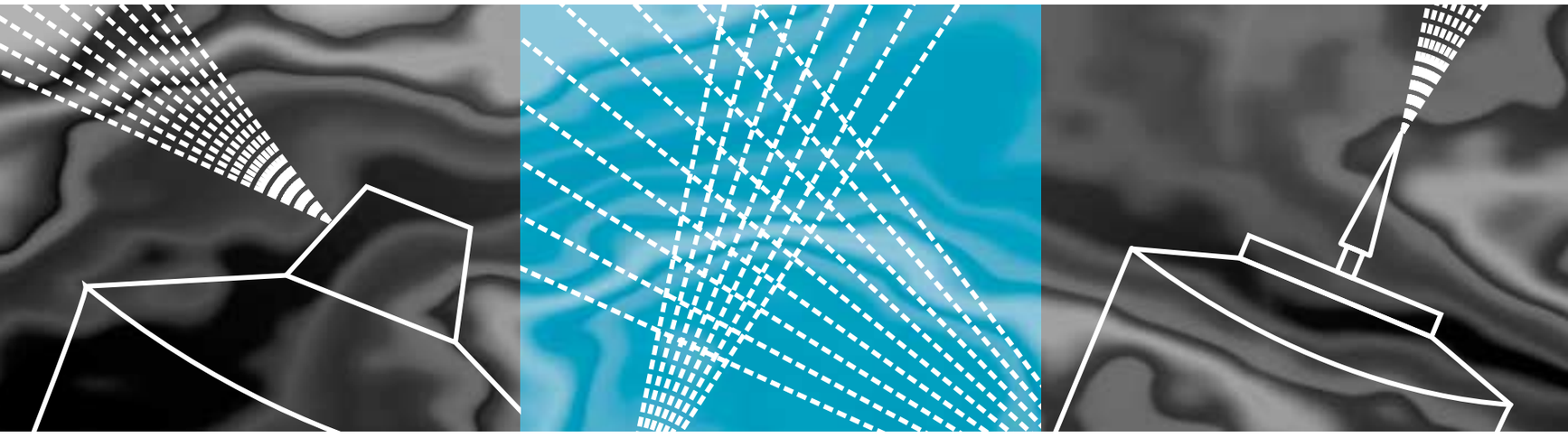
Management response to inhalant use

Guidelines for the community care and drug and alcohol sector



Department of Human Services

State Government Victoria

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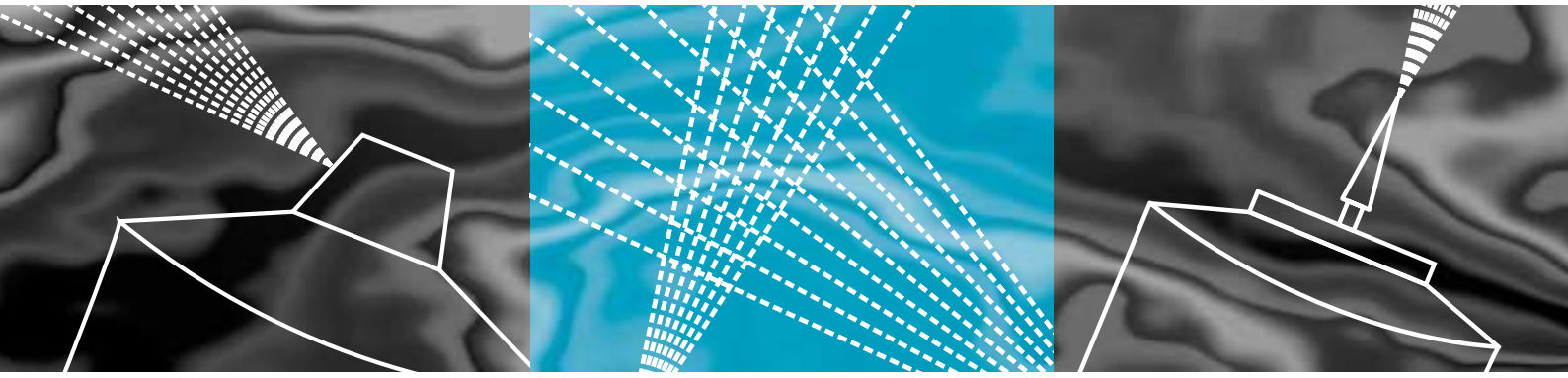

Drugs Policy and Services Branch
Child Protection and Juvenile Justice Branch

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Foreword

These Guidelines were developed for front line workers in services funded by the Department of Human Services (DHS) who are working with people who use inhalants.

DHS has a clear policy that does not permit the passive observation/supervision of clients using inhalants.

DHS recognises that inhalant use occurs in people, often young people, who have suffered abuse and neglect. They will often resort to inhalant use, typically chroming, to cope with past traumatic experiences.

DHS endeavours to exercise its duty of care to these young people by continuing to combat inhalant use.

DHS is committed to helping these young people by putting in place strategies to stop inhalant use.

In February 2002, DHS released the following chroming policy to provide clear advice for Community Service Organisations (CSOs) delivering out of home care services.

1. **No illicit drugs are allowed on premises.** This guideline is in keeping with current standards including the Scope of Service and Minimum Standards and Outcome Objectives for Residential Care Services in Victoria (Minimum Standards) – both of which require compliance with all relevant Commonwealth and State legislation in the operation of services.
2. **All children and young people with substance use issues must be referred to drug and alcohol treatment services.** This requirement was put in place in *Stronger youth, stronger futures – the safety and wellbeing strategy* which was developed in partnership with CSOs in response to the findings of the *Audit of children and young people in residential care.* Referral to drug and alcohol treatment will also be measured as part of the quarterly data collection that monitors improvements for children and young people in residential care.
3. **Children and young people are not permitted to have any non-prescribed inhalants in their possession or use such inhalants in residential care facilities. Items that are essential to the day-to-day operation of the residential care service and which clients could use as inhalants are to be securely stored.** This guideline is reflected in the minimum standards.
4. **Strategies relying on passive observation of clients using substances are not permitted.**
5. **CSOs are expected to do everything reasonable and consistent within safe work practices to stop young people from using non-prescribed inhalants, to remove inhaling implements as soon as possible, and to reinforce that using non-prescribed inhalants is not permitted.**
6. **In situations where children and young people present to the residential care facility in a substance affected state our duty of care remains to ensure that they are appropriately assisted.** This includes seeking medical intervention where required and monitoring the young person's wellbeing.

Following the release of this policy, new detailed guidelines have been developed to provide front-line workers with clear information regarding what is required of them to ensure that their duty of care responsibilities are met and strategies undertaken to address inhalant use.

The guidelines were developed after an extensive consultation process. Where possible the guidelines are based upon the best available evidence on the effectiveness of inhalant interventions. Where research evidence was lacking, the guidelines rely upon expert opinion.

The two key audiences for these guidelines are out-of-home care services and alcohol and drug treatment services.

There are two separate sections: one for out-of-home care settings, the other for alcohol and drug treatment settings. The chapter on detection and assessment is a shared chapter. Some of the sections of the guidelines will not be relevant to all readers – however they have been produced as a comprehensive document as it is helpful to all relevant parts of the service system working with people who use inhalants to be aware of each others roles.

The guidelines concentrate on management strategies and interventions for regular and chronic inhalant users, with less attention to experimental inhalant use. They are concerned primarily with the use of chrome paint and butane as inhalants. Further resources are recommended for other forms of inhalant use, such as petrol sniffing. The Department of Human Services (DHS) has developed guidelines for Indigenous health and community workers. This resource can be obtained at the Drug Treatment and Health Protection website at: www.health.vic.gov.au/drugservices/pubs/koori_inhalants.htm

Following recommendations by the Victorian Government's Parliamentary Drugs and Crime Prevention Committee (DCPC) the *Drugs Poisons and Controlled Substances Act 1981* was amended to include the *Drugs Poisons and Controlled Substances (Volatile Substances) Act 2003* ("the Act"). The Act came into operation on the 1 July 2004.

The Act does not make inhalant use an illegal activity. The legislation enables police to search a young person under 18 years suspected of having inhaled a volatile substance, and seize the volatile substance and any items used to inhale. Police can also detain the young person in certain circumstances. In using their powers under the Act police must act in the best interests of the young person.

The *Interagency Protocol between Victoria Police and nominated agencies (July 2004)* has been developed to support the implementation of the Act. The Protocol is between the Victoria Police, Child Protection, Indigenous Services, Out of Home Care Services and Alcohol and Drug Agencies. The Protocol can be obtained from the Department of Human Services, Drug Treatment and Health Protection Website at: http://www.health.vic.gov.au/drugservices/index.htm

Acknowledgements

In the preparation of the Management Response to Inhalant Use document, the Drugs Policy and Services Branch of the Department of Human Services (DHS) commissioned Turning Point to provide a base document on management guidelines and principles for Inhalant Use in Out of Home Care and Alcohol and Drug Agencies. This final document has been informed by that report. Thanks to Nicole Lee, Alison Ritter, Moira Scanlon, Richard Cash, Lisa Johns, Nicolas Clark and Paul Gardiner for their contribution to this report.

Further to this a number of people gave generously of their time in the development of these Guidelines. Their contributions in the form of professional advice, suggestions, critical commentary and practical assistance are greatly valued. In particular:

- Turning Point staff, especially Barbara de Graaff, Research Assistant, who provided assistance with content and format of the guidelines; Bridget Roberts, Maria Papadontas, Linda Corcoran, Penny Heale, Wendy Dodd, Caro Clarke, Lynda Berends, Julie Bowen from Turning Point Alcohol and Drug Centre who facilitated focus groups; Chrissie Webster, RN, who provided advice and resources on the management of acquired brain injury; Yvonne Bonomo, Medical Officer, who provided comments on earlier drafts.
- Sarah Maclean from the Youth Research Centre who provided assistance with resources.
- The participants of the focus groups who provided valuable contributions.
- Karen O'Neill and Robin Fisher from the Department of Human Services who provided advice and organised the Department of Human Services Inhalants Forum and the Drug Treatment Services Providers Conference workshop and Carol Bennett from Victorian Alcohol and Drug Association (VAADA) who organised the forum 'Chroming: beyond the headlines'.
- All the key informants (see Appendix A) including those who read earlier drafts and provided feedback.

Drugs Policy and Services Branch and the Child Protection and Juvenile Justice Branch of DHS have been responsible for the final version of these Guidelines, and many thanks to those Branch staff who participated in preparing this final report.

Contents

Introduction to the guidelines

These operational guidelines were developed to underpin the management by front-line workers employed in DHS funded services of people using inhalants. They cover assessment, clinical management and follow up of people using inhalants.

DHS has a clear policy that does not permit the passive observation/supervision of clients using inhalants.

The two key audiences for these guidelines are out-of-home care services and alcohol and drug treatment services.

Out-of-home care includes:

- Kith and Kin: This involves placement with family, relatives or friends that have been approved by DHS.
- Foster Care: Provided by volunteer foster carers who care for children or young people in their home.
- Shared Family Care: This placement option targets children and young people with either/or a developmental delay/intellectual disability.
- Adolescent Community Placement: This involves home based care in volunteer carers' home for young people.
- High-Risk Adolescent 1 to 1 Care: This is a specialised home-based care option which offers specially recruited carers looking after one very high risk and challenging young person.
- Residential Care: This option is primarily for young people over 12 years of age. These units are staffed on a 24-hour basis.

Alcohol and drug treatment services include youth services, withdrawal services, residential rehabilitation, and counselling services along with other specialist alcohol and drug treatment services.

These guidelines aim to:

- clarify minimum expectation regarding duty of care responsibilities
- clarify minimum expectation regarding strategies to respond to inhalant use
- promote consistent and high quality interventions for people abusing inhalants
- broaden the menu of options available to workers
- be used as a learning tool for workers new to the field or those with little experience or knowledge of interventions for inhalant use
- be useful and appropriate for workers across diverse fields, those working in different settings, modalities of treatment and geographic locations
- be adaptable to different environments in which people work
- be user friendly, simple and client specific.

Organisation of the guidelines

Chapter 1 covers the basic facts about inhalant use – reasons and methods of use, effects and harms from use, and rates of drug use.

Chapter 2 is concerned with detection and assessment.

Chapter 3 is for workers in out-of-home care settings. It details management strategies for out-of-home care workers: dealing with intoxication and acute effects; short-term interventions; and long-term interventions.

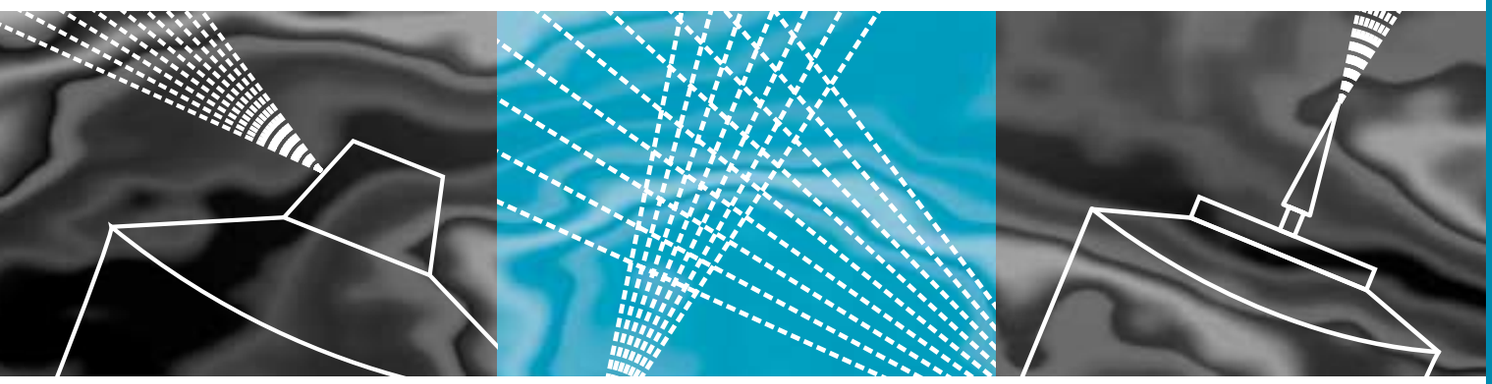
Chapter 4 is for alcohol and drug workers. It details management strategies for alcohol and drug workers in relation to dealing with intoxication and acute effects; short-term interventions; and long-term interventions.

Chapter 5 covers acquired brain injury (ABI).

Chapter 6 covers petrol sniffing, amyl nitrate and nitrous oxide as special cases of inhalant use.

Chapter 7 outlines community interventions.

Chapter 1:
Background information



Types of inhalants

Inhalants are a range of products (many of which are familiar household items) which, when vaporised and inhaled, may cause the person to feel intoxicated or 'high' (Australian Drug Foundation, 1999).

There are a number of different ways in which inhalants have been classified. In these guidelines they have been classified according to the United States National Institute on Drug Use (NIDA) system. This classification system lists inhalants under four categories:

1. Volatile solvents - these are liquids or semi-solids such as petrol, glue or paint thinner that vaporise at room temperature. There are many common, household and industrial products that contain volatile solvents. These include dry-cleaning fluids, contact adhesives, correction fluids and felt-tip markers.
2. Aerosols - propellant gases and solvents contained in spray-cans are known collectively as aerosols. This group also includes easily accessible products such as spray paints, deodorants and hairsprays, insect sprays, air fresheners, fabric protectors and vegetable oil sprays for cooking.
3. Gases - The most commonly used substance in this category is nitrous oxide. This is a gas used by doctors and dentists as an anaesthetic agent. It is often referred to as 'laughing gas' because it can induce a state of giggling and laughter. Other medical gases that are commonly used include ether, chloroform and halothane. Household or commercial gases that can be used include butane cigarette lighters, bottled domestic gas and cylinder propane gas.
4. Nitrates – Unlike most other inhalants, which are used to alter mood, nitrates have been used primarily as sexual enhancers. They are different to most other inhalants in that they dilate the blood vessels, increase heart rate and relax the muscles, rather than acting directly on the central nervous system.

'Chroming' is within the aerosol class and refers to the practice of spraying chrome paint from an aerosol can into a plastic or paper bag and inhaling the vapours. These guidelines are concerned primarily with chroming and butane use, however a small section is devoted to petrol, amyl nitrate and nitrous oxide with further resources recommended for these classes of inhalant use.

Table 1: Commonly accessible inhalants

Group	Substances	Chemicals
Volatile solvents	Nail polish remover	Acetate, ethyl acetate
	Paint stripper	Toluene, acetone
	Correction fluid and thinner	Trichloroethylene
	Dry-cleaning degreaser	Tetrachloroethylene, xylene
	Petrol	Benzene compound, lead, Toluene, aliphatic hydrocarbons
	Modelling glue	Toluene, ethyl acetate
	'Kwikgrip' (super glue)	Benzene, n-hexane, xylene
	rubber cement	
Aerosols	Spray paint	Butane, toluene
	Hair spray and deodorant	Butane, propane
	Non stick sprays	Toluene, acetate
Gases	Fuel gas and lighter fluid	Butane, isopropane
	Fire extinguisher	Bromochlorodiflurometane
	Whipped cream bulbs	Nitrous oxide
Nitrates	Video head cleaner and 'room odorisers' (sex aids)	Alkyl nitrate, (iso)amyl nitrate, (iso)butyl nitrate, isopropyl nitrate

Reasons for use

Inhalants are depressants, that is, they slow down the central nervous system. The reasons for use are largely no different from the reasons for use of any drug. Hence the four most common reasons for using drugs, including inhalants, are:

1. to have fun
2. to get high
3. to be part of a group (peer pressure)

   and
4. to deal with problems, including emotional states.

Young people often choose inhalants over alcohol or other types of drugs because they are accessible, relatively cheap, legal and provide speedy intoxication. Drug use of any form also more usually co-occurs with a specific socioeconomic circumstance: poverty, marginalisation, unemployment and disenfranchisement.

Methods of use

The most common techniques for using inhalants are:

1. Squeezing contents of glue tube into a plastic or paper bag and inhaling contents.
2. Saturating a cloth with substance and holding over face or putting directly into mouth.
3. Sniffing directly from a container or gas tank.
4. Spraying aerosol propellant directly into mouth or into a balloon and allowing the balloon to implode inside the mouth.
5. Spraying chrome paint into a plastic or paper bag and inhaling the vapours.
6. Spraying paint on the inside of clothing (eg sleeves).

Other methods include:

1. Heating: some inhalants come in liquid form and are heated to produce higher vapour concentrations, for example methylene chloride.
2. Filling a vessel (sink, bathtub) in a closed room.

Apart from ‘chroming’, other colloquial terms used to describe methods of inhalant use are

- ‘bagging’: inhaling fumes from a plastic bag
- ‘huffing’: stuffing an inhalant soaked rag into the mouth
- ‘sniffing’ or ‘snorting’: inhaling through the nose
- ‘nanging’: use of nitrous oxide from whipping cream bulbs
- ‘poppers’: use of amyl nitrate through the breaking of vials causing a popping sound.

Effects of use

There is some difficulty in summarising the effects of inhalant use as it depends on the substance used, the age and gender of the inhaler, the amount inhaled, the environment in which it is used and the method and duration of use. However, despite these variations, there are some common immediate or short-term effects as well as effects of longer-term use.

Short-term effects include:

- rapid intoxication and recovery
- euphoria
- hallucinations
- loss of inhibition
- loss of muscular coordination
- slurred speech and blurred vision
- feelings of invulnerability/invincibility
- drowsiness
- dizziness
- confusion and incoherence
- aggression
- increased risk taking behaviours
- vomiting.

Long-term effects

Most studies that have been conducted have examined inhalant use by industrial workers, not young people. However, there are valid indications that inhalants can cause damage to many parts of the body, including the brain, the sensory organs, the liver, the peripheral nerves, the kidneys, and the bone marrow.

Some of the harms from longer-term or chronic use include:

- recurrent nose bleeds
- oral and nasal ulceration
- sinusitis
- diminished cognitive function (memory loss)
- lethargy
- indigestion
- conjunctivitis and blood-shot eyes
- chronic or frequent cough
- tinnitus
- chest pain or angina
- depression
- anxiety.

Pregnancy

The chemicals in solvents can pass through the placental barrier and enter the fetal bloodstream. However, except for evidence of birth defects among petrol inhalers, the scientific evidence that use of other inhalants can damage the fetus is inconclusive. There is little doubt however, that drugs have some effects on an unborn child and using inhalants during pregnancy can harm the baby.

Risk of death

There is no safe level of inhalant use. They have the capacity to suddenly and unpredictably cause death. There are two primary causes of death in people who use inhalants:

1. Direct toxic effects of the substance, such as cardiac arrhythmia (abnormal heart rhythm), depression of breathing, vaso-vagal inhibition (slowing of the heart and a fall in blood pressure) and hypoxia (blocking of oxygen supply). Deaths resulting directly from the toxic effects of inhaling the volatile substances are known as ‘sudden sniffing death’ (SSD).
2. Accidental injury whilst intoxicated, such as falling, inhalation of vomit, asphyxia from plastic bag, fire or explosion from ignited vapour.

Death associated with aerosols and gas fuels is more likely to be due to SSD than accidental death. The one national Australian study of mortality from inhalation of volatile substances that is available reveals that 121 deaths occurred between 1980 and 1987 (National Drug Abuse Information Centre, 1988). In Victoria, between 1991–2000, 44 deaths associated with inhalants were reported. These deaths were attributed to the following causes:

- 17 deaths were suicides or likely suicides, in which inhalants had a known role. They were all males.
- 13 deaths were directly related to the toxicity of the volatile substance that had been deliberately inhaled. Butane and propane gases were the major volatile substances used in these cases.
- Two deaths were due to the accidental inhalation of volatile substances.
- Eight deaths involved fatal accidents sustained just after the individuals had been inhaling volatile substances.
- Four deaths were of individuals with a known history of inhalant use. Two of these involved the interactions of other drugs.

Rates of inhalant use

Table 2 summarises the available information on the rates of inhalant use. In the general population, 4% of over 14 year olds have tried inhalants, with 1% using in the last year. Compare this with 91% who have ever tried alcohol and 80% who have consumed alcohol in the last year. Likewise 40% have tried cannabis and 18% have used cannabis in the last year. Clearly, inhalant use has a very low prevalence in the general population.

Given that inhalant use is largely a young person's activity, the rate of use specifically amongst students and young adults is of interest – 26% of students have tried inhalants and 19% have used them in the last year. Alcohol, analgesics, tobacco and cannabis all have significantly higher rates of use amongst students.

Within the out-of-home care setting, it has been estimated that approximately 16% of young people have ever tried inhalants, although there are some methodological issues that may distort these data. This compares with rates of 37% for alcohol and cannabis and 14% for heroin. The proportion of alcohol and drug treatment seekers who present with chroming is 0.57%.

It is likely that the inhalant user is young (12 to 15 years of age), engaging in use of other drugs heightening the risk of developing drug problems in adulthood.

Table 2: Rates of inhalant use

	Percentage	Source
General population	3.9% ever tried 0.9% in last year	National Drug Strategy Household Survey (1998)
Students	26% ever tried 19% in last year	School Students and Drug Use (1999)
Out-of-home care	16.4% currently use	Audit of children and young people in residential care (2001)
Secure welfare	38% of admissions with chroming as primary reason for admission (13 to 16 years)	Secure welfare audit (2001)
Alcohol and drug treatment population	0.57% of the 24,124 episodes of treatment were for inhalant use	Alcohol and Drug Information System (ADIS) (2000/2001)

Patterns of use

In order to provide the most appropriate treatment to an individual, it is important for workers to be aware of the different patterns of drug use and how these patterns of use relate to risk. Patterns of drug use can be classified into four types:

1. experimental
2. regular
3. chronic
4. situational.

Definitions of each are offered below. Examples of inhalant use for each pattern are also presented. These four different patterns of drug use apply to all drugs – both legal and illegal. All drug use commences at the experimental stage, with some people moving on to regular use and others ceasing at the experimental stage. Likewise for people who regularly use inhalants, a small proportion of these will become chronic or dependent users, whilst the rest will remain as regular inhalant users. Thus, most inhalant users will stop at the experimental stage. While a small number of inhalant users will move to more intensive (chronic) use, the majority will use inhalants for a short period of time only.

Experimental

Experimental drug use generally occurs in early adolescence and is typically short lived. Experimental use is motivated by curiosity to experience new feelings/moods or as a consequence of peer pressure. Some examples of experimental drug use include drinking for the first time and getting drunk, or trying cigarettes at school.

The majority of young people who use inhalants fall into this group. It is most commonly identified with teenagers in schools, trying out sniffing of glue or liquid paper. Primary risks in this context include accidental overuse due to drug naivety.

Regular

Regular drug use often occurs as part of a recreational or group activity. The amount and duration of use may vary depending on the occasion. It is most often perceived as fun and enjoyable and is not perceived to have a dramatic negative impact on the person's functioning. An example of regular drug use is using ecstasy at a nightclub on the weekends.

Inhalants are often used in a social context but usually these young people grow out of their use of inhalants within a few months. Primary risks in the social context include overuse due to peer influence, short-term physical effects and injury.

Chronic

Chronic drug use occurs in a small percentage of people who try drugs. Even for heroin, only around 50% of people who use heroin are thought to be chronic dependant users. Around 90% of smokers are chronic dependent users. For most other drugs, the percentages are much smaller. Chronic use is usually identified by regular habitual use, and is often accompanied by a physical dependence syndrome. Some examples include someone using heroin 2–3 times daily, or individuals who drink above the recommended safe drinking levels.

Chronic use of inhalants occurs in only a small number of young people. They are usually older adolescents who will use alone or with other long-term users. It is also likely that they are using inhalants in conjunction with other substances. There is no evidence to suggest physical dependence to inhalants, but withdrawal symptoms to other substances may inaccurately be attributed to the cessation of inhalant use. Primary risks in this context include injury and short-term or chronic physical effects.

Situational

Situational drug use occurs when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought.

Inhalants are rarely used in this context. Examples of situational inhalant use include people who work with toxic chemicals, such as cleaners, who deliberately inhale as they are working, and use of nitrous oxide by dentists. Primary risks in this context include short-term physical effects and injury. Situational drug use is not covered by these guidelines.

Table 3: Patterns of inhalant use

Experimental	• Usually early adolescence • Short-lived • Motivated by curiosity, attention-seeking, peer pressure to try it out • Examples: Young people in schools, trying out glue sniffing/liquid paper; in care, someone trying chroming because someone else in the house doing it (contamination).
Regular	• Early or later adolescence • Social group activity • Motivated by fun, enjoyment • Examples: inhalant use as part of regular group activity
Chronic	• Drugs play large role in life and associated with negative consequences • Impairment in social, educational or occupational functioning • Drug-seeking behaviour • Multiple problems and likely polydrug users • More likely to be isolated inhalant users (not part of group-based inhalant use) • Examples: young people who carry a bag and paint with them and inhale several times daily
Situational	• Usually in a work context or specific situation • Often opportunistic • Rare in inhalant users • Examples: use of nitrous oxide by dentists; cleaners inhaling cleaning chemicals

Developmental considerations in drug treatment

Many of the young people who develop chronic drug use patterns are marginalised adolescents who have significant stressors in their life. The frequency of their drug use may also further disrupt a young person's ability to negotiate the demands of transition from adolescence to early adulthood.

When working with young people who are abusing inhalants, it is important to place this in the context of their physical, cognitive and emotional development. This will provide valuable information about how best to engage the young person in treatment and assist them in reducing the risks associated with their use.

Older adolescents would be expected to have a greater capacity for abstract thinking and therefore a greater ability to understand how particular actions may affect their lives. This level of insight, however, would not necessarily be evident when working with much younger adolescents. They may still be operating in very concrete terms and, therefore, may have difficulty making these connections.

Using drugs may also impair a young person's ability to develop these skills further. With this in mind, it is important for workers to assess the young person's developmental stage and provide information and interventions that will offer flexibility for a variety of cognitive abilities.

Inhalant use appears to be an early marker for other drug use. It may also be a sign that the young person's personal, emotional, social or educational wellbeing is compromised, increasing risk of harm in later adolescence.

Duty of Care

This section is drawn directly from the DHS document on *Duty of Care* (January, 2000).

One of the key principles in deciding an appropriate intervention is duty of care. Duty of care is a duty to take reasonable care of a person. Thus it is assessed based on the 'reasonableness' of the action taken (would a reasonable person do the same thing). A duty of care is breached if a person behaves unreasonably. Failure to act can also be unreasonable in a particular situation. What is considered reasonable will depend upon all the circumstances.

Staff must use their professional skills and experience to decide what is reasonable, weighing up the various circumstances and factors. Some of the factors to consider when making this judgement of reasonable duty of care include:

- risks of harm and the likelihood of risks occurring
- injuries that may occur, and how serious they are
- precautions which could be reasonably taken
- powers which might be vested in a worker by their employer or organisation
- any statutory requirements or specific directions from the organisation or employer
- current professional and ethical standards
- current legislation, guidelines and protocols.

Overarching intervention principles

DHS has a clear policy that does not permit the passive observation/supervision of clients using inhalants. Young people who have suffered abuse and neglect will often resort to inhalant use, typically chroming, to cope with past traumatic experiences.

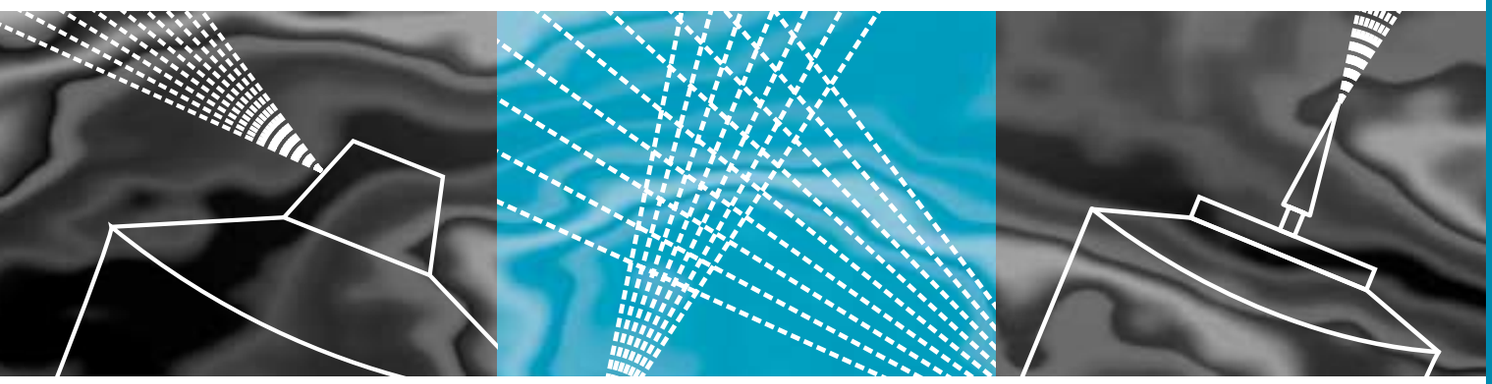
DHS endeavours to exercise its duty of care to these young people by putting in place strategies to stop inhalant use.

1. Inhalant use should be treated like other alcohol or drug problems or behaviour management problems.
2. Each individual is different, whether a child, adolescent or adult, and requires a tailored response. Multiple responses for one individual may be required.
3. Responses should start with the least intrusive strategy and escalate to more complex responses if necessary.
4. The pattern and extent of inhalant use (experimental, regular, chronic) should be considered when deciding on intervention or management strategies.
5. Inhalant use is rarely an isolated issue and should be dealt with in the context of other psychosocial factors; thus consistent long-term engagement is fundamental to build the therapeutic relationship, trust and rapport.
6. All interventions should be implemented within the context of duty of care responsibilities, safety of staff and all other people as a primary concern.
7. A coordinated case management plan should be developed collaboratively with all services involved. Consistency of care plans and consistency of messages to the person is vital.
8. Drug use is a cyclical and relapsing condition – interventions may need to be applied repeatedly, without judgement, before significant change is achieved.
9. Inhalant use should not be discussed with people not using inhalants in order to avoid contamination and experimentation.
10. Avoid sensationalising or creating attention around inhalant use. This may lead to contamination and may make those who are already using inhalants more committed to this.

Notes

Notes

Chapter 2:
Detection and assessment



Detection

Inhalants are absorbed into the blood stream quickly and the onset of action is rapid. Recovery from the acute effects is also rapid, unless the person is heavily intoxicated. This recovery depends on the volatility of, and the length of exposure to, the substance.

Kurtzman et al. (2001) outline four progressive stages of intoxication:

1. Initial: This occurs within minutes of use
    - euphoria
    - excitation
    - sneeze, cough, and wheeze
    - heart palpitations
    - nausea, vomiting, diarrhoea
2. Central Nervous System (CNS) depression
    - slurred speech
    - delusions
    - disorientation
    - confusion
    - tremor
    - hallucinations
3. Further CNS depression
    - poor balance, ataxia, staggering
4. Stupor
    - seizures
    - coma
    - cardiopulmonary arrest
    - death

Detection using physiological signs is a difficult task as these signs may also reflect poor general health or medical problems. However, other signs of chronic use include:

- chronic nosebleed
- increased salivation and spitting
- sores in the nose and mouth
- dry throat
- bloodshot eyes
- reduced appetite
- low energy and motivation.

The easiest way to distinguish between inhalant use and other drug use is by the smell. Inhalants generally leave a characteristic unpleasant odour on the breath and clothes. People who inhale paint ('chromers') also may have traces of paint on their face and clothes.

Assessment strategies

These guidelines provide three different assessment tools:

- Brief screen
- Full assessment
- Emergency services workers assessment.

The aim of the brief screen (Appendix B) is to gather some information quickly and simply to understand current inhalant use and the potential risks for the purpose of immediate intervention or referral. The aim of the full assessment (Appendix C) is to gain a full understanding of the predisposing, precipitating and maintaining factors for use, as well as patterns and risks in order to develop a comprehensive treatment plan with the person abusing inhalants. The emergency services assessment is a prompt sheet for ambulance and emergency department personnel (Appendix D).

Out-of-home and alcohol and drug workers need to choose between the brief screen and the full assessment. Which of these is used will depend upon circumstances, degree of confidence of the worker, experience in conducting assessment, level of engagement with the person and type of drug use pattern identified. Table 4 outlines recommendations regarding which tool to use for different patterns of drug use and different settings.

