SELECT COMMITTEE ON SUBSTANCE ABUSE IN THE COMMUNITY

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Training frontline workers:
Young people, alcohol and other drugs

Training Frontline Workers:

Young People, Alcohocl &

Other Drugs

Working with Young People Who are Intoxicated

Pilot June July 2002

Learner's Workbook

Learner's Workbook Contents

Section A:

Section B:

SECTION

A

1. Background Information

1.1 The National Illicit Drug Strategy - Training Frontline Workers Strategy

Background

The Training Frontline Workers - Young People and Alcohol and Other Drugs project was initiated as a result of identified gaps in educational resources for generalist, frontline workers responding to the needs of young people with alcohol and other drug issues. The project was funded by the Commonwealth Department of Health and Aced Care as part of a broader strategy to meet the educational needs of a range of frontline worker groups.

The Project Management Committee for this project is comprised of representatives from TAFE NSW, Northern Territory Health Services and Next Step Drug and Alcohol Services in Western Australia.

Project Aim:

"To develop nationally relevant educational resources to enhance the capacity of frontline workers in responding to the needs of young people with alcohol and other drug issues."

1.2 The Young People, Alcohol and Other Drugs Program

The "Young People, Alcohol, and other Drugs" program consists of 13 modules, which address four competency units from the Community Services Training Package. Each of the modules has been designed to address particular areas of need for generalist frontline workers in relation to young people and their use of alcohol and other drugs.

While drug use represents a functional behaviour for both young people and adults, developmental and cognitive issues distinguish adolescent drug use from that of adults.

This means that young people's issues and needs regarding the use of alcohol other drugs differ from those of adults & should therefore be dealt with in customised learning resources.

1.3 Target Occupational Groups

Although a diverse range of "frontline workers" have been identified as a high priority for alcohol and other drug training, a smaller group have specific needs in relation to working with young people with alcohol and drug related issues. From both research publications and consultation undertaken prior to the development of these modules, the highest priority occupational groups requiring education and training about young people and drugs include.

- Youth Workers
- Accommodation & Crisis Workers
- Counsellors (including school based)
- Primary and community health and welfare workers
- Juvenile Justice
- Teachers
- Police

Both the learning and assessment strategies have been developed specifically for these target groups.

2. Learner Information

2.1 Using the Learner workbook

This learner workbook is a comprehensive, workbook style document that can be used to compliment face to face or supported distance learning modes or a combination of the two.

The learner workbook has been divided into two sections.

Section A: provides details of how to use the learner workbook.

Section B: provides the actual content details related to the module.

The content details of this module have been divided into topic areas. In each ill be provided with activities which may be exercises for you to work on, information for you to read or a range of other different events that should assist you in completing this module.

2.2 Icons used in the learner workbook

R *Read* the following

W *Write* a response

2.3 Assessment Events

Your facilitator will provide you with information on any assessment activities you might be required to undertake. If you are not provided with assessment information when you commence this module, make sure you ask your facilitator if there are any assessment activities that are a requirement of completion.

3. Module Information – "Working with Young People who are Intoxicated" .

3.1 Introduction to the module

This module has been designed to help any one who, in the course of their employment or volunteer role, will find themselves helping young people who are intoxicated. No assumption is made as to your background, profession or specialised training received. Therefore, the information contained in this module is of a general nature. Consequently, frequent reference is made to seeking qualified medical and psychological assistance when an emergency situation arises or when you have concern that a situation may develop that is beyond your level of experience and skill.

The emphasis in this module is on responding directly to the needs of the young person when they are intoxicated. However, it is recognised that any contact with a young alcohol and other drug user is potentially an opportunity to deliver harm reduction strategies to reduce the risks associated with drug use, and to increase their motivation for change.

3.2 Learning outcomes

After completion of this module you will be able to provide services to young, people who are intoxicated within organizational policy and procedures, and specifically:

- Identify factors associated with the individual user, the setting of drug **Lise** and the drug(s) used that are contributing to an episode of intoxication
- Obtain detailed information on recent drug use where possible
- Identify signs of intoxication for different pharmacological categories of drugs
- Identify signs of overdose and know appropriate first aid responses
- Identify signs of physical and mental distress and make appropriate responses (both first aid and establishing contact with qualified personnel)
- Assess the risk of self-harm and take preventive measures
- Take appropriate measures to defuse aggression and/or disruptive behaviour
- List appropriate communication skills with intoxicated young people
- Assess the immediate needs and wishes of the young person and respond wherever possible
- Describe a low-risk sobering-up environment
- Explain the need for close supervision and medical attention for those who are grossly intoxicated

3.3 Depth of material

This module is suitable for anyone who works, or intends to work, **in** any context with young intoxicated persons. No assumption is made as to background, training **or** qualifications. A general harm reduction approach is presented with an emphasis on seeking medical management and the back-up of any relevant authorities in a crisis.

3.4 **Relationship to other modules**

This is the first module in the *Orientation to the Alcohol and Other Drugs Sector* unit, which follows on from the *Social, economic, and legal contexts of* AOD module and the *How Drugs Work* module, in which leamers explored an introduction to drug use in our society and pharmacology of drug use respectively. The knowledge leamers will gain from this module about the level and patterns of drug use among young people will provide a solid foundation in understanding drug use issues in order to learn about the use of interventions for drug use in the following modules.

