.

The Programme also offers an Assisted Community Detoxification (methadone only) subject to agreement from the service users own GP or clinic to work in partnership with the service. 85% of clients admitted under the Assisted Community Detoxification programme complete their detoxification.

ADMISSION CRITERIA

Admission criterion are:

- + That individuals are detoxified and drug free in relation to all problematic substances prior to admission. Or
- + Individuals can be admitted under the Assisted Community Detoxification programme subject to agreement from their GP or clinic. They should be on a maximum of 30mls of methadone per day and must be detoxified and drug free in relation to all other problematic substances prior to admission.

PRIMARY MODEL USED

Cognitive Behavioral Model.

CATCHMENT AREA

They do not operate on a catchment basis.

GP INVOLVEMENT

Project GP - Dr Gibney, Ballymun Health Centre.

A large number of GPs and Addiction Clinics work in partnership with our service as part of our Assisted Community Detoxification programme.

AFTERCARE

High Park Residential Programme has a Residential Settlement Worker as part of their team. The primary aim of this worker's role is to support clients leaving the

programme in accessing appropriate accommodation, counselling and further treatment programmes, where required. The Residential Settlement Worker also facilitates a weekly aftercare group and 1-1 work with clients for up to one year after completing the High Park Programme.

CHILDCARE

They cannot accommodate children in treatment however they do encourage family involvement and hold regular family days. In addition, visits are facilitated throughout the course of the programme.

COSTS

Clients are asked to contribute to living costs at their own discretion.

BEAUMONT HOSPITAL/ST MICHAELS WARD

Beaumont Rd, Dublin 9

CONTACT Staff Nurse

PHONE 8093288

SERVICES OFFERED

Detoxification or Stabilisation for individuals with substance dependency. They are a ten bedded residential unit, delivering effective high quality individualised treatment, in a caring holistic and professional manner with nursing, counselling and medical support. The length of stay varies depending on the clients needs an average stay would be in the vicinity of 3-4 weeks. Referrals are made from the local addiction services for assessment via Trinity Court, Drugs Treatment Centre, Pearse St, Dublin 2.

ADMISSION CRITERIA

- + All referrals from Trinity Court, Pearse St, D2. Through Dr O'Connor ph 648 8600.
- + Heroin and other opiates accepted following assessment.
- + In the case of a methadone detox clients should be stabilised on 40mls or less
- + There is a waiting list for admission

PRIMARY MODEL USED

Medical detox

CATCHMENT AREA

Referrals from all areas will be considered.

GP INVOLVEMENT

Dr. O'Connor is the resident consultant. GP involvement is facilitated as required. Discharge summaries are sent to all GPs at the end of treatment.

AFTERCARE

Information and support is provided for client self-referrals. All clients will leave with aftercare plan.

CHILDCARE

Not provided. Visits by family are encouraged although visiting is restricted by time and depending on client needs.

COSTS

No costs.

CUAN DARA

Cherry Orchard Hospital, Cherry Orchard Dublin 10

CONTACT Jason Farrell (Acting Manager)

PHONE 620 6050

SERVICES OFFERED

Cuan Dara primarily offers a 6 week therapeutic detoxification programme which provides a medical detox from Methadone and Heroin. The Programme offers support and provides tools for management of both the physical and emotional aspects of detoxification through motivational interviewing, individual and group interventions. Poly substance abusers who have a primary addiction to an opiate are also accepted. The Program offered provides an effective foundation for further recovery and treatment. Cuan Dara also provides a 2-4 week stabilisation programme.

ADMISSION CRITERIA

For Detoxification clients must have :

- + Reduced to 50mls of Methadone / 2-3 bags of heroin, 40mgs of Diazepam (or equivalent),
- + Have attended at least 4 counselling sessions with an addictions counsellor,

PRIMARY MODEL USED

Bio/psycho/social model.

CATCHMENT AREA

Greater Dublin Area.

AFTERCARE

Further rehabilitation options explored and provided for all clients.

CHILDCARE

None

COSTS

No cost

COOLMINE LODGE

MEN'S RESIDENTIAL PROGRAMME

CONTACT Yvonne Booth, Manager
yvonne@coolminetc.ie

REFERRALS Gerry Ryan
gerryryan@coolminetc.ie

PHONE (01) 679 4822 086 123 0145

SERVICE OFFERED

Coolmine lodge offers a six month residential treatment programme for men with drug and alcohol problems. The service seeks to support and assist participants to achieve the awareness, skills and coping strategies to maintain a drug free lifestyle. The service is staffed 24 hours a day, 7 days a week and on completion participants are offered a further six months residence in one of our community based housing projects as part of their integration and aftercare programme.

The programme at the Lodge offers an Assisted Community Detoxification (methadone only) subject to agreement from the clients own GP or clinic to work in partnership with the service.

ADMISSION CRITERIA

- ✦ Desire to complete six months abstinence based primary treatment programme
- ✦ Engagement with Coolmine pre entry requirements and/ or participation on our stabilization day programme prior admission.
- ✦ Agreement and cooperation with clients GP or clinic
- ✦ Regular urinalysis is and integral part of the process

PRIMARY MODEL USED

Therapeutic Community Model

CATCHMENTS AREA

Nationwide at present

GP INVOLVEMENT

Coolmine currently finalising governance arrangements with consultant and local GP's (to be completed in May 2008)

AFTERCARE

On completion participants are offered a further six months residence in one of our community based housing projects as part of their integration and after-care programme.

CHILD CARE AND FAMILY SERVICES

Cannot facilitate children in treatment at present. There is a well established family service in place with a dedicated worker facilitating weekly therapeutic and educational groups as well as three way case management meetings with staff. Family visits are encouraged and regular.

COSTS

Clients are asked to contribute to living costs.

ASHLEIGH HOUSE

WOMEN'S RESIDENTIAL PROGRAMME

CONTACT David Madden
david@coolminetc.ie

REFERRALS Gerry Ryan
gerryryan@coolminetc.ie

PHONE (01) 679 4822 086 123 0145

SERVICE OFFERED

Ashleigh House offers a six month treatment programme for women with drug and alcohol problems. The service seeks to support and assist participants to achieve the awareness, skills and coping strategies to maintain a drug free lifestyle. The services is staffed 24 hours a day, 7 days a week and on completion participants are offered a further six months residence in one of our community based housing projects as part of their integration and aftercare programme.

The programme at the Ashleigh House offers an Assisted Community Detoxification (methadone only) subject to agreement from the clients own GP or clinic to work in partnership with the service.

ADMISSION CRITERIA

- ✦ Desire to complete six months abstinence based primary treatment programme
- ✦ Engagement with Coolmine pre-entry requirements and/or participation on our stabilization day programme prior admission.
- ✦ Agreement and cooperation with clients GP or clinic
- ✦ Regular urinalysis is an integral part of the process

PRIMARY MODEL USED

Therapeutic Community Model

CATCHMENTS AREA

Nationwide at present

GP INVOLVEMENT

Coolmine currently finalising governance arrangements with consultant and local GP's (to be completed in May 2008)

AFTERCARE

On completion participants are offered a further six months residence in one of our community based housing projects as part of their integration and after-care programme.

CHILD CARE AND FAMILY SERVICES

Child care facilities are being upgraded and we currently facilitate women with children in treatment. These services will expand incrementally in 2008 and 2009. Family service in place with weekly therapeutic and educational groups as well as three way case management meetings with staff.

COSTS

Clients are asked to contribute to living costs.