Table 4: Assessment strategy by setting and drug use pattern

	Out-of-home Care Agencies	Alcohol and Drug Services	Emergency Services
Experimental user	Brief screen (Appendix B) Purpose: To identify a baseline for assessing risk of further use	Brief screen (Appendix B) Purpose: To identify a baseline for assessing risk of further use	Emergency workers (Appendix D) Purpose: To manage acute intoxication effects, and to provide information for subsequent referral
Regular user	Brief screen (Appendix B) Purpose: Assessment of harm, determination of whether referral to Alcohol and Drug Services is indicated	Brief screen (Appendix B) Purpose: To determine whether full assessment is required, or whether brief intervention sufficient	Emergency workers (Appendix D) Purpose: as above
Chronic user	Brief screen at a minimum, full assessment where possible/practical Purpose: To provide as much information as possible for the referral and case management plan	Full assessment (Appendix C) Purpose: To gain a full understanding of the factors influencing the person's drug use in order to develop a comprehensive treatment plan	Emergency workers (Appendix D) Purpose: as above

Proformas for the brief screen and full assessment are provided in the appendices. Agencies can incorporate components from these proformas into their own assessment modules, or use the full proforma as provided here.

Prior to describing in more detail the brief screen and full assessment, some general principles of effective assessment technique are outlined.

Effective assessment techniques

Principles of assessment

General principles of conducting a brief screen or assessment include:

- Ensure the physical environment is comfortable and conducive to disclosure.
- Respect and practise confidentiality within statutory requirements.
- Ensure you use a motivational assessment style (see below).
- Act as the client's advocate.
- Act as a role model for the client.
- Ensure the client's right to make age appropriate decisions and have input into his/her treatment.
- Document all relevant information.
- Assessment is a continuous process, and should be conducted multiple times.

Motivational assessment style

The way a question is asked can influence the response received. It is important to maintain an open and non-judgemental style when undertaking assessment in order to facilitate openness and honesty in the client. This questioning style should be used when assessing for all drugs, not just inhalants, and can also be used when asking questions about other areas of the client's functioning. Some strategies to assist with this include:

1. **Assume use:** Ask questions like 'How often do you use lighter fluid?' rather than 'Do you use lighter fluid?' or 'You aren't using lighter fluid are you?'. This gives the message that you are expecting the client to be using and open to them revealing their use.
2. **Use a top high approach:** Exaggerate the potential top end of use to indicate that you are open to the client using a lot. Ask prompts like 'Would you say you chrome 30 or 40 times a day', rather than 'Would you say you chrome two or three times a day?'.
3. **Maintain a non-judgemental approach:** Use non-judgemental body language and responses. During the assessment don't show surprise, raise your eyebrows or say things like 'that's heavy use' when the client tells you how much they are using. You can address the extent of use after the assessment if necessary, by providing some feedback on the assessment and brief advice.
4. **Be alert to the client's comfort with level of disclosure:** Remain alert to client's changing needs, problems and the possible need for reassessment. If there are particular areas the client is not willing to discuss with you right now, don't push the point, the assessment can continue later. It is more important to retain rapport than to complete the assessment.

Brief screen

A brief screen is aimed at gaining an understanding of current use and potential risks for the purpose of immediate intervention or referral. Appendix B contains an example of a brief screen. It covers the following key points:

1. Type of inhalant use
2. Frequency and pattern
3. With whom
4. Other drug use (drug types, patterns, risks)
5. Perception of harm or risk: does the young person see any problems or harms with their inhalant use?

Full assessment

A full assessment is aimed at gaining a full understanding of the predisposing, precipitating and maintaining factors for use, as well as patterns and risks. It is used to develop a comprehensive treatment plan with the person.

In most situations assessment is a continuous process throughout treatment that identifies problems and changes as they emerge, thus providing valuable information for planning treatment, as well as providing a baseline to evaluate a client's progress. Assessment is just one step in the intervention process and is an opportunity to establish rapport. Thus a non-judgemental open approach is essential. The assessment may take time to complete; the more rapport that can be built, the more information likely to be obtained.

A full assessment is available in Appendix C and includes:

1. Presenting issues, including the client's understanding of the problem and the consequences of use.
2. Demographic information.
3. Psychosocial assessment that covers
    - support services
    - statutory issues
    - accommodation
    - relationships
    - health, including mental health
    - education/vocation
    - leisure/recreational activities
    - barriers and motivation to change
    - coping skill level.
4. Full psychiatric assessment, if indicated.
5. Medical assessment, if indicated.

Identifying dependence and withdrawal

A full assessment will include consideration of dependence and withdrawal. There is some evidence that physical tolerance can develop to inhalants, so that over time a person abusing inhalants will experience a lower intensity response using the same amount, or require increased use to gain the same high. There is also some evidence that a small percentage of people will develop a compulsive syndrome, sometimes referred to as psychological dependence. However, there is no evidence that a dependence syndrome develops as a result of chronic inhalant use. Withdrawal syndromes have been reported, but it is likely that these are a reflection of polydrug use and withdrawal from other drugs. If a person abusing inhalants appears to be experiencing a withdrawal syndrome, assess for the use of other drugs.

Documenting a formulation

A formulation is a summary of the client's presentation that draws together the important features and allows a logical treatment plan. The main areas to cover are:

- Summary of the presenting problem.
- Predisposing factors: factors that put the client at risk, such as poor parenting, social marginalisation.
- Precipitating factors: factors that are immediate triggers for inhalant use, such as anger, friends offering.
- Maintaining factors: factors that make maintain inhalant use, such as circle of friends.
- A diagnosis is sometimes made as part of a formulation if required.
- Treatment plan that addresses each of the above areas.

An example of a formulation is provided in Appendix E.

Further specialist assessment

In the case of a chronic inhalant user, two further specialist assessments are recommended: a neuropsychological assessment and a mental state exam. These would be conducted by a relevant specialist within the alcohol and drug treatment service, or via referral to another specialist service. Brief details are provided here.

Neuropsychological assessment

A neuropsychological assessment or cognitive status exam should be performed. Generally a specialist neuropsychologist is required, although clinical psychologists may also have some expertise in neuropsychological assessment. The Department of Human Services Alcohol and Drug Specialist Assessment Form includes the Cognitive Status Examination. This is recommended where there is some indication that the young person may have acquired brain injury. The signs and symptoms to look out for include:

- memory problems
- coordination problems in the absence of intoxication
- poor problem-solving capacity
- sensory problems like vision and hearing problems.

Mental state examination

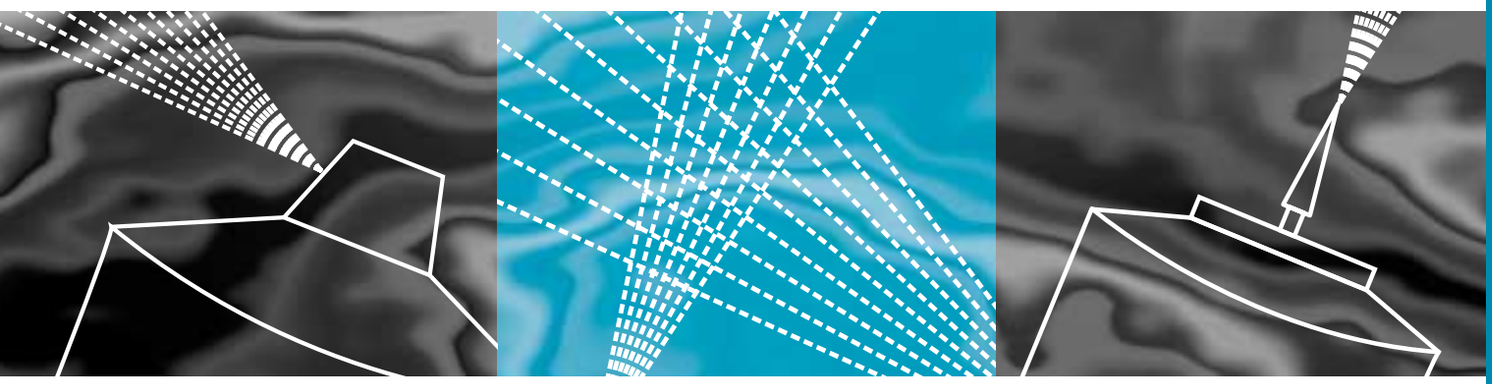
If the assessor is suitably trained, a mental state examination should be conducted. Generally this would be conducted by a trained mental health professional, such as a psychiatrist, psychologist or mental health nurse, although other health professionals may have additional training and experience in undertaking a mental status examination. The usual contents of a mental state exam are:

- appearance and behaviour
- speech
- mood (how they feel)
- affect (how they act)
- thought form and content
- perception
- orientation, attention and concentration
- memory and consciousness
- cognitive functioning and intelligence
- judgement and insight.

If insufficient time, or inexperience with mental state assessment, a brief mental state screen should be undertaken (see Appendix F) and referral made to specialist services if indicated by suicidal intent, psychosis or other acute presentation.

Notes

Chapter 3:
Management strategies for out-of-home care settings



This chapter outlines strategies specifically for out-of-home care settings. Out-of-Home Care includes:

- Kith and Kin: This involves placement with family, relatives or friends that have been approved by DHS.
- Foster Care: Provided by foster carers who care for children and young people in their home.
- Shared Family Care: This placement option targets children and young people with either/or a developmental delay/intellectual disability.
- Adolescent Community Placement: This involves home based care in volunteer carers' home for young people.
- High-Risk Adolescent 1 to 1 Care: This is a specialised home-based care option which offers specially recruited carers looking after one very high risk and challenging young person.
- Residential Care: This option is primarily for young people over 12 years of age. These units are staffed on a 24-hour basis.

These strategies have been developed to ensure consistency with the DHS Chroming Policy of 1 February 2002. Appendix J outlines the DHS Chroming Policy and practice guidelines.

Management strategies in alcohol and drug settings are outlined in Chapter 4. The overarching intervention principles outlined in Chapter 1 apply, and are repeated here.

Overarching intervention principles

DHS has a clear policy that does not permit the passive observation/supervision of clients using inhalants. Young people who have suffered abuse and neglect will often resort to inhalant use, typically chroming, to cope with past traumatic experiences.

DHS endeavours to exercise its duty of care to these young people by putting in place strategies to stop inhalant use.

1. Inhalant use should be treated like other alcohol or drug problems or behaviour management problems.
2. Each individual is different, whether a child, adolescent or adult, and requires a tailored response. Multiple responses for one individual may be required.
3. Responses should start with the least intrusive strategy and escalate to more complex responses if necessary.
4. The pattern and extent of inhalant use (experimental, regular, chronic) should be considered when deciding on intervention or management strategies.
5. Inhalant use is rarely an isolated issue and should be dealt with in the context of other psychosocial factors; thus consistent long-term engagement is fundamental to build the therapeutic relationship, trust and rapport.
6. All interventions should be implemented within the context of duty of care responsibilities, safety of staff and all other people as a primary concern.
7. A coordinated case management plan should be developed collaboratively with all services involved. Consistency of care plans and consistency of messages to the person is vital.
8. Drug use is a cyclical and relapsing condition – interventions may need to be applied repeatedly, without judgement, before significant change is achieved.

9. Inhalant use should not be discussed with people not using inhalants in order to avoid contamination and experimentation.
10. Avoid sensationalising or creating attention around inhalant use. This may lead to contamination and may make those who are already using inhalants more committed to this.

Consideration of duty of care issues as outlined in Chapter 1 apply and are repeated here.

Duty of Care

This section is drawn directly from the DHS document on *Duty of Care* (January, 2000).

One of the key principles in deciding an appropriate intervention is duty of care. A duty of care is a duty to take reasonable care of a person. Thus it is assessed based on the 'reasonableness' of the action taken (would a reasonable person respond in the same way). A duty of care is breached if a person behaves unreasonably. Failure to act can also be unreasonable in a particular situation. What is considered reasonable will depend upon all the circumstances.

Staff must use their professional skills and experience to decide what is reasonable, weighing up the various circumstances and factors. Some of the factors to consider when making this judgement of reasonable duty of care include:

- risks of harm and the likelihood of risks occurring
- any statutory requirements or specific directions from the organisation or employer
- injuries that may occur, and how serious they are
- precautions which could be reasonably taken
- powers which might be vested in a worker by their employer or organisation
- current professional and ethical standards.

Four management strategies

These guidelines provide four management strategies, each one tailored to a particular goal.

1. Deterrence

These are strategies aimed at deterring inhalant use, and reflect basic principles that can be applied to all high-risk groups. Deterrence strategies aim to establish a set of approaches already in place that make inhalant, and other drug use, less attractive.

2. Dealing with intoxication and acute effects

These strategies list the specific courses of action required when a person is acutely affected by inhaled substances. These outline the immediate medical and psychological strategies for intervening in acute circumstances, including life-threatening emergencies.

3. Short-term behavioural management strategies

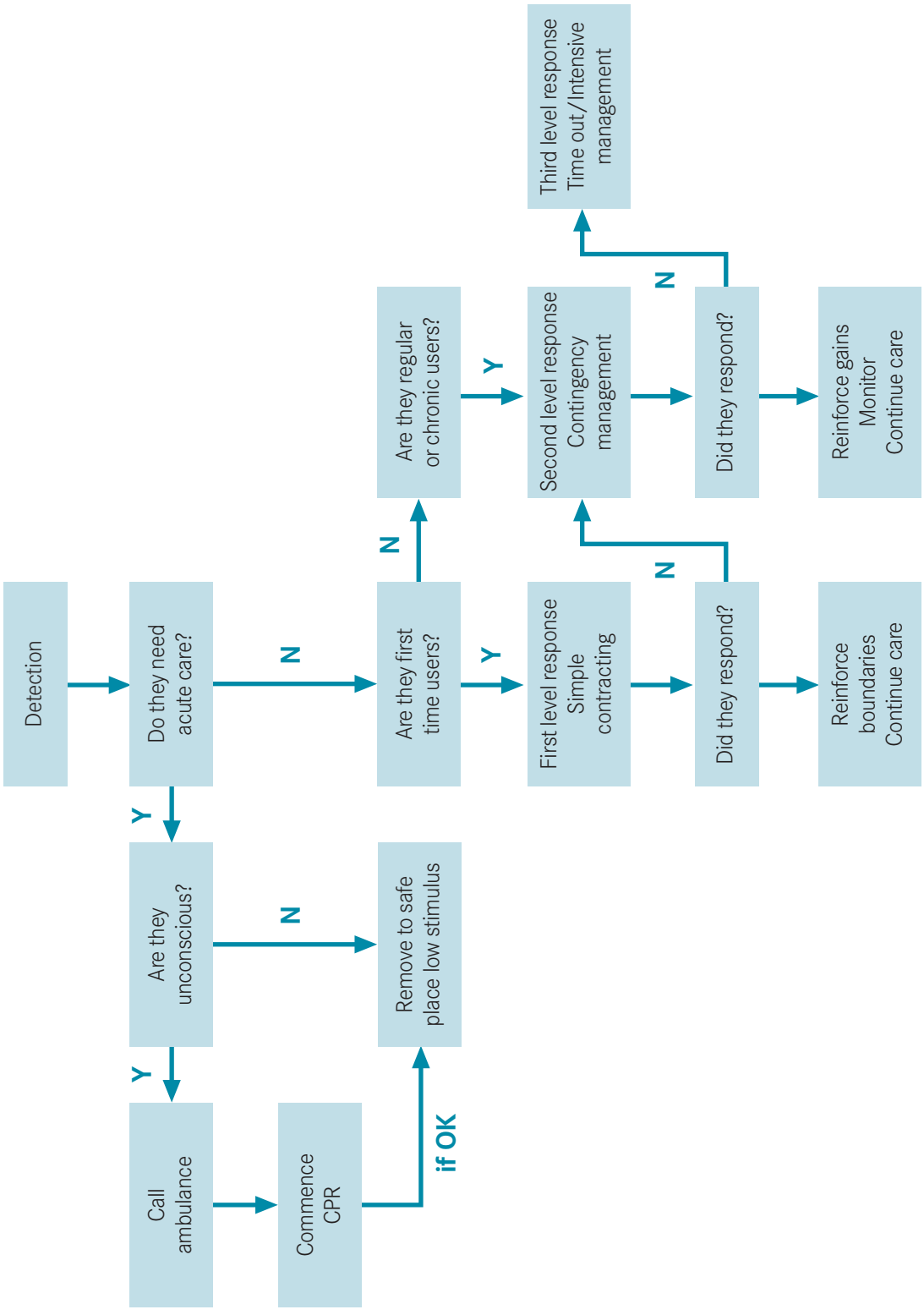
These behavioural management strategies are concerned with assisting a person who is currently engaged in inhalant use. These strategies are aimed at immediate behavioural intervention.

4. Long-term behavioural maintenance strategies

These strategies are long-term and focus on a range of factors that are maintaining inhalant use. They are aimed at longer-term behaviour change by individual and broader community intervention.

The flow chart assists in choosing the most appropriate intervention.

Pathway to choosing an appropriate intervention



See following page

Deterrence

Goal: Prevention of inhalant use in the setting

The aim of deterrence strategies is to make inhalant use more difficult and less desirable. Deterrence relies on establishing consistent rules and operatives that are known from the outset, with known consequences. The focus of deterrence strategies is at the point of entry to an out of home care placement.