The 13 modules are:

Module 1. Action Planning for professional development and ongoing learning in the workplace

Module 2. Perspectives on Young People

Module 3. General Risk and Protective Factors for young people

Module 4. Working with Young People

Module 5. The Social, Economic and Legal Context of young people's AOD use

Module 6. How Drugs Work

Module 7. Prevalence and patterns of young people's AOD use in Australia

Module 8. Introduction to AOD Interventions for young people

Module 9. Assist Clients to identify their needs

Module 10. AOD Counselling and Interventions with young People

Module 11. Working with families and peers

Module 12. Professional Conduct

Module 13. Working with young people who are intoxicated

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Module 12. Professional Conduct

Module 13. "Working with young people who are intoxicated

3.5 Relationship to the Community Services Training Package (CSTP)

The "Drugs and Young People" program does not in isolation, comprise sufficient units of competency to lead to a qualification. The units addressed within this program can, if successfully completed, contribute to part of a qualification.

The "Working with Young People who are Intoxicated" module is designed to meet the requirements for the CHCAOD6A Unit of Competence from the Community Services Training Package (CST 99).

3.6 Recognition processes

If this module is offered by a Registered Training Organisation (RTO), then Recognition of Prior Learning (RPL) should be available for leamers who already have the skills and knowledge that are contained in this module.

If a learner wants to apply for RPL, they will need to discuss this with the facilitator.

3.7 References

MacAndrew, C & Edgerton, R B (1969). *Drunken Comportment*. *Nelson* & Sons, London. National Health and Medical Research Council (NHMRC). (2001). *Australian Alcohol Guidelines.. Health risks and benefits*. Commonwealth of Australia.

Novak, H, et al (1989). Alcohol: Nursing management of intoxication and withdrawal. NSW Health Department.

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Prochaska, J 0., Di Clemente, C C & Norcross, J C. (1997). In search of how people change: Applications to addictive behaviours. In: Marlatt, G A & VandenBos, G R. *(Eds) Addictive Behaviours*. (pp.671-696) American Psychological Association, Washin-ton DC.

Stewart, T (1987). *The Heroin Users*. Pandora, London.

Thorley, A. (1 982). Medical responses to drinking problems, *Medicine, 35, p* 1 816. Well, A. (1 972). *The natural niiizd*. Penguin, Middlesex.

Ziberg,, N. (1 984). *Drug, set and setting.. The basis for controlled intoxicant use*. Boston: Yale Uni. Press.

4. Key Terms

Key Terms

These are terms that are used throughout this module. As you work through the module, you will see some words or terms in the text that are written in bold italics. This indicates that they are terms that some leamers may not be familiar with and a definition has been provided here for your convenience

Intoxication	any alteration whatsoever in our perception, mood, thinking processes and motor skills as a result of the impact of a drug(s) on our central nervous system.
Motivational Interviewing	a therapeutic style developed in the AOD **field** in the early 1980s as an alternative to a more confrontational approach used **in** some sectors of the treatment field. The main focus of motivational interviewing is to work with clients through the process of change in a client-centred manner. Issues such as resistance and ambivalence are embraced. The aim of motivational interviewing is to build on a client's own motivation and encourage choices for change
Potentiation	the combined effects of two or more substances are greater than the sum of the effect of each used alone.
Tolerance	occurs when a person needs to have increased doses of a drug to obtain the same effect. Tolerance is a state of progressively decreasing responsiveness to a drug, as the body adapts to the presence of the drug.

SECTION B

Working with Young People who are Intoxicated

AOD 6A

Learner's' Workbook

Contents

Topic 1: Introduction

1.1 Introduction

The module is divided into topic areas for easy reference, and within each topic area, you will find:

- **Readings** which provide details of important information that you should read

Learning Exercises exercises designed to assist you to explore some of the issues related to working with young people where alcohol and drugs are a factor

Additional References these are not essential readings (unless specified). They are provided so that you can find additional information about a particular topic should your require it.

1.2 Learning Outcomes

When learners have successfully completed this module they will be able to:

- identify factors associated with the individual user, the setting of drug use and the drug(s) used that are contributing to an episode of intoxication
- Obtain detailed information on recent drug use where possible
- Identify signs of intoxication for different pharmacological categories of drugs
- Identify signs of overdose and know appropriate first aid responses
- Identify signs of physical and mental distress and make appropriate responses (both first aid and establishing contact with qualified personnel)
- Assess the risk of self-harm and take preventive measures
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Topic 2: What is Intoxication?

Key Issues to be covered in this topic:

- What is intoxication?
- Young people and intoxication

2.1 What is intoxication?

Often intoxication is thought of in extreme terms, when someone is ‘drunk’ of ‘off his or her head' with drugs. But, in fact, some degree of intoxication occurs with any single dose of alcohol or other drugs. One can be mildly intoxicated so that it is hardly detectable to others, and yet behind the wheel of a car that same level of intoxication could be disastrous. Risky activities of all sorts increase from low levels of intoxication.

> ***Intoxication*** is the term for any alteration whatsoever **in** our perception, mood, thinking processes and motor skills as a result of the impact of a drug(s) on our central nervous system.

Seeking a change **in** our consciousness (Intoxication) is the main reason that we use drugs. We may express our motives differently - to 'relax', to 'socialise', to 'have fun', but the basis of all these and other reasons is a change in the way we feel, perceive, think and behave after we have consumed alcohol and other drugs. Let's remind ourselves how pleasurable and tempting the experience of intoxication can be, as expressed by some users:

The rush is so hard to describe. It's like waitiiig for a distant thunderstorm to move overhead ... A feeling starts to grow like a rumble from the horizon. The feeling swells, surging, soaring, crashing, and screaming to a devastating crescendo. The gear *(heroin) smashes against the top of your* skull *with the power of an uncapped oil well. You won't be able to bear the intense ecstacy,...The rock that is your head shatters harmlessly into a million sparkling, tinkling smithereens. They tumble at a thousand miles an hour straight back* **down** *over body , warming insulating, tingling, denying all pain, fear or sadness. