What constitutes effective treatment for inhalant abusers?

Inhalant abusers are thought to be an easily over-looked and under-treated population. They are in many ways like other people who are chemically dependent, but they also have unique treatment needs. Currently, treatment protocols are based on limited experience and research, primarily with disadvantaged Native American and Hispanic populations in Southwestern and Midwestern United States. What follows are some questions treatment professionals can ask as they review their treatment protocols or guide program development.

- Do you **outreach** to referral sources about inhalant abuse? Do they understand the dangers of inhalant abuse and the need for intervention? Inhalant abusers are a hidden population-they rarely seek treatment and use is often undetected because inhalant abuse "is not on the radar."
- Do you **rigorously assess** for inhalant abuse? Do you know what products are being used and how they are used? Do you understand patterns of abuse so you can pursue a conversation with a client who may be reluctant and embarrassed to discuss use? What are their attractions to inhalants (Very quick acting? Short duration? Free or low cost? Easy availability? Not prosecuted? Hard to test for? Liked the high? Often overlooked as a drug?)
- Does your program allow for **adequate detoxification**? Depending on length of use and type of product used, detoxification from the acute effects of solvents and gases may last for two to four weeks. During this time, program expectations may need to be reduced.
- Do you thoroughly **assess** for cognitive functioning, neurologic damage, and physical effects? Some inhalant abusers show profound levels of dysfunction and deterioration, but there is a great deal of variation in this. Physical damage needs to be assessed early in the assessment process but other testing for cognitive and neurologic evaluation is often postponed until after detoxification. In some treatment populations, abusers have been found to have higher rates of physical and sexual abuse.
- Does **treatment** include specific inhalant focused components? Because many people in treatment aren't aware of the toxicity and lethality of inhalants, (they are after all, *toxins, poisons, pollutants, and fire hazards*), do you provide inhalant abuse prevention education? Do you address life skills issues? Some abusers have started as early as elementary school, which along with the neurological damage can result in poorly developed life and academic skills. Do you take into account cognitive deficits by using briefer (20 minutes) and more concrete interventions?
- Does **family involvement** include education about inhalants, removing inhalants from the home, and the extra support and supervision that inhalant abusers and their families may need? Treatment programs need to thoroughly assess the stability, structure, and dynamics of the family. If there is limited family support, develop alternatives such as foster care.

- Are **inhalants accessible** in your treatment program? Do you have a policy about dry erase markers, nail polish and remover, typewriter correction fluid, solvent-based glues, aerosol products (such as deodorants, hair spray, shaving cream, cleaning products, and canned whipped cream)?
- Is your **staff knowledgeable** about inhalant abuse? Do they have realistic expectations for recovery? In order to effectively treat inhalant abuse, counselors need to understand the unique aspects of the problem, including a slow rate of recovery.
- Does your **aftercare planning** take into account the special problems of inhalant abuse? This includes easy availability of inhalants, residual cognitive impairment, and poor social functioning. Has a school-based advocate/counselor been included in the plan?

Sources included:

Pamela Jumper-Thurman, Barbara Plested, and Fred Beauvais, "Treatment Strategies of Volatile Solvent Abusers in the United States." in, Epidemiology of Inhalant Abuse: An International Perspective, M. Kozel, Z. Sloboda, & M. De La Rosa, Eds., NIDA Research Monograph 148, 1995. Available at www.drugabuse.gov/pdf/monographs

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