If a young person **with a known inhalant use problem** enters an out-of-home care placement:

1. **Clarify expectations and undertake a clear orientation process**
   - Approach the issue of inhalant use confidently and assertively: provide information that drug use is not permitted in out-of-home care settings. Clear statements to this effect are helpful to staff and the young people.
   - Include a request for bags and paraphernalia.
   - Undertake a clear orientation process including a clear outline of the house rules about the consequences of inhaling.
   - Agree on a behavioural management plan that includes explicit logical consequences of contravening house rules around inhalant use. This might include a contract or written agreement signed by both the young person and their case manager/worker. Consequences that may be used include loss or reduction of pocket money, sweets or other treats, watching TV or video games.
2. **Increase physical safeguards in the household**

   Including ensuring potential inhalants are secured and inaccessible.
3. **Contact local alcohol and drug services as a preventative measure**

   This is aimed at linking the young person to specialist care prior to problem behaviour emerging in the facility. It may be a primary or secondary consultation, depending upon the level of use. Every effort should be made to contact the young person's previous or current case manager in the alcohol and drug service if they are already known to these services, as engagement is a primary consideration in treatment.

There are five regionally based Specialist Therapeutic Alcohol and Drug Workers. This is a collaborative pilot project due to end 30 June 2003, between the Drug Policy and Services Branch and the Child Protection and Juvenile Justice Branches.

These positions provide secondary consultation and support for child protection clients and staff in out-of-home care residential care units, Adolescent Community Placement and Secure Welfare Services. The contact details for these specialist workers are provided in Table 5.

Table 5: Agencies providing specialist therapeutic alcohol and drug workers

Region	Location	Contact details
Eastern Metropolitan (& Hume)	Salvation Army Eastcare Network	9890 4330
Western Metropolitan (& Barwon & Gippsland) & Secure Welfare	DASWEST	8345 6682
Northern Metropolitan (& Loddon Mallee)	Uniting Care Moreland Hall	9386 2876
Southern Metropolitan (& Gippsland)	Youth Substance Abuse Service (YSAS)	9415 8881

Dealing with intoxication and acute effects

Goal: Safety of person abusing inhalants

If a young person appears intoxicated, assess their need for immediate medical attention. The young person's safety is the highest priority.

If conscious and not in need of immediate first aid:

- Confiscate substance if it is safe to do so.
- Reduce any immediate risks to the young person or surrounding people:
  - open doors and windows if in an enclosed area (staff to be mindful of impact on themselves if they are in a vapour-filled room).
  - remove matches and do not permit smoking.
  - call police if appropriate (see section below on when to call the police).
  - reduce stimulation by
    - removing to a safe location with low stimulus, or
    - making the immediate environment low stimulus by removing spectators. Over stimulating environments for an intoxicated person could result in an acute physiological reaction such as shock or sudden death.
- Keep calm, reassure the person, speak quietly.
- Instigate appropriate agency protocols in relation to contacting on-call, recall or after hours arrangements.

If unconscious:

- **Start 'ABC' procedure:** Check airways, breathing and circulation. If not breathing/no pulse, start EAR/CPR. Use standard first aid procedures – put the person on their side, loosen clothing, keep warm.
- **Call ambulance.**
- **Segregate:** If possible remove to safe space or remove other people from the area.
- **Remove paraphernalia:** Retain for identification at hospital if required.
- **Keep calm.**
- **Reduce any immediate risks** to the young person or surrounding people:
  - open doors and windows if in an enclosed area
  - remove matches and no smoking
  - defuse/debrief other young people and other witnesses.
- **Stay with young person** until effects have worn off.
- **When recovered, check and ask:** What happened? Which drugs have been taken? How? How long ago? Is anybody else involved who might need help?

When to call ambulance

Call an ambulance when:

1. The person:
   - is unconscious
   - has difficulty breathing
   - is not breathing
   - has no pulse.
2. The person has:
   - troubled breathing (audible wheeze/crackle)
   - altered conscious state
   - cyanosed – blue skin, clammy skin, hot, red, dry skin
   - a history of breathing problems such as asthma
   - recent undiagnosed psychotic symptoms and the CATT (Crisis Assessment And Treatment Team) cannot attend or there is immediate life threat to patient or staff (police to respond as well – Section 10 of Mental Health Act).

When to call police

If staff/carers assess that they require assistance to confiscate volatile substances and/or items used to inhale, they may call the police to enact the search and seizure powers under the provisions of the Act. Also refer to the *Interagency protocol between Victoria Police and nominated agencies (DHS July 2004).*

It must be noted that inhalant use is not an illegal activity.

When to call unit supervisor or on-call worker

The unit supervisor or on-call worker should be contacted to provide advice in these situations or at any other time that the worker is concerned or unsure of the next steps and procedures.

Incident reporting

Complete the required Incident Report and comply with other standard agency procedures.

Short-term interventions

Goals: Safety, behaviour management, cessation of use

Before undertaking any of these strategies, first

1. Assess the risk to the young person – do they need immediate medical attention?
2. Assess the risk to others, such as self, staff or other young people.

Only if both of these risks are manageable, then proceed with the steps outlined below. If there is a risk to the young person or others, follow steps outlined in the previous section: Dealing with Intoxication and Acute Effects.

Short-term intervention strategies are set out as a menu of escalating responses. The first is simple contracting. If simple contracting is insufficient to contain behaviour then proceed to contingency management. If unsuccessful at containing behaviour, consider a Level 3 response including time-out/intensive management.

First level response: simple contracting

The first response is suitable for either first time users or known regular users. The response should be repeated a number of times unless the behaviour escalates.

1. **Confiscate:** Request that the young person hand over the substance.
2. **Explain consequences:** Describe what you will do and why, based on policy or house rules. Explain the consequences that may be applied.
3. **Express concern.**
4. **Educate:** Indicate the harms that may result from inhalant use.
5. **Distract:** Attempt to engage the child or young person in another activity eg eating, physical activity, games.

6. **Deliver consequences:** Implement the consequences that were outlined on admission. It is important to apply this consistently and as understood at entry.
7. **Contract:** Get assurance from young person that they will cease inhalant use. An outline of the principles and practice of contracting is contained in Appendix G.
8. **Undertake assessment.**
9. **Seek secondary consultation:** Contact local Alcohol and Drug Services and discuss management options and a potential care plan, including potential respite options if behaviour escalates in the future.
11. **Repeat these steps** if inhalant use continues. Escalate consequences to second response when behaviour intensifies or first response is not effective in reducing or eliminating use.
12. Continue to *assess the physical state* of the child or young person throughout this intervention and take appropriate action such as calling police or ambulance. (See section Dealing with Intoxication and Acute Effects).

Second level response: Contingency management

The second level response is suitable when the first level response fails to provide satisfactory results in a reasonable time frame or for regular and chronic users or behaviour escalates. This response should be repeated unless it fails to provide satisfactory results after a number of episodes or the behaviour escalates.

1. **Confiscate:** Request that the young person hand over the substance.
2. **Explain consequences:** Describe what you will do and why.
3. **Express concern.**
4. **Educate:** Indicate the harms that may result from inhalant use.
5. **Review contract with young person:** Review the agreed contract from first level response.
6. **Distract:** Attempt to engage the child or young person in another activity eg eating, physical activity, games.
7. **Develop an individual contingency management plan:** This might include negative consequences for continued inhalant use (eg loss of, or reduced pocket money) or positive consequences for cessation (eg additional outings or activities). At each cycle through the second level response, increase the level of consequences if necessary, explaining why. An outline of the principles and practice of contingency planning is in Appendix G.
8. **Review assessment and case management plan.**
9. **Refer:** to local specialist substance use services for full assessment.
10. **Assess motivation to change:** Undertake strategies to increase motivation to change. Motivational interviewing strategies have been successfully used with young people for a range of issues, including substance use. (See Appendix H: Useful resources for further information on these techniques, Addy & Ritter.)
11. **Repeat these steps** if inhalant use continues. Escalate consequences to third response when behaviour intensifies or repeated attempts at second level response are not effective in reducing or eliminating use.
12. *Continue to assess the physical state* of the child or young person throughout this intervention and take appropriate action such as calling police or ambulance. (See section Dealing with Intoxication and Acute Effects.)

Third level response: time-out/ intensive management

When repeated attempts to stop the child or young person's inhalant use have been unsuccessful, it may be necessary to consider placement of the young person in Secure Welfare Service or Residential Alcohol and Drug Service. These options should be considered as part of a long-term plan.

1. **Time-out at residential alcohol and drug services:** Inhalant users do not generally need withdrawal services but residential alcohol and drug services may accept inhalant users for respite from inhalant use under voluntary admission. This should be negotiated in the first level response when alcohol and drug services are contacted for secondary consultation and care plans are developed.
2. **Assess suitability for placement in Secure Welfare Services[1]:** Secure Welfare Services has strict criteria that need to be met for entry; these criteria should be checked prior to referral. The criteria and legislation for admission to Secure Welfare Services require a threshold of risk to be exceeded.

If:

- admission to residential respite facilities is not immediately available
- risk-taking, inhalant use and other behavioural difficulties continue to escalate
- second level response is not effective in containing or reducing behaviour

then:

- consult on-call supervisor and obtain back-up support
- assess risks to user and others
- continue second level response
- undertake active intervention with the person including
  - request cessation and confiscate paraphernalia if safe to do so
  - actively assess immediate health and safety of user and others
  - inform about dangers and risks
  - implement distraction and inducements to cease, such as food, alternative activities.

Continue to assess the physical state of the child or young person throughout this intervention and take appropriate action, such as calling the police or ambulance. (See section Dealing with Intoxication and Acute Effects.)

Interventions for group-based inhalant use

A proportion of people use inhalants as part of a group social activity. In this instance there are likely to be young people who are still in the experimental stage, as well as at least one group member more experienced at inhalant use, and possibly a chronic user. It is important that workers take into account the importance of social bonds, and the sense of belonging derived from group activities, including when abusing inhalants in a group.

The key goals in intervening here are:

- to prevent further group-based inhalant use
- to differentiate the experimental from the regular and chronic inhalant users
- to deliver appropriately tailored interventions to the experimental, regular and chronic users.

1 The Children and Young Persons Act (CYPA) 1989 outlines the legislative requirements for the provision of Secure Welfare Services (SWS). The CYPA specified that SWS provide short-term care 21 days which can be extended a further 21 days for young people up to 17 years of age who are assessed by Child Protection as being at substantial and immediate risk. Young people who are typically admitted to SWS are known to be at significantly higher risk of mental health problems and disorders, including substance use and abuse, than the general community.

Interventions for group-based inhalant use include:

- Where possible, separate the group.
- Assess and reflect on the group membership and group process.
- Identify which young people are experimental users and which are regular or chronic inhalant users.
- Select the chronic or regular inhalant users and discuss the inhalant use on an individual basis.
- Encourage the regular or chronic user to reflect on their influence over others and ask them not to encourage others to use inhalants. Provide positive, pro-social messages to this individual, such as 'don't harm other people' and 'look after your mates'.
- Refer regular/chronic inhalants users for further assessment and intervention.
- For the experimenters, discuss individually the risks and harms of inhalant use, along with discussion around alternative group-based activities.
- Offer alternative activities.

There has been some limited work on the use of peer educators for reducing and eliminating inhalant use. Peer educators are ideally suited to this group-based scenario where they can spread pro-social messages and encourage protective factors.

Long-term interventions

Goal: Addressing maintaining factors of inhalant use, long-term cessation

Problematic drug use is a chronic, relapsing condition, like any other chronic illness, such as diabetes or schizophrenia. Change can be very slow and incremental. Long-term interventions should address underlying risk factors, skill and knowledge deficits, and maintaining factors of use. Many at risk young people have difficulty forming relationships with their peer group and adults, so modelling stable, consistent relationships and exercising consistent parenting is important.

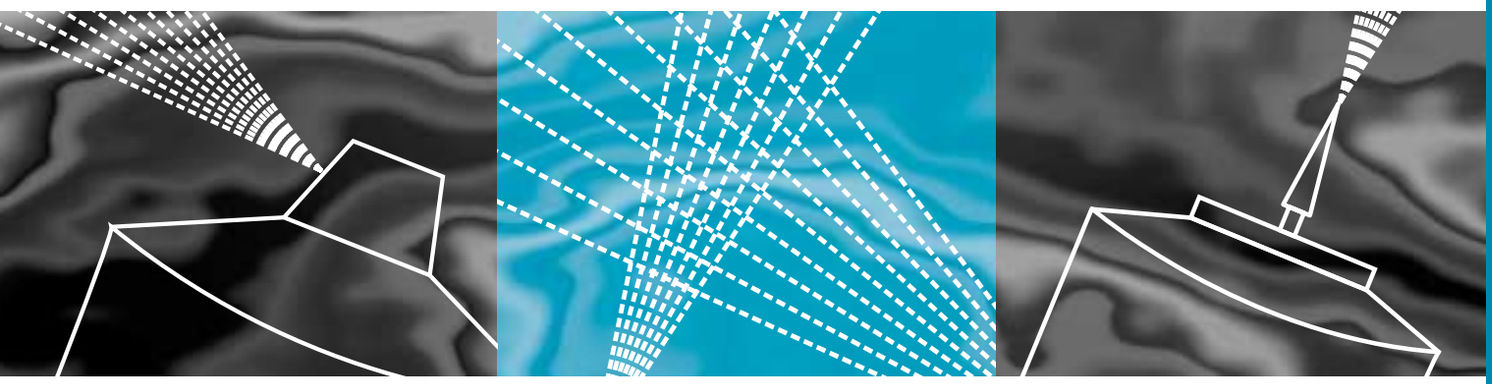
For immediate inhalant use, workers should use the steps outlined in the previous section (short-term strategies). The long-term interventions described here form part of an ongoing case management plan and are designed for people at the regular or chronic end of the inhalant use spectrum.

- **Outline harms:** Most young people are not aware of physical, psychological and neurological harms associated with drug use.
- **Engagement and supportive counselling:** Staff should be well trained in therapeutic engagement and good listening skills. Consistency of support and counselling is important.
- **Develop coping strategies:** Many young people in this group lack the basic skills in assertiveness (refusal skills), as well as strategies for controlling and managing their emotions (eg anger, sadness). Basic skill development is essential if these appear to be underdeveloped. Consult your supervisor for further resources.

- **Understanding drug use:** Examine the broader reasons why the young person is abusing inhalants and ways to address these with the young person:
  - What are the historical factors that predispose the young person to drug use? (eg history of trauma, family history of drug use, personality traits).
  - What current factors sustain use?
  - What are the immediate triggers for use (eg friends offering, boredom, re-experiencing trauma).
- **Offer alternatives to inhalant use:** Encourage long-term engagement in non-drug activities. Consider implementing a structured day program for residents if feasible.
- **Community reinforcement approaches:** Mobilise the local health and welfare service system in individual care plans (see Chapter 7 for more detail on implementing community approaches).
- **Family interventions:** Increasing or reinitiating communication with the family and assisting the family to communicate and support each other better may be a useful strategy. This is most effectively done in consultation with a family specialist, within or external to the carer organisation.

Notes

Chapter 4:
Management strategies for specialist alcohol and drug settings



This chapter outlines strategies for alcohol and drug settings. This includes community and inpatient facilities. Management strategies for out-of-home settings are outlined in Chapter 3. The overarching intervention principles outlined in Chapter 1 apply and are repeated here.

Overarching intervention principles

DHS has a clear policy that does not permit the passive observation/supervision of clients using inhalants. Young people who have suffered abuse and neglect will often resort to inhalant use, typically chroming, to cope with past traumatic experiences.

DHS endeavours to exercise its duty of care to these young people by putting in place strategies to stop inhalant use.

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5. Inhalant use is rarely an isolated issue and should be dealt with in the context of other psychosocial factors; thus consistent long-term engagement is fundamental to build the therapeutic relationship, trust and rapport.
6. All interventions should be implemented within the context of reasonable duty of care: safety of staff, inhalant users and other people as a primary concern.
7. A coordinated case management plan should be developed collaboratively with all services involved. Consistency of care plans and consistency of messages to the young person is vital.
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Consideration of duty of care issues as outlined in Chapter 1 apply and are repeated here.

Duty of Care

This section is drawn directly from the DHS document on *Duty of Care* (January, 2000).

One of the key principles in deciding an appropriate intervention is duty of care. A duty of care is a duty to take reasonable care of a person. Thus it is assessed based on the 'reasonableness' of the action taken (would a reasonable person do the same thing). A duty of care is breached if a person behaves unreasonably. Failure to act can also be unreasonable in a particular situation. What is considered reasonable will depend upon all the circumstances.

Staff must use their professional skills and experience to decide what is reasonable, weighing up the various circumstances and factors. Some of the factors to consider when making this judgement of reasonable duty of care include:

- risks of harm and the likelihood of risks occurring
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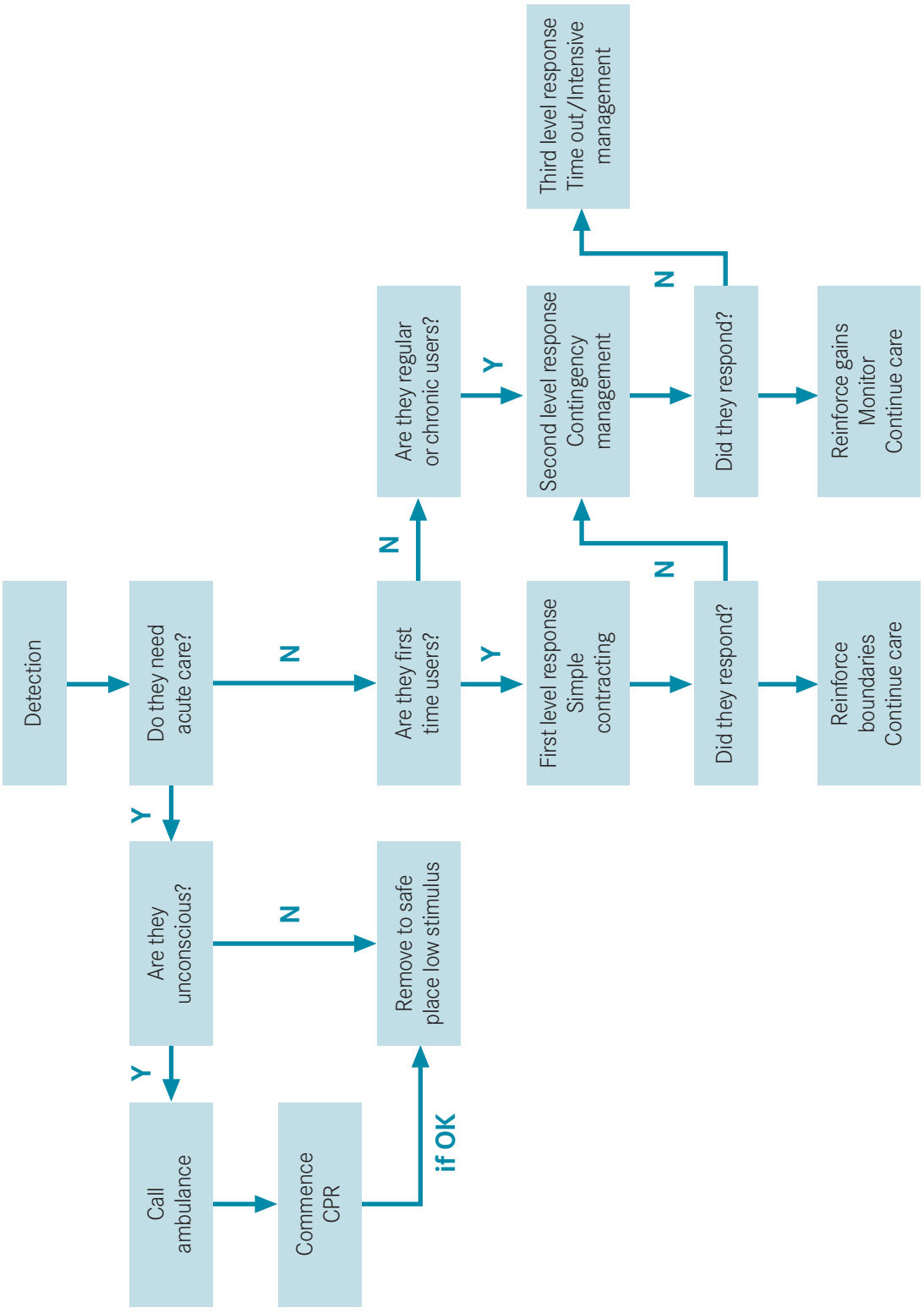
These behavioural management strategies are concerned with assisting a person who is currently engaged in inhalant use. These strategies are aimed at immediate behavioural intervention.

4. Long-term behavioural maintenance strategies

These strategies are long-term and focus on a range of factors that are maintaining inhalant use. They are aimed at longer-term behaviour change by individual and broader community intervention.

The flow chart assists you in choosing the most appropriate intervention.

Pathway to choosing an appropriate intervention



Deterrence

Goal: Prevention of inhalant use in the setting

The aim of deterrence strategies is to make inhalant use both more difficult and less desirable. Deterrence relies on establishing consistent rules and operatives that are known from the outset, with known consequences. The focus of deterrence strategies is at the point of entry to an alcohol and drug service.

If a person **with a known inhalant use problem** commences treatment with an alcohol and drug service:

1. **Clarify expectations and undertake a clear orientation process:**
   - Approach the issue of inhalant use confidently and assertively: provide information that drug use is not permitted in alcohol and drug treatment settings.
   - Include a request for bags and paraphernalia.
   - Include a clear outline of the expectations and rules about the consequences of inhaling.
   - When rules are set, agree on a behavioural management plan that includes explicit logical consequences of contravening rules around inhalant use. This might include a contract or written agreement signed by both the young person and their case manager/worker.
2. **Increase physical safeguards in the service:** Including ensuring potential inhalants are secured and inaccessible.

Dealing with intoxication and acute effects

Goal: Safety of inhalant users

If a young person appears intoxicated, assess their need for immediate medical attention. The person's safety is the highest priority.

If conscious and not in need of immediate first aid:

- Confiscate substance if it is safe to do so.
- Reduce any immediate risks to person or surrounding people by
  - opening doors and windows if in an enclosed area (staff to be mindful of impact on themselves if they are in a vapor-filled room).
  - remove matches and do not permit smoking.
  - reduce stimulation by
    - removing to a safe location with low stimulus, or
    - making the immediate environment low stimulus by removing spectators. Over stimulating environments for an intoxicated person could result in an acute physiological reaction such as shock or sudden death.
- Keep calm, reassure the person, speak quietly.
- Instigate appropriate agency protocols in relation to contacting on-call, recall or after hours arrangements.

If unconscious:

- **Start 'ABC' procedure:** Check airways, breathing and circulation. If not breathing/no pulse, start EAR/CPR. Use standard first aid procedures – put the person on their side, loosen clothing, keep warm.
- **Call ambulance.**
- **Segregate:** If possible remove to safe space or remove other people from the area.
- **Remove paraphernalia:** Retain for identification at hospital if required.
- **Keep calm.**

- **Reduce any immediate risks** to young person or surrounding people by
  - opening doors and windows if in an enclosed area
  - remove matches and no smoking
  - defuse/debrief other young people and other witnesses.
- **Stay with person** until effects have worn off.
- **When recovered, check and ask:** What happened? Which drugs have been taken? How? How long ago? Is anybody else involved who might need help?

When to call ambulance

Call an ambulance when:

1. The person:
   - is unconscious
   - has difficulty breathing
   - is not breathing
   - has no pulse
2. The person has:
   - troubled breathing (audible wheeze/crackle)
   - altered conscious state
   - cyanosed – blue skin, clammy skin, hot, red, dry skin
   - a history of breathing problems such as asthma
   - recent undiagnosed psychotic symptoms and the CATT (Crisis assessment and treatment team) cannot attend or there is immediate life threat to patient or staff (Police to respond as well – Section 10 of Mental Health Act).

When to call police

If staff assess that they require assistance to confiscate volatile substances and/or items used to inhale, they may call the police to enact the search and seizure provisions of the Act. Also refer to the *Interagency protocol between Victoria Police and nominated agencies (DHS July 2004).*

It must be noted that inhalant use is not an illegal activity.

When to call unit supervisor or on-call worker

The unit supervisor or on-call worker should be contacted at the time of inhalant use on the premises. Take any direction and advice from them.

Incident reporting

Complete the required Incident Report or other standard agency procedures.

Short-term interventions

Goals: Safety, behaviour management, cessation of use

Before undertaking any of these strategies, first

1. Assess the risk to the young person – do they need immediate medical attention?
2. Assess the risk of others, such as self, staff or other young people.

Only if both of these risks are manageable, then proceed with intervention. If there is risk to the young person or others, follow steps outlined in the previous section: Dealing with intoxication and acute effects.

If risks are manageable some of the strategies outlined in Chapter 3 under short-term interventions may be useful, such as contracting and contingency management.

Interventions for group-based inhalant use in inpatient alcohol and drug facilities

A proportion of people use inhalants as part of a group social activity. In this instance there are likely to be young people who are still in the experimental stage, as well as at least one group member more experienced at inhalant use, and possibly a chronic user. It is important that workers take into account the importance of social bonds, and the sense of belonging derived from group activities, including when abusing inhalants in a group.

The key goals in intervening here are:

- to prevent further group-based inhalant use
- to differentiate the experimental from the regular and chronic inhalant users
- to deliver appropriately tailored interventions to the experimental, regular and chronic users.

Interventions for group-based inhalant use include:

- Where possible, separate the group.
- Assess and reflect on the group membership and group process.
- Identify which people are experimental inhalant users and which are regular or chronic inhalant users.
- Select the chronic or regular inhalant users and discuss the inhalant use on an individual basis.
- Encourage the regular or chronic user to reflect on their influence over others and ask them not to encourage others to use. Provide positive, pro-social messages to this individual, such as ‘don’t harm other people’ and ‘look after your mates’.
- For the experimenters, discuss individually the risks and harms of inhalant use, along with discussion around alternative group-based activities
- Offer alternative activities.

There has been some limited work on the use of peer educators for reducing and eliminating inhalant use. Peer educators are ideally suited to this group-based scenario, where they can spread pro-social messages and encourage protective factors.

Long-term interventions

Goal: Addressing maintaining factors of inhalant use, long-term cessation

Alcohol and drug workers have an array of techniques and tools available to them in working with a people who use inhalants. The principles of effective specialist alcohol and drug interventions apply equally to people who use inhalants as they do to people who use other drugs. Considerations of age, including developmental age, and strategies for working with young people and poly drug users are particularly relevant.

These guidelines provide a brief summary of some of the standard approaches and interventions for alcohol and drug workers. It is beyond the scope of these guidelines to cover the techniques in detail, but manuals and instructions on these interventions are available elsewhere, and alcohol and drug workers should make themselves familiar with these techniques, if they are not already.

Provide sound information and advice

Outline harms in detail. Most people are not aware of physical, psychological and neurological harms associated with drug use.

Engagement and supportive counselling

Staff should be well trained in therapeutic engagement and listening skills. Consistency of support and counselling is important.

Understanding drug use

Examine the broader reasons why the young person is abusing inhalants and ways to address these with the young person:

- What are the historical factors that predispose the young person to inhalant use? (eg history of trauma, family history of drug use, personality traits).
- What are the current factors sustaining inhalant use?
- What are the immediate triggers for inhalant use (eg friends offering, boredom, re-experiencing trauma).

Alcohol and drug counselling and development of coping strategies

Most of the standard alcohol and drug interventions can be appropriately tailored in individual circumstances, such as motivational interviewing, self-monitoring, and relapse prevention.

Motivational interviewing techniques have been successfully used with young people for a range of health issues, including substance use. Information about these techniques is available in the resources outlined in Appendix H: Useful Resources. The *Turning Point clinical treatment guidelines on motivational interviewing* may also be useful.

Inhalants are perceived as 'gutter' drugs. For older people abusing inhalants, this can be utilised in motivational techniques, such as examining reasons for use. For younger people abusing inhalants, examining reasons why and building insight around the extent of their inhalant use and the harms associated with this behaviour may be helpful in increasing motivation to stop.

Cognitive and behavioural techniques may be useful in increasing awareness and self-control. Increased insight should lead to goal setting and action. Specific relapse prevention and coping skills techniques, such as refusal skills and identification of high-risk situations for use, to facilitate self-control over use are useful, particularly for older people abusing inhalants. Diary keeping or monitoring may be difficult for this group, but exploration of daily use in other ways may facilitate insight into behaviour. Practising decision-making and problem solving in counselling, as well as positive modelling of these skills by the therapist/worker may also be useful techniques for this group.

Drug use is often maintained by poor communication skills and by systemic interpersonal factors, such as poor familial relationships. Improving communication skills and addressing issues with the family may be useful as part of counselling. Many young people in this group lack the basic skills in assertiveness (refusal skills), as well as strategies for controlling and managing their emotions (eg anger, sadness).

McCartney (1999) notes that adolescent drug users often have difficulties forming a cohesive sense of self. Techniques that develop sense of self worth and confidence may also be of benefit.

Assertive outreach and follow-up

Organisations may consider implementing an outreach system of engagement. Marginalised young people who inhale volatile substances are less likely to present to an alcohol and drug service for treatment. The service needs to be flexible and mobile in order to engage these young people. Assertive follow-up should be undertaken when they do not appear for scheduled appointments (see *Turning Point clinical treatment guidelines for alcohol and drug clinicians series: assertive follow-up)*

Polydrug management

Many people abusing inhalants may be also using other substances such as cannabis and alcohol (see *Turning Point clinical treatment guidelines for alcohol and drug clinicians series: working with poly drug users)*

Secondary consultation

Alcohol and drug specialist services should offer support services to other workers. This usually involves providing management advice and assisting with treatment plans. It may or may not include primary management responsibility or a shared care arrangement.

Comorbidity

Most people who are abusing inhalants who are referred to alcohol and drug services are likely to come from the chronic group of inhalant users. This group of people often have primary or secondary diagnosis of conduct disorder, Attention Deficit and Hyperactivity Disorder (ADHD) or mood disturbance (especially depression) and should be thoroughly assessed for these and other mental health conditions.

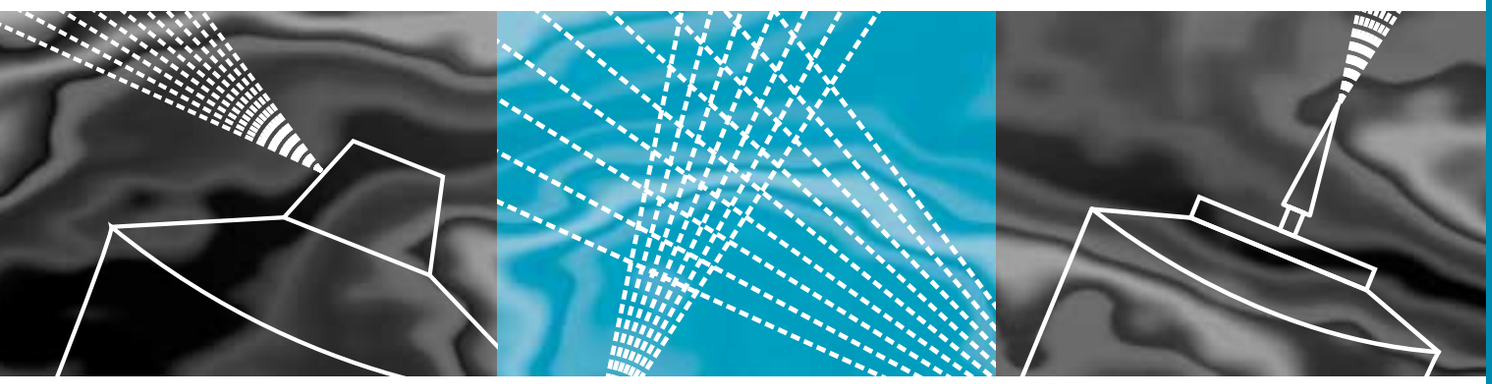
The generally accepted approach for dealing with comorbidity is integrated treatment within the same service, thus alcohol and drug workers need to address these underlying psychiatric and psychological issues alongside the substance use issues.

Social marginalisation

Where inhalant use is part of a subcultural or group phenomenon, treatment is generally more successful when the social network is also actively engaged (McCartney, 1999). Thus, effective community and family interventions may be useful. Assisting the young person to engage in alternative prosocial activities with a non-using peer group is also useful.

Notes

Chapter 5:
Inhalant use and brain injury



What is the nature of the association between inhalant use and brain injury?

Persistent neurological effects of inhalant use include:

- Peripheral neuropathy (disturbance in sensation and function of the nervous system peripheries, eg hands and feet).
- Cerebellar dysfunction.
- Optic and otic neuropathy (dysfunction of nerves effecting eye and ear) and encephalopathy (degenerative disease of the brain).

Exposure to inhalants has also been associated with a range of psychological disturbances including depression, antisocial personality disorder and psychosis, but the link remains controversial. The specific brain injury incurred is related to the frequency and duration of exposure, as well as the specific chemicals involved (although there is also individual variation).

How much inhalant use leads to brain injury?

Neurological damage from inhalant use develops with regular long-term exposure. Abusing inhalants several times per week or more may put the person at risk of developing neurological deficits detectable by psychometric testing or neuroimaging. This may occur after six months of use, but it is generally years before symptoms become apparent. Although inhalers tend to use for a short period of time, risk of brain injury through chronic use is low but still possible.

There appears to be considerable individual variation in the degree of exposure to various solvents before neurological injury results. Use of alcohol or other drugs and poor eating habits may increase the risk of development of injury.

Which particular substances cause brain injury and how?

The most common volatile agents to cause neurological injury are toluene, n-hexane, and trichloroethylene and methyl butyl ketone. All solvents are lipophilic (have an affinity for fat) and are rapidly absorbed into fatty tissues such as the brain. They persist at high levels in fatty tissues long after the acute effects have worn off. The protective sheath around nerves (myelin) and the nerve cell membranes are particularly vulnerable to the solvent damage due to their high lipid content (Lolin, 1989). Inhalant use also affects the blood flow to the brain and it is possible that this increases risk of neurological damage (Mathew & Wilson, 1991).

What are the clinical patterns of injury?

Peripheral neuropathy

Peripheral neuropathy associated with n-hexane and methyl butyl ketone use includes:

- Subacute lower limb muscular weakness.
- Muscle wasting progressing to involve the upper limbs.
- Stocking and glove sensory loss.
- Proximal muscle weakness (limb muscles close to the trunk).
- Depressed Achilles (ankle) reflex.
- Slowed nerve conduction.
- Diffuse nerve conduction blocks.
- Demyelination (loss of myelin sheath).
- Degeneration of axons (long processes of nerve cells).
- Neurogenic atrophy (wasting of nervous tissue).

There is usually partial or complete reversal of symptoms after cessation of exposure to the volatile agent, although this may take months to years and symptoms may worsen during the initial weeks of abstinence.

Neuropathy has also been described in association with nitrous oxide use.

Chronic Toxic Encephalopathy

Chronic Toxic Encephalopathy (CTE) is a syndrome of diffuse brain damage strongly associated with long-term exposure to toluene and trichloroethylene. It is generally years before symptoms develop, although neurological impairment may be detectable with psychometric testing and magnetic resonance imaging (MRI) during this time.

Symptoms include:

- Memory impairment.
- Reduction in intelligence.
- Depression.
- Neurasthenia (debility of nerve functioning).

- Personality changes.
- Paranoid psychosis.
- Temporal lobe epilepsy.
- Tremor and ataxia (partial or complete loss of coordination of voluntary muscle movement).
- Visual impairment.
- Deafness.
- Nausea.
- Dizziness.

Postmortem studies of inhalant users have shown generalised damage to nerve cells[2] and wasting of the brain.

There appears to be a dose response relationship.

MRI studies show:

- Diffuse cerebral, cerebellar, and brainstem atrophy.
- Loss of differentiation between the gray and white matter throughout the CNS.
- Abnormalities of brain function[3].

Although the loss of cortical white matter is largely irreversible, cessation of toluene exposure usually results in some improvement in symptoms over the following months to years.

What to do if I suspect inhalant use has caused brain damage?

Assessment should be conducted by someone experienced with assessment of neurological impairment and the effects of inhalant use. This would typically be a neurologist and/or neuropsychologist. The main purpose of the assessment is to exclude or confirm brain injury and distinguish the effects of inhalant use from the other similar neurological injury. MRI and nerve and muscle biopsies may be recommended by the specialist for further assessment of central nervous system injury and peripheral nerve damage.

2 axonal degeneration, demyelination

3 Increased white matter signal intensity in areas around the brain ventricles (periventricular) on T2 weighted images

General principles of management of people with brain injury

Brain injury may occur as a result of risky behaviours whilst intoxicated or as a result of overdose and hypoxia. Strategies for effective behaviour management for people with ABI include:

- the provision of structure and consistency in the relationship
- the provision of specific and simplistic information
- ensuring practicality
- allowing for repetition
- undertaking activities in short timeframes in an environment with limited stimuli.

For attention problems:

- give the person extra time to process information
- focus on one task or activity at a time
- ensure an environment free of distractions (visual and auditory)
- keep activities or tasks simple and of short duration.

For memory problems:

- break down information into small pieces
- write down information and prompts regarding the task or activity
- repeat information as often as required
- give written and verbal reminders as often as needed (notes, phone calls).

For planning problems:

- arrange for external help with setting up routines and general help
- assist with developing alternative options or plans
- assist with building awareness of inappropriate behaviours by providing immediate feedback
- assist with decision making and related actions to carry this out.

Acquired Brain Injury Resource Workers

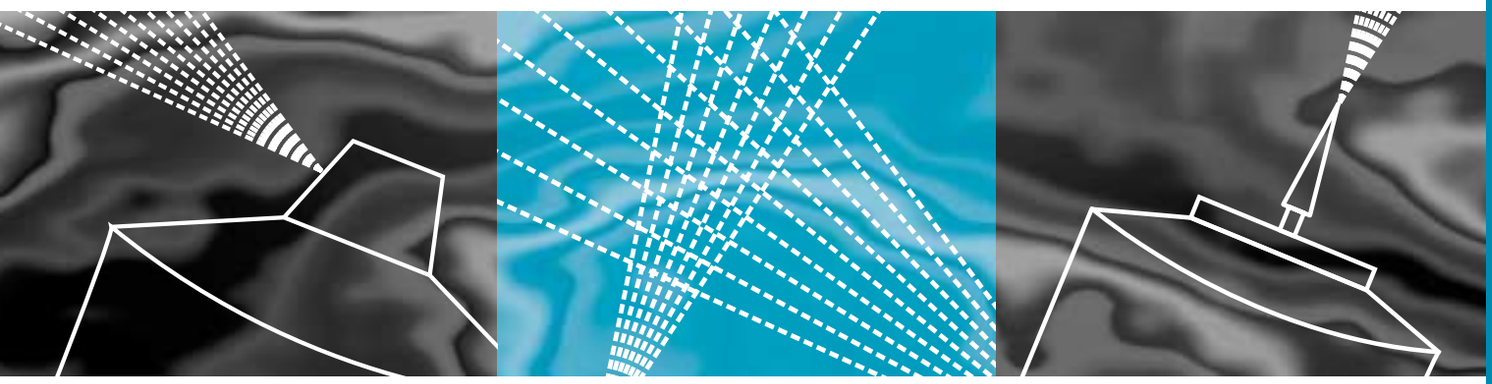
Each region has a designated ABI worker who is able to provide a secondary consultation.

Table 6: Nominated ABI Resource Workers by Alcohol and Drug Agencies

Region	Name	Agency	Address	Telephone
Southern	Mandy Philactides	South East A&D Service	229 Thomas St Dandenong, 3175	03 8792 2330 0405 180 412
Eastern	Carmel Fox	Eastern Drug and Alcohol Service (EDAS)	Monashlink Community Health Service 7 Dunscombe Ave Glen Waverley 3150	9803 0300
Western	Vacant			
Northern	Chrissie Webster	Turning Point Alcohol and Drug Centre Inc.	54–62 Gertrude Street Fitzroy 3065	03 8413 8413 0407 524 600
Grampians	Karen Royle	Ballarat Community Health Centre	710 Sturt Street Ballarat 3350	03 5333 1635
Grampians	Jan St John	Palm Lodge	25 David Street Horsham 3400	03 5381 1062
Gippsland	Farron Vanderputt	LaTrobe Community Health Centre	251 Princess Drive Morwell 3840	03 5134 2011 0413 199 668
Loddon Mallee	Bruce Shillington	Sunraysia Community Health Centre	Ramsay Court 197 10th Street Mildura 3500	03 5025 2518
Hume		Goulbourn Valley Community Health Centre	272 Maude Street Shepparton 3630	03 5831 2012
Barwon S/W	Sharon Amos	Western Region Alcohol and Drug Centre Inc. (WRAD)	325 Timor Street Warrnambool 3280	03 5562 0022

Notes

Chapter 6:
Special groups of inhalant users



This chapter briefly covers other types of inhalants.

Petrol sniffing and Indigenous communities

Petrol sniffing is a form of inhalant use that occurs most particularly in some Australian Indigenous communities. The majority of Indigenous petrol sniffers are male and in their late teens.

Harms associated with petrol sniffing include long-term ill health and brain injury, social conflict and violence, and social isolation and dislocation. The Central Australian Rural Practitioners Association (CARPA) treatment manual (1997) outlines three main problem areas. These are fits, strange or violent behaviour and weaknesses and infections (especially anaemia, STDs, chest and other infections).

According to CARPA (1997) immediate treatment for these three problem areas includes:

- Fits: Follow usual procedure for fitting; may need paraldehyde as well as diazepam.
- Strange or violent behaviour: Call for passive back up from colleagues, family, doctor or police and remove any potential weapons. Keep calm and speak quietly to the person, reassuring them that they are safe. Try to keep them in a well-lit room. A medical practitioner may prescribe diazepam to calm them down and/or haloperidol for hallucinations or delusions.
- Weaknesses and infections: Send to hospital if having frequent fits or fits that do not respond to treatment, if condition is worsening, if they are unconscious or semi-conscious, if they contract a serious illness such as pneumonia, or for respite for the family.

In the main, longer-term interventions for petrol sniffing are multi-targeted – that is they target the community, the individuals affected, and the broader socioeconomic context. Individual treatment should be complemented by prevention and early intervention including a whole-of-community approach. Long-term preventative strategies are strongly recommended along with early intervention with individuals before the practice becomes entrenched.

The principles outlined in these guidelines for managing inhalant use can be applied to petrol sniffing, however there are particular considerations and more specialist information available for petrol sniffing interventions. A brief summary of interventions for individual petrol sniffers is provided here, but readers are referred to the excellent resources already available, such as *Petrol sniffing and other solvents: A resource kit for Aboriginal communities, booklet 3 community development* (Biven, 2000).

DHS is currently finalising a resource for the Koori community on solvent use. The resource is based on South Australian material *Petrol sniffing and other solvents: A resource guide for Aboriginal communities* (by the Aboriginal Drug and Alcohol Council of SA) referred to above. The resource kit is being adapted to suit the needs of the Victorian Indigenous community. The kit will be made available to the Koori Alcohol and Drug Workers across the state and other relevant organisations.

Physical signs of petrol sniffing

- Empty tins and cut down plastic bottles that smell of petrol.
- Spots or sores around mouth.
- Looking drunk, dazed, staggering.

Dealing with petrol sniffing intoxication and acute effects

- Follow the principles outlined in Chapter 3
  - Keep them calm.
  - Remove petrol and make sure there is plenty of air.
  - Assess ABC and seek medical help if required.

Short-term interventions for petrol sniffing

- Follow the principles outlined in Chapter 3
  - First level response – simple contracting
  - Second level response – contingency management
  - Third level response – respite options.

Long-term interventions for petrol sniffing

- Follow the principles outlined in Chapter 3
  - Outline harms
  - Engagement and supportive counselling
  - Develop coping strategies
  - Alternatives to inhalant use
  - Family interventions.

Amyl nitrate

One special class of inhalants is amyl or butyl nitrates. Amyl nitrate was originally manufactured for use in the treatment of angina.

They are a muscle relaxant and dilate the blood vessels, intensifying the sexual experience. Physical effects include headache, flushing of the face, decreased blood pressure, increased pulse, dizziness, and relaxation of involuntary muscles especially the blood vessel walls and the anal sphincter. People who use amyl nitrate report feeling light headed, dizzy and have a slowed perception of time. There is no known withdrawal syndrome. Due to the effect of amyl nitrate on blood vessels, particular care should be taken if used in conjunction with Viagra. The interactions of these two drugs can lead to death.

Amyl nitrate users tend to be older than other inhalant users and as such, usual interventions for substance use can be applied, including motivation techniques to enhance readiness to change, relapse prevention and cognitive behavioural techniques to reduce or stop use.

Nitrous oxide

Nitrous oxide, known as laughing gas, is most commonly used as anesthesia in a situational or recreational context. It is mixed with oxygen when used in anesthetic use, most frequently by dentists. It is thought to pose a relatively minor problem to society – few people use it and there are few known toxic effects with short-term use. However it may be a specific problem for health care workers and dentists because of the ease of access.

Pure nitrous oxide, however, can push oxygen out from the blood into the lungs, depriving organs of oxygen. Early symptoms include dizziness, light-headedness and euphoria, mild numbness of hands and feet, loss of balance, loss of coordination and muscular weakness. Later symptoms include a staggering gait, sphincter impairment, loss of a sense of vibration, headaches, poor memory, decreased tendon reflexes, altered mood, impotence, peripheral anesthesia, and an electric shock-like sensation provoked by neck flexion known as Lhermitte's sign (Jastak, 1991). Chronic exposure can cause neurological deficits and abnormalities of the blood system.

Users tend to be adult and usual techniques for managing substance use can be utilised. However, nitrous oxide users rarely present for treatment at alcohol and drug treatment agencies. Consideration should be given by primary health care workers to asking about and providing brief advice about reducing or stopping use.

Notes

Chapter 7:
Other important community interventions

A common theme throughout many of the interviews conducted for these guidelines and the resources consulted was the importance of the broader community response. Individual interventions alone are insufficient. The local community has potential to be very influential in reducing harm and minimising drug use and abuse. These guidelines are mainly concerned with clinical interventions but will briefly outline potential community initiatives in this chapter.

There are excellent resources available for agencies or services wanting to develop community responses. These include the:

- *Responsible Sale of Solvents – A Retailer's Kit* (DHS, 2002)
- *Traders' Resource Kit* (Sunshine Chroming Awareness Program (SCAP), 2001)
- *Retailers Acting Against Solvent Use – Resource Kit* (Western Australian Drug Strategy Office (WADASO, 2001)
- *Petrol Sniffing and other Solvents: Community Development* (Biven, 2000)
- *Community Partnership Kit: Supporting local community action on illicit drug issues* (Keenan et al, 2000)

Multi-level community mobilisation

Community mobilisation involves campaigns to coordinate community action aiming to reduce inhalant use. Through a variety of socialisation environments (schools, families, community, media, peers) communities can provide various options for reducing risk and increasing protective factors.

There is some evidence for its effectiveness although the costs and resources required to implement a multi-level community based intervention are considerable. For a further summary of community projects undertaken and evaluated see Toumbourou et al. (2000).

Below are some smaller scale initiatives that may assist in deterring and managing inhalant use.

Develop a relationship with traders in the area

Run a local inhalant awareness group amongst businesses/traders. Outline benefits to traders of being involved in reducing drug-related harm in the area. Provide them with the guidelines that are available in the DHS Retailers Kit (see Appendix I).

DHS has developed a Retailers Kit in partnership with a number of key retail groups to assist retailers with the responsible sale of solvents, with the aim of reducing the access to solvents by people who may use them. The Kit will be distributed to traders who retail solvents; in particular, those who retail the more commonly used products.

There are seven components of the kit, including:

- Guidelines for the responsible sale of solvents (see Appendix I).
- Frequently asked questions about solvent use (see Appendix I).
- How to respond to customers wanting to purchase solvents (see Appendix I).
- Flow chart for responding to customers (see Appendix I).
- Point of sale sticker to remind staff about responsible solvent sale.
- Sticker to indicate your support for responsible sale of solvents (for front door of store).
- Poster to display your legal responsibilities.

Copies can be ordered: solvents@dhs.vic.gov.au

Develop a relationship with local police

Police are usually contacted for assistance in crisis situations, for example when inhalers have become aggressive or violent, or there is damage to property. Staff should be made aware that under the provisions of the Act, police will take into account the best interests of the young person. It is important that agencies have a clear understanding of these Guidelines and the *Interagency protocol between Victoria Police and nominated agencies (DHS July 2004).*

It is desirable for agencies to work collaboratively with police, focusing on shared concerns and best outcomes for the young people involved. It may be useful to develop a memorandum of understanding between your agency and local police.

Develop a relationship with neighbours

A community education session or one-to-one discussions with neighbours could be run to educate local residents about inhalant use, including what inhalant use involves, what the effects are, what to do in a crisis, finding common ground and shared concerns.

In order to develop and establish these relationships, the 'community action model' can be used as a guide. The community action model is based on four components, which emphasise an ongoing process. These are: reflection, action, evaluation and change. These can be further simplified by:

- LOOK: What is happening? Find out who the key players are and talk to the relevant people in your community
- THINK: Encourage all community parties to think about why it is happening, what should be done about it. This promotes a shared understanding of the issue
- ACT: Action that is taken depends upon the understanding of the issue. Action is required to keep a project alive and moving forward
- REFLECT: Evaluate what has been learnt, what has been achieved, and what could have been done differently.

Community development

The following is a summary of the Community Development Program compiled by Andrew Biven for *Petrol sniffing and other solvent use.* For more information and detail please refer to the Petrol Sniffing and Other Solvents Resource Kit for Aboriginal Communities, Booklet 3.

Community development aims to improve the lives of individuals, families and whole communities, to increase the opportunities for people to take more control over their lives, and to improve how people feel about themselves and the community. Whilst many successful community development initiatives are led by community leaders, health and community workers play an important role in supporting, encouraging and assisting community action. Health and community workers bring expertise, skills and information to support community groups in making informed decisions.

Stages of community development

Planning

The planning stage requires careful consultation with community groups in order to:

- learn about the problem and what options are available
- explore options for collaboration
- build skills and confidence in taking action.

Several key stages need to be followed.

1. Knowledge about the problem: What information do we have about the problem/issue? Do we need more information? What consensus is there?
2. Knowledge about the community: Who are the important decision makers/stakeholders? What methods/strategies will and won't work? What ways are culturally appropriate? Other special issues?
3. Knowledge about tools and resources: People, skills, equipment, and money.
4. Knowledge about other communities: Ascertaining what has been tried in other communities.

Gathering tools

Once the planning stage has yielded an action plan, requisite tools and resources must be collected. This stage may involve approaching and enlisting the support of individuals and organisations, writing submissions for funding, employing staff, training people, collecting information, researching, and political consultation.

Action

When the project is in action, the emphasis is on monitoring compliance with the project and, if necessary, making adjustments to its implementation. Regular meetings with stakeholders are one way of monitoring and maintaining consultative links.

Evaluation

Evaluation is a crucial part of ensuring and demonstrating that initiatives are meeting stakeholder's requirements. Formal evaluation is commonly multi-modal, with service providers, the action's target group (inhalant users) and community representatives involved. Evaluation may take the form of asking for people's perceptions of change or program utility, or by choosing measurable criteria – such as incidence of ambulance attendances, and incidence of theft of inhalants.

Evaluation commonly involves pre and post testing to demonstrate the effects of the intervention, with the option of ongoing monitoring to ensure compliance with the agreed action plan.

Looking ahead

Ideally, the results of the evaluation process, married with ongoing consultations with stakeholders, allow community development strategies to be maintained or modified as required. It may be that changes can be made to improve the project, or that a new process of planning and action is necessary.

Notes

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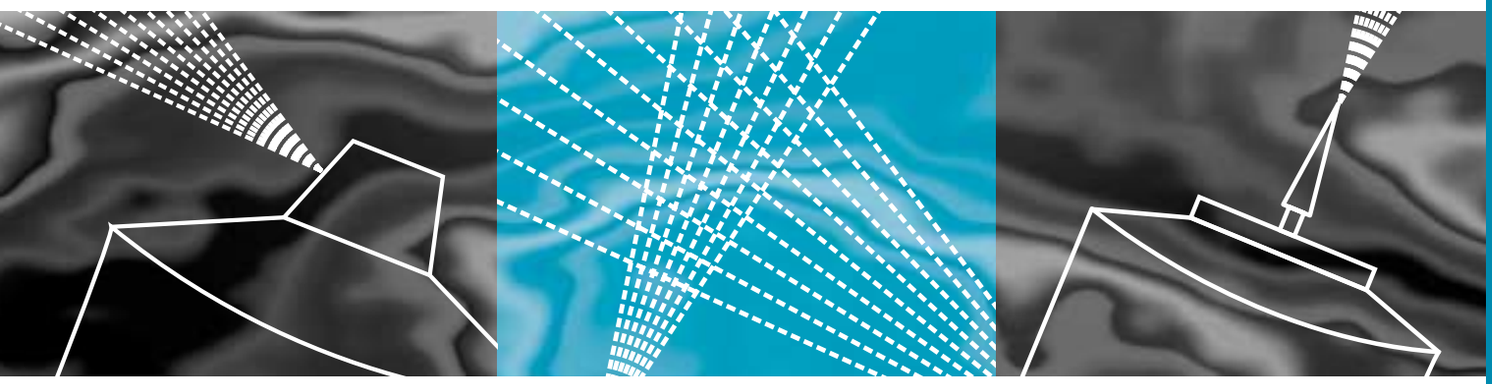

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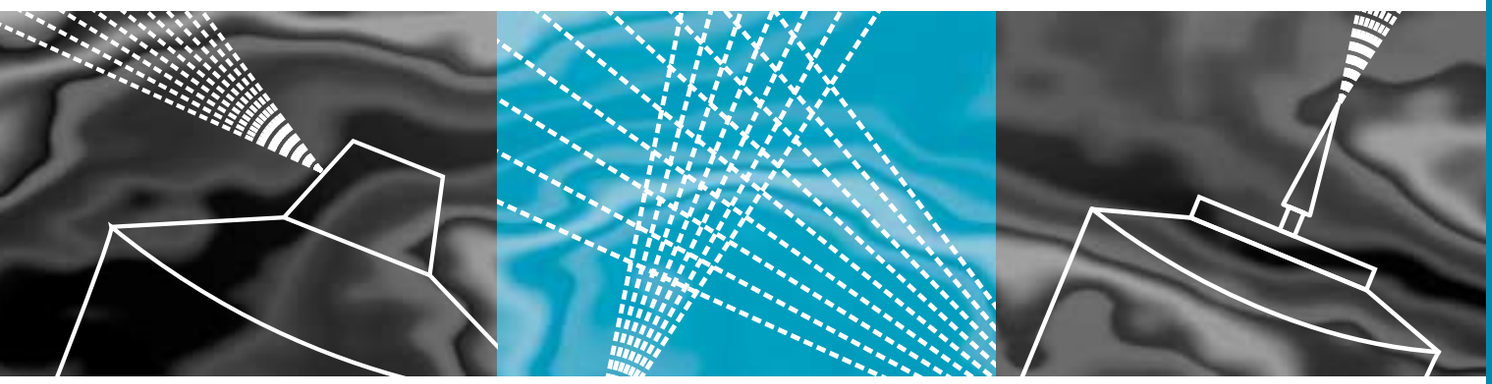
Appendices



Appendix A: Key informants, focus group participants and draft reviewers

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Beth Allen	Western Metropolitan Region Department of Human Services
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Brendan Aplin	St Luke's Family Care
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Penny Armytage	Operations Department of Human Services
John Avent	Salvation Army - Westcare
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Ray Barnes	Inner South Foster Care
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Cheryl Baxter	Salvation Army – Eastcare
Sheryl Bayliss	Salvation Army – Southeast Services
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Bob Bellhouse	Consultant
Carol Bennett	Victorian Alcohol and Drug Association
Lindsay Bent	Metropolitan Ambulance Service
Ian Berry	The Menzies Incorporated
Andy Bevan	Southern Metropolitan Region Department of Human Services
Marc Billing	Youth For Christ
John Biviano	Business and Administration Support – Department of Human Services
Belinda Blair	CARA Inc.
Luz Bland	Department of Human Services
Toni Bloodworth	Department of Human Services
Johanna Bock	Kew Residential Services Department of Human Services
Brenda Boland	Child Protection and Juvenile Justice Branch Department of Human Services
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Gail Bowen	Wesley Youth Services
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Name	Organisation
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Andrew Bruun	Youth Substance Abuse Service
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Judy Budge	Gippsland Region Department of Human Services
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Gerard Cameron	Salvation Army – Westcare
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Sam Cavarra	Southern Metropolitan Region Department of Human Services
Debbie Challman	Drug Policy and Services – Hume Region Department of Human Services
John Cheshire	Child Protection and Juvenile Justice Department of Human Services
Derek Chilton	Drug Policy and Services– Eastern Region Department of Human Services
Colleen Clare	Children's Welfare Association of Victoria
David Clements	Anglicare Victoria Northern Region
David Clements	Child Protection and Juvenile Justice Department of Human Services
Pat Clinton	Berry Street Victoria
Anne Condon	MacKillop Family Services
Beth Costello	North Yarra Community Health Centre
Craig Cowie	Berry Street Victoria
Bryan Crebbin	Grampians Region Department of Human Services
Kate Crombie	Drug Policy and Services– Southern Region Department of Human Services
Jeffrey Cooper	Koorie Care – Gippsland

Name	Organisation
Vic Coull	Glastonbury Child and Family Services
Tina Coviello	Child Protection and Juvenile Justice Department of Human Services
Jenny Cummings	Berry Street Victoria
Doug Dalton	Uniting Care Connections
Sue Davey	Drug Policy and Services – Loddon Mallee Region Department of Human Services
Matt Davis-Allen	TASKFORCE
Sandie de Wolf	Berry Street Victoria
Greg Denham	Alcohol and Drug Education – Victoria Police
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Bruce du Vergier	Community Connections (Vic) Ltd
Elizabeth Dyer	Western Metropolitan Region Department of Human Services
Allen Elliott	St Luke's Family Care
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Sue Gavan	Rehabilitation and Family Therapy (RAFT)
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Name	Organisation
Amanda Hamilton	Northern Metropolitan Region Department of Human Services
Margaret Hamilton	Turning Point Alcohol and Drug Centre Inc.
Bernard Hanson	Community Offenders Advice and Treatment Service (COATS)
Kim Harris	Ballarat Community Health Centre
Denise Harrison	Eastern Metropolitan Region Department of Human Services
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Tim Harrop	Barwon South Western Region Department of Human Services
Sigrid Haslam	Hume Region Department of Human Services
Craig Hemsworth	Gippsland Region Department of Human Services
Andrew Higgs	St Luke's Anglicare
Sue Hildebrand	Northern Metropolitan Region Department of Human Services
Sharon Hill	Salvation Army – Westcare
Adela Holmes	Berry Street Victoria
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Jill Parriss	Wesley Mission Melbourne
Marlon Parsons	Swan Hill Aboriginal Co-Operative
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Name	Organisation
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Neil Taylor	San Remo and District Community Health Centre
Keryl Thomas	Grampians Region Department of Human Services
Doug Tonge	Mallee Accommodation Support Program
John Toumbourou	Centre for Adolescent Health
Michael Traynor	MacKillop Family Services – Barwon
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Deb Tsorbaris	Salvation Army Consultancy Unit
Anne Turley	Melbourne City Mission
Andy Turner	Odyssey
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Grant Walker	Quantum Support Services

Name	Organisation
Chris Walters	Visy Cares Centre
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Peter Wearne	Youth Substance Abuse Service
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Liz Weir	Department of Education, Employment and Training
David Welch	Gippsland Metropolitan Region Department of Human Services
Angie Were	Anglicare
Sandy West	MacKillop Family Services
Pam White	Community Care Department of Human Services
Alan Wilson	Quantum Community Care
David Wright-Howie	Salvation Army Consultancy Unit
Donna Zander	Orana Family Services
Kevin Zibell	Ballarat Child and Family Services
Michaela	Access Youth Support (Richmond)

Appendix B: Brief screen

Background details

Worker

Date of first contact / /

Young person's name

Date of birth

Gender (circle one) M/F

Inhalant use

Type of inhalant (be specific):

Mode of administration (be descriptive):

How are they obtaining the substance:

With whom are they using (on their own, in a group):

Frequency of use (record in number of times per day/week etc):

What is the typical pattern of use?

Other substance use

Develop a picture of this young person's current substance use.

Type of substance(s) used (list in order of preference)					
Frequency of use					
Context of use *(eg with whom, where, when)*					
Reason(s) for use					

Risk factors

List any specific risks for this young person

List harms or risks the young person identifies

Referral and intervention plan

Outline intervention plan including any specific referrals to other services.

Appendix C:
Full assessment (youth)

Worker Date of first contact / /

Young person's name Gender M / F

Presenting issues

What are the key issues for this young person? Immediate needs? Why have they contacted this agency now *(eg voluntary or mandated client)? What is the client's understanding of the problem? What are the perceived consequences of their use?*

Presenting strengths
(eg articulate, stable accommodation, attending school, employed)

Demographics

Name

Address

Postcode

Phone

Date of birth

If this young person is a minor, date parent/guardian was contacted (mandatory): / /

Country of birth

Aboriginal/Torres Strait Islander Y / N If yes, circle below:

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Interpreter required Y / N

First language

Second language(s)

Language spoken at home

Contact issues *(eg can this young person be contacted at home?)*

Is there anyone the young person does not want to know about their contact with this service?

Emergency contact person

Support services

Are there other workers with whom this young person currently has contact?
(eg Protective Worker, Juvenile Justice Worker, Housing Worker, Social Worker, General Practitioner, Case Manager, Religious Worker)

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Name Phone

Position/relationship to client

Organisation

Address

Postcode Fax

Referral Source

Name Phone

Position/relationship to client

Organisation (where relevant)

Address

Postcode Fax

Statutory issues

Current legal guardian *(where relevant)*

Current orders
(eg Protective, Juvenile Justice, Community Based Corrections, include dates)

Immediate legal commitments
(eg Court, signing on at police station)

Pending court dates

Accommodation

Accommodation issues
(eg Stable, unstable, short/medium/long term, supportive, rental, homeless/at risk of homelessness, substance use in household)

With whom does this young person live?

Age first left home
(Include reason for leaving)

Relationships

Explore relationships - which are important/significant to the young person at this time?
(eg Which relationships are supportive, conflictual?)

Is there anyone (parents, partner, friend) whom the young person would like to involve in this process?

Family

Explore the nature of this young person's involvement with family members
(eg Identify supports. What do they think about your substance use? Do they use substances?)

Mother/Caregiver

Father/Caregiver

Siblings

Other family relationships *(eg grandparents, relatives, partner, parent's defacto)*

Is this young person married or in a defacto relationship? Y / N

Does this young person have children? Y / N If yes, number of children

Age(s) of children , , , .

Do the children live with this young person? Y / N

Problematic family issues

(eg Traumatic events, separation/divorce, death/loss, abuse, other AOD use, mental illness)

Peers

Explore peer relationships
(eg identify important friends, influence of peers, drug related relationships, gender mix, where does this young person socialise?)

Other significant adults

Identify other significant adults and their relationship to this young person *(eg carer, mentor)*

Health

Emotional/Mental health

What are the current emotional/mental health issues for this young person?
(eg When was the last time you were happy? Sad? Is something worrying you? What's on your mind? Do you have trouble sleeping? Do you feel angry?)

Explore suicide ideation/attempts
(eg Indicators include mood (depression), thoughts (suicidal ideation), behaviour (risk-taking activities) and history (previous suicide ideation/attempts and treatment).

Physical health

Explore diet/nutrition, illness, hygiene and Blood Borne Viruses *(BBVs include Hep B, Hep C, HIV/AIDS).*

Does the young person want testing for BBVs *(eg Hep B, Hep C, HIV/AIDS)?* Y / N

Current prescription medication and compliance *(eg Serapax, Methadone)*

Substance use

Develop a picture of this young person's current substance use.

Type of substance(s) used *(list in order of preference)*					
Frequency of use					
Duration of use *(age at first use, periods of abstinence etc)*					
Context of use *(eg With whom, where, when)*					
Reason(s) for use					

Substance use continued ...

What was happening in this young person's life at the time they began using drugs?
(eg Experiencing problems, new peer group etc.)

What is this young person's experience of using drugs?
(eg Likes? Dislikes? Is use problematic? What is not using like?)

What, if anything, does this young person want to do with their drug use?
(eg Continue using, control using, abstain - specify for each substance)

Past attempts to control, reduce or stop use
(eg When, where, experiences of withdrawal – physical, psychological, support people)

Injecting drug use? Explore risk taking behaviour with this young person.
(eg Share equipment, use alone, poor injecting technique, blackouts, overdoses).

Education and vocation

School

What is this young person's experience of school?
(eg Likes, dislikes, attendance, literacy and numeracy skills).

Employment and training

Currently employed? Y / N

Has this young person worked in the past? What type of work?

What employment would this young person like to pursue?

Any steps taken towards this employment?

Current sources of income?
(eg Major source, other sources, legal and other)

Leisure and recreation

What does this young person do in their spare time?
(Explore interests, activities, sports etc.)

Barriers and motivation to change

Describe any potential barriers to change. Where is the person at in the change cycle (use the stages of change model)

Coping skills

Describe the person's coping skills for change. Include a statement about skills in coping with high risk situations and refusal and in coping with emotional change.

Summary

Key issues

Young person's strengths

What positive supports does the young person have?
(eg Family member, friend, employer)

What prevents the young person from achieving their goals?
(eg Family, friends, lack of employment skills, accommodation issues)

Example of an individual treatment plan (ITP)

Name

Worker

Date	Issues and goals (list in order of priority)	Steps/tasks to reach goal	Review date	Outcome

Appendix D: Emergency workers

1. ABC (airway, breathing, circulation) assessed and stabilised.
2. Cardiopulmonary monitoring recommended due to risk of cardiac arrest or extreme CNS depression with apnoea.
3. Pulse oximetry and maintenance of hydration with 0.9% saline, or if appropriate resuscitation with major volumes of saline solution. Continual monitoring.
4. Attention to vital signs, cardiorespiratory status, mental state and neurological findings.
5. ECGs if cardiac or pulmonary manifestations of solvent exposure – chest x-rays taken if exposure deemed to be severe (indicated by evidence of chronic abuse such as pronounced wheezing and crackles in respiratory status check) to assess for chemical pneumonitis.
6. When medically stable, all inhalant using patients should be referred to ECAT (Enhanced Crisis Assessment and Treatment Services) or the local psychiatric outreach team.

The decision to use a brief screen or full assessment will depend upon the service type coupled with the worker's confidence and available time. Table 4 summarises the minimum recommended standard for assessment for the two settings and the drug use type.

Appendix E: Formulation

John is a 14 year old who was referred to the service by his residential care worker to address his chronic inhalant use. Workers reported up to eight hours of nearly continual use of chrome paint daily for the past two weeks.

Predisposing factors

John has been in state care since age seven due to a high-risk domestic violence situation. There is a family history of problem drinking – both parents are reported to be heavy drinkers. John suffered from poor parenting from birth to seven years and has been diagnosed with ADHD.

Precipitating factors

John reports that immediate triggers for use are boredom. It also appears from worker reports and discussions with John that depressed mood and anger are also immediate antecedents for use.

Maintaining factors

John is engaged in a peer social group of inhalant abusers. He appears to be one of the leaders. This sense of power and control may be maintaining use.

Stage of change

John appears to be in the contemplation stage of change. He can identify some negative features of his inhalant use but overall believes that the benefits far outweigh the disadvantages.

Diagnosis

Substance abuse (inhalants)

Query/exclude ADHD

Query/exclude dysthymia/depressed mood

Treatment plan

1. Further assessment of mood disturbance is required
2. Increase motivation and insight through counselling
3. Referral for management of behavioural problems and/or ADHD
4. Begin a problem of alternative structured daily activities to reduce boredom and decrease time available to ‘chrome’

Appendix F:
Mental health screen

Brief mental health assessment

Have you ever been hospitalised for emotional or psychiatric problems? ☐ Yes ☐ No

If yes, please provide details

Are things so bad at the moment that you have considered hurting yourself or others? ☐ Yes ☐ No

If yes, please specify

If there is intent, means and a plan, immediately refer to mental health services for an assessment

Has anyone in your immediate family ever had a mental illness? ☐ Yes ☐ No

If yes, please specify

Has anyone in your immediate family attempted or contemplated suicide? ☐ Yes ☐ No

If yes, please specify

Are you currently seeing a GP/Psychiatrist/Counsellor for any emotional or health reasons? ☐ Yes ☐ No

If yes, please specify

Do you ever hear or see things that other people cannot hear or see? ☐ Yes ☐ No

If yes, please specify?

