RECOVERY MINDED

Detox is just as much about the psychological as the physical and services ignore this at their peril, argue **Nick Barton** and **Tina Mobsby**

Detoxification is the medically managed withdrawal of, and from, chemicals on which a person has formed a physical dependency. Since it involves medicines and skilful care of the body's reactions to them, it's all too easy to think of the detoxification process as a purely physical matter – a technical, pharmacological intervention – and often one that has to be got out of the way before getting down to rehabilitation and recovery.

Of course it is a biomedical intervention but by no means only that. One might argue that those who approach the management of detox from such a limited perspective betray a lack of understanding of addiction – they miss not only the opportunity to maximise the benefits of the medical treatment to achieve safe and early withdrawal, but they also risk reducing the chances of achieving the broader, longer-term outcome of recovery and wellbeing. It's as well to remember that we are treating addiction, not simply intoxication – that is why a fully integrated approach, with detoxification embedded *within* a psychosocial change programme, makes more sense than the traditional sequence of a discrete medical treatment followed at some point by a psychosocial intervention.

The trouble is that the old separation persists, to a large extent because historic commissioning and funding arrangements effectively keep it that way. There also seems to be a commonly held belief that clients are not ready to experience the one until they have undergone the other. Experience tells us otherwise, and we do a disservice when we underestimate what clients can achieve.

Detox is a necessary process for achieving and maintaining an alcohol and drug free state – a key staging post. The keys to the success of recovery as a whole, however, lie almost entirely in the psychosocial domain. The person undergoing physical withdrawal is in a state of mind that will both affect and be affected by that withdrawal – one that will inevitably have a direct bearing on their engagement with treatment and the process of change as a whole.

Personal psychological dynamics do not slip conveniently into neutral simply because of an intervention occurring at the physical level – withdrawal, like addiction, is a psychological as well as physical process. The patient may no longer be intoxicated but the underlying (partly unconscious) dependent relationship to substances, which is where vulnerability to relapse lies, may have changed little.

Relationship is an important word in this context. Addiction is often best understood as a consuming relationship with a substance or behaviour, and relationships operate primarily in the realms of feeling and thinking. The relationship to mood-altering chemicals is no different. The attachment to alcohol or opiates is not just a matter of the body's acquired dependence on the chemicals to stave off the symptoms of withdrawal – the *thought* of being without them arouses anxiety, from fear of physical discomfort or the prospect of being without them for any length of time, while the thought of imminently obtaining them produces an anticipatory mood elevation or 'buzz' of its own.

Handing over the management of drug intake to someone else involves letting go and is therefore a matter of trust. No matter how much control has already been lost in the addiction, the necessary loss of control in submitting to medically supervised detoxification is likely to cause anxiety.

It stands to reason that the management of withdrawal must take account of the psychological aspects of the relationship – how people feel about the process in general, including the context in which it occurs, and about the particular mode of detox to be applied to them. Indeed, anything that might affect how the person feels about detox needs to be considered. The UK *Orange book* guidelines on clinical management state: 'A full programme of psychosocial support needs to be in place *during* [our italics] detoxification.' While fully endorsing this prescription we should note that it does not suggest what such a programme might consist of, or make any reference to things that might affect the way the process is experienced or how that may influence outcome.

It's also quite a surprise to discover that NICE guidelines on detoxification make no reference to the psychological aspects of this process other than a passing nod to the patient's treatment preference. The guidance focuses solely on the administration of the pharmacological treatment – a serious failing as it ignores the very areas that are the real keys to addiction and critical to withdrawal, recovery and relapse.

Bearing in mind that patients bring to their treatment all manner of mental health issues as well as treatment-specific beliefs, hopes and anxieties – often based on previous experiences – it's wise to discover what those might be and a good idea to ensure that everything relating to the management of withdrawal is as positive as it can be. It's essential for patients to make informed decisions regarding their medical treatment, and sensible not to overplay the importance of the withdrawal process, encouraging a focus on recovery instead. Our view is that this is more easily achieved when detoxification is undergone *within* the context of a psychosocial treatment and recovery programme rather than separately – people are more easily diverted from any tendency to isolate themselves with morbid preoccupations about their physical state.

Everything that goes into conducting that psychosocial programme will have a bearing on the experience of withdrawal and thus engagement with, and completion of, treatment. This will include the physical environment, the staff and organisational culture, the food and other aspects of care. The context needs to optimise the conditions for achieving withdrawal as early but as safely as possible. A collaborative approach helps avoid it becoming a purely 'done-to' experience – if a person feels supported, well cared for and in good hands, it will be easier for them to let go of their attachment to substances in both the physical and psychological sense.

While it's always essential to treat each person as an individual, a sense of shared purpose among the patients may be as important in keeping people on track. The availability of supportive peers at different stages of treatment may also help – patients may draw inspiration from those ahead of them in the process, while in others they may be reminded of conditions they are relieved to have left behind.

The question arises, however, as to whether people should be shielded from all discomfort associated with withdrawal or if there is some benefit to be had from

keeping people in touch with one of the realities of addiction. Or should we make it as easy as possible to help the person focus on psychological and lifestyle change instead of physical sensations? Patients puzzle over this and it's interesting that opiate addicts in particular frequently hold the view that it's good for the process not to be too easy.

It's our experience that patients often compare experiences and even, in some cases, compete. If we can minimise potential distractions that might be inherent in managing a wide variety of detoxes in one setting, patients will be able to focus to where it is most needed – on recovery. While it will always need to be tailored to the individual, a broadly uniform approach to managing withdrawal within a particular unit has its merits.

The communications of the staff, whether overt or indirect, are also critical as they give more or less subtle messages that may directly affect the person's experience. The 'therapeutic relationship' should be just that – it sometimes breaks down if, for whatever reason, part-time staff are frequently on duty. Full-time staffing affords much more continuity and consistency of messages, which gives confidence to the patients.

The medical and nursing staff must also be fully in tune with the psychological treatment and recovery programme, working in an integrated and complementary fashion with their colleagues. Patients' lives are so often fragmented that it makes little sense for those treating them to operate in the same way – integration is the key.

Here, then, are our 15 key considerations for managing the psychological aspects of detox in a residential treatment setting to improve the chances of successfully completing withdrawal:

1. *Ensure that people have excellent, straightforward information about the facility and its approach before they arrive.*
2. *Recognise that, in making the decision to undergo withdrawal, a process of psychological change has already begun.*
3. *This step may excite anxiety, which will need to be contained.*
4. *Inform openly, show respect and empathise. Take a collaborative approach.*
5. *Recognise that many patients will have had previous experiences of detox and may hold strong views.*
6. *Foster an approach that takes the drama out of detox. Focus on recovery, rather than withdrawal, from the word go.*
7. *Offer complementary alternative therapies where appropriate.*
8. *Apart from prescribed medication, maintain a well-boundaried alcohol and drug free environment.*
9. *Foster a 24-hour atmosphere that is positive, encouraging, supportive and optimistic.*
10. *Encourage a mutually supportive community spirit among patients.*
11. *The presence of people who are further along in the process can be a great help and encouragement.*
12. *Help people to engage in the psychosocial therapies as early as possible. Do not wait for detox to be completed.*
13. *Ensure staff are confident, knowledgeable communicators and able to mix professionalism with humanity.*
14. *Foster an integrated approach between medical, psychological and other staff.*
15. *While taking full account of individual needs, a regimen that varies as little as possible from one patient to the next can benefit everyone.*

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Next issue: Brendan Georgeson looks at community detox

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