Have there been times that you thought anything strange or inexplicable was going on? ☐ Yes ☐ No

If yes, please specify?

Appendix G: Behavioural contracting and contingency management

Contracting and contingency management are two methods of behaviour modification.

The theoretical underpinning to contracting and contingency management is what is known as 'rule governed behaviour'. It involves two main parts:

a. Most people can learn an instruction more quickly than when exposed to natural consequences

b. People are inherently rewarded by approval from others.

A behavioural contract is a contract between two or more parties that establishes acceptable behavioural patterns for the future. A simple contract may involve the person whose behaviour is to change agreeing to that change verbally or in writing. They are extensively used in preventing suicide, weight loss and other behaviour change.

A contingency contract is similar but also involves agreed rewards and punishments for engaging or not engaging in the desired behaviour. It makes the consequences of an action easier to learn by making them explicit.

When contracting:

- The target behaviour must be identified
- The time frame that the behaviour should be performed in must also be specified.
- The contingencies to the behaviour should be made explicit (for contingency management).

To be effective, behavioural contracts must be set at an attainable level and contracts may need to change slowly to reach the ultimate goal. For example, if you want a child to study one hour a day and they are currently not studying at all, you may need to get them to study 10 minutes a day initially, gradually increasing it to an hour.

Sometimes under contracting and contingency conditions, problematic behaviours might initially increase. It is important to remain consistent, apply contingencies as agreed, even if behaviour begins to escalate. There are no clear guidelines about the length of time to apply behavioural management before escalating your response. It may be days or weeks.

Sample simple contract

I _____ (name) understand the rules of the household/clinic agree to do the following:

_____

_____

_____

Signed

_____ (resident/client)

_____ (carer)

Sample contingency contract

I _____ (name) understand the rules of the household/clinic agree to do the following:

_____

_____

_____

My efforts to reach my goal will be considered acceptable and complete when:

_____

_____

_____

My reward for maintaining this behaviour change will be:

_____

_____

_____

If I fail to maintain this behaviour change, I agree that the following is a reasonable action by my carer/s:

_____

_____

_____

Signed

_____ (resident/client)

_____ (carer)

Appendix H: Useful resources

Resources for Workers

Addy, D., & Ritter, A. (2000). *Clinical treatment guidelines for alcohol and drug clinicians. No 2: motivational interviewing.* Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

Biven, A. (2000). *Petrol Sniffing and Other Solvents: a resource kit for aboriginal communities.* Adelaide, South Australia: Aboriginal Drug and Alcohol Council SA Inc. (ADAC)/Department of Human Services, South Australia.

Central Australian Rural Practitioners Association (CARPA). (1997). *Standard treatment manual, 3rd Edition.* Alice Springs, Northern Territory: CARPA.

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Drugs and Crime Prevention Committee. (2002). *Inquiry into the Inhalation of Volatile Substances [Discussion Paper].* Melbourne, Victoria: Victorian Government Printer.

About Inhalant Use: for Indigenous health and community workers
http://www.health.vic.gov.au/drugservices/pubs/inhalants.htm

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Appendix I:
Excerpts from DHS Retailers' Kit

Guidelines to Retailers (Victoria)

These guidelines have been written to assist retailers to sell solvents responsibly.

Solvent abuse

Solvent abuse can be a serious problem in our community. Solvent abuse (or chroming) involves the inhalation of solvents (such as spray paints, gas lighter refills, thinners, petrol or glues) for the purpose of getting high. Sniffing solvents is not only harmful to mental and physical health, it is also potentially fatal. There have been 44 solvent abuse related deaths recorded in Victoria over the last decade. It is also more often early adolescents who sniff, sometimes as young as 10 years old.

Retailers have a responsibility as community members and by legislation to act responsibly with regard to the sale of solvents. The following guidelines have been developed by the Victorian Government in partnership with retailers.

Which solvents?

Spray paints and gas lighter refills are the most commonly abused. However retailers should be on the alert for misuse of any solvents. Propellent based products and gas lighter refills pose risks in terms of the likelihood that a person can become unconscious and in some cases suffocate. The legislation (Sections 57 and 58 of the *Drugs, Poisons and Controlled Substances Act, 1981)* defines solvents as plastic solvent, adhesive cement, cleaning agent, glue, nail polish remover, lighter fluid, gasoline or any other volatile product derived from petroleum, paint thinner, lacquer thinner, aerosol propellant or anaesthetic gas.

Managing the responsible sale of solvents

The majority of customers purchase solvents for legitimate reasons. However, some people abuse solvents. The following steps provide a guide to managing the sale of solvents in your store:

1. **Identify:** The potential products and how they are stored and displayed.
2. **Display and storage:** Most solvents used for the purposes of inhaling are stolen rather than purchased so it is important that solvents are thoughtfully stored. You could:
   - Display solvents in sight of shop staff, near tills, on high shelves, under the counter or in locked display cabinets.
   - Use dummy containers for display purposes.
3. **Training staff:** Let your staff know how to deal with customers who may abuse solvents. You may like to use the materials in this kit to provide an information session for staff.
4. **Signage:** Display signs that indicate your support for the responsible sale of solvents and your right to refuse sales of solvents. (See the signs included with this kit.)

Retailers' legal rights and responsibilities

The law

In Victoria it is an offence for a retailer to sell solvents to a person they reasonably believe intends to introduce it into their body or sell or supply it to another person for this purpose. This law is set down in Sections 57 and 58 of the *Drugs, Poisons and Controlled Substances Act, 1981*. The penalty is $5,000, imprisonment of up to two years or both.

Selling solvents to customers

Under Victorian legislation, stores have the right not to sell solvents to particular customers. Additionally, retailers have the right to withdraw particular items from sale.

Requesting an individual to leave your store

A store manager has the right to ask any individual to leave the store, particularly if an individual appears to be behaving unusually or has been known to steal from the shop in the past.

Solvents: Frequently asked questions

What are solvents?

Solvents (also known as inhalants and volatile substances) are a range of products which, when vaporised and inhaled, can cause people to feel intoxicated or 'high'.

What products are abused?

Any product that contains solvents, fuel gases, aerosol propellants and can be inhaled to cause intoxication can be abused. These are widely available over the counter and include:

- Household aerosol sprays: paint, hair spray, fabric protectors and analgesics.
- Gases: butane cigarette lighter refills, refrigerant gases, fuel gases such as butane, propane and LPG.
- Industrial and domestic cleaning products.
- Solvents, glues and correction fluid.

The most commonly misused solvents in Victoria at present are spray paints and butane cigarette lighter refills. Solvent abuse trends change from time to time.

What harms are caused by solvent abuse?

Solvents are poisonous if abused, and can slow down the heart, brain and breathing. They can cause loss of balance, slurred speech and disorientation—effects similar to being drunk. Regular 'sniffers' can have fits or hallucinations and even 'blackout'. Solvent abuse causes sneezing, coughing, salivation and red eyes. Long term effects include serious heart, liver and brain damage.

Can solvent sniffing kill?

Yes. Sniffing large amounts of solvents too quickly can cause an 'overdose' resulting in a person having heart problems or a 'blackout'. This can be very dangerous, especially if the person is alone or their friends get frightened and run away. Solvent sniffing has led to injury and death from falls or accidents due to an intoxicated person suffering from agitation, hallucinations, loss of balance or confusion.

How are solvents misused?

The vapours from solvents can be sniffed or snorted directly or by spraying or squirting into a plastic bag. They can also be sprayed onto a rag and inhaled.

Who abuses solvents?

People who abuse solvents can come from all walks of life. However, abusers fall into 3 main groups:

- **Experimental:** Young people under 18 years. (However it is more likely to be young people between the ages of 10 and 16 years.)
- **Occasional/Regular:** Young people who sniff with their peers.
- **Chronic:** Users who may be socially isolated, have emotional problems or difficulties at home or at school.

Why do young people choose to misuse solvents?

Solvent abusers are looking for effects that change the way they feel; such as wanting to feel 'out of it' or drunk. They are often bored, angry or lonely and may feel unloved and unwanted. They are often easily influenced by peer pressure and have a need to be part of the gang. They choose solvents because they are cheap and readily available.

How do I know if someone has been sniffing solvents?

There are some obvious signs that someone has been sniffing solvents.

- The smell of vapour on the clothes or breath.
- A rash or sore spots around the mouth.
- Red and watering eyes and a runny nose.
- Appearing to be drunk or falling over.
- Paint stains around the mouth, skin or on the clothes.
- Confusion or disorientation.

Does solvent abuse affect behaviour?

Solvent abuse can cause agitation and hallucinations. Long term sniffers can become very aggressive and paranoid. (They think everyone is out to get them). They can suffer mood swings, anxiety and depression. Their behaviour can be very threatening and unpredictable. Regular 'sniffers' often get involved in petty crime and theft. Some may steal the products they abuse.

Can I be prosecuted for refusing to sell solvents to customers?

No, there is a law preventing the sale of deleterious substances (solvents) if the retailer 'knows' or has 'reasonable cause' to believe the purchaser is going to use it (or sell or supply to another) for harmful purposes. *(Drugs Poisons and Controlled Substances Act 1981, Sections 57 and 58.)*

How to respond to customers

This document provides retailers with suggested responses to people who attempt to buy or otherwise acquire solvents for harmful purposes.

Tips for Retailers

1. Remain calm and friendly. It's best not to argue with the customer; just restate firmly the company policy. Most customers will accept this approach and leave the store.
2. Use 'we' not 'I'. Don't take direct responsibility for this policy. Telling a customer: "We can't sell you this product" indicates that it is not your fault, but a management or government decision. This makes it harder for the purchaser to blame the individual sales person.
3. It would be best not to refuse to sell if there is any threat or fear of violence. If at any stage you believe that somebody could be injured because you have refused to sell a product, then comply with their wishes and call the manager or the police.
4. If a customer appears intoxicated, exercise caution and remember safety of all customers and staff is the first priority.

Suggested Responses

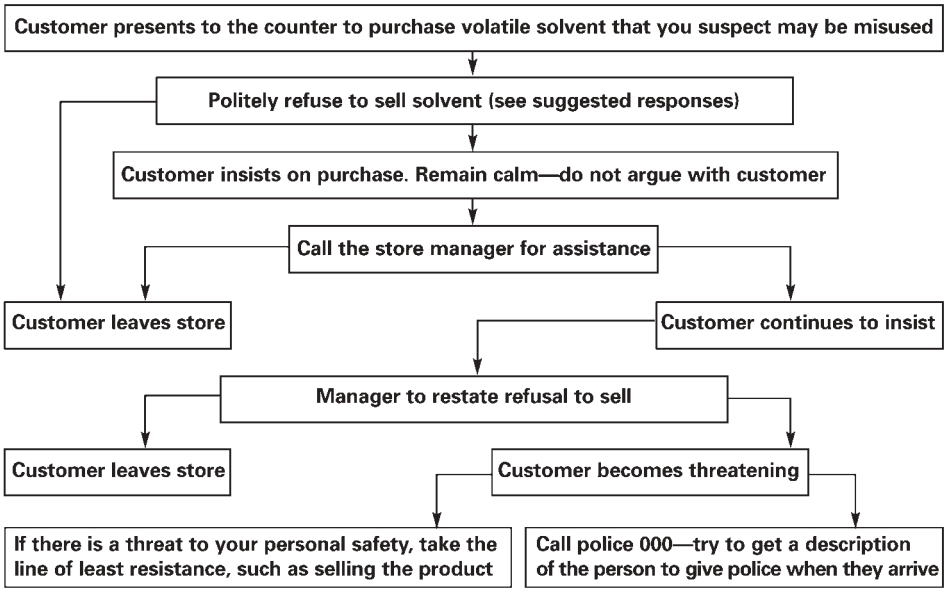
Customer says:	Retailer says:
You can't refuse to sell to me; I'll have you up for discrimination.	We're sorry, but we do have the right not to sell this product.
You have to sell to me; I'm over 18 years old.	We've been told the law covers all age groups and we have to comply with the law or we can be prosecuted.
The law says you have to sell to me or I'll report you to the authorities.	I really don't want to argue with you. You have the right to complain but I think you will find we are acting within the law.
My mother has sent me up for 3 cans of spray paint.	We'd like to help but you will need to bring your mother/father or an adult in with you. The Government has directed us not to sell this product to young people.
I have a letter from my mother so it's OK for me to buy it.	As above.
You may as well sell it to me or I'll just go up the street and buy it.	The Government has advised us to restrict sales of this product. We think you will find the same response in that store. Ring the manager of the store mentioned and discuss your concerns with them.
This (product) will not do any harm. It's not one of those things that kids sniff.	We're sorry but that's one of the products that the Government has asked us to control the sale of because of the harm it can cause if used incorrectly.
Please give me some just this once and I won't ask again.	We're sorry but we don't sell this product to young people. The Government has asked us not to and it is against company policy.
Why won't you sell it to me, you've sold it to the guy in front of me?	Focus on the difference between the customers, i.e. age, when making a decision.
Groups of teenagers standing around areas where solvent products are displayed.	Ask if you can help them. If they do not want to purchase ask them politely to move on. If they refuse, call the manager or store security.
Frequent purchase of solvent-based products from the same individual.	We're sorry but there are restrictions on the sale of this product.

State Government Victoria

Retailer's flow chart

Suggested procedure for dealing with customers who you suspect may abuse solvents.

Suggested procedure for dealing with customers who you suspect may abuse solvents.



Signs of solvent abuse

It can be difficult to identify someone who may be abusing solvents. The following are some things you can look out for in making your decision.

- Nervous or anxious behaviour or a drowsy, vacant or glazed expression in their eyes.
- Frequent or large purchases of solvents by the same individual.
- Solvents are more often abused by young people between the ages of 10 and 16 years.
- Individual or groups of young people standing around counters or areas where solvents are displayed.
- Traces or smell of solvent on breath or clothing.

Contacts for further information or assistance

- For copies of the retailers kit: (03) 9637 4030 or email: solvents@dhs.vic.gov.au
- Website with Traders kit information: www.drugs.vic.gov.au/solvents
- For further information and advice about preventing crime and improving safety in your store ring the Victorian Police Crime Prevention Unit on 9247 5311.
- Emergency–Police or Ambulance 000 or your local police.

Appendix J:
DHS Chroming Policy

The Department of Human Services have developed guidelines regarding alcohol and other drug issues in Community Service Organisations that deliver residential care services across Victoria. These guidelines are as follows:

1. **No illicit drugs are allowed on premises.** This guideline is in keeping with current standards including the Scope of Service and Minimum Standards and Outcome Objectives for Residential Care Services in Victoria (minimum standards) – both of which require compliance with all relevant Commonwealth and State legislation in the operation of services.
2. **All children and young people with substance use issues must be referred to drug and alcohol treatment services.** This requirement was put in place in "Stronger Youth, Stronger Futures - the Safety and Wellbeing Strategy" which was developed in partnership with CSOs in response to the findings of the Audit of Children and Young People in Residential Care. Referral to drug and alcohol treatment will also be measured as part of the quarterly data collection that monitors improvements for children and young people in residential care.
3. **Children and young people are not permitted to have any non-prescribed inhalants in their possession or use such inhalants in residential care facilities. Items that are essential to the day-to-day operation of the residential care service and which clients could use as inhalants are to be securely stored.** This guideline is reflected in the minimum standards.
4. **Strategies relying on passive observation of clients using substances are not permitted.**
5. **CSOs are expected to do everything reasonable and consistent within safe work practices to stop young people from using non-prescribed inhalants, to remove inhaling implements as soon as possible, and to reinforce that using non-prescribed inhalants is not permitted.**
6. **In situations where children and young people present to the residential care facility in a substance affected state our duty of care remains to ensure that they are appropriately assisted.** This includes seeking medical intervention where required and monitoring the young person's wellbeing.
7. Where necessary contact police for assistance under the provisions of the *Drugs Poisons and Controlled Substances (Volatile Substances) Act 2003.* Also refer to the *Interagency Protocol between Victoria Police and nominated agencies (July 2004).*

Case management and day to day care management issues

In line with current service standards, all children and young people in out-of-home care are required to have Care Plans which are developed in consultation with the Departmental regional staff. These plans should address the use of alcohol and other substances. For most of the children and young people this may involve advising them of the harmful effects of alcohol and other substances and providing them with preventive strategies.

For those children and young people for whom substance use is a serious risk, the strategies must be clearly articulated and explicit. It is sound practice to develop with the child or young person, their case manager (Departmental or CSO), their residential care staff and, where appropriate, their families, a raft of strategies aimed at reducing and eventually eliminating use. These strategies include:

- reducing the child or young person's motivation to access and use substances
- diverting the child or young person away from opportunities to use substances
- linking them to specialist alcohol and drug treatment services or outreach counsellors
- reducing health risks if they are actively using substances.

Substances that are confiscated must be disposed of appropriately (including contacting police in the case of illegal substances where appropriate) to ensure that clients are not able to gain access to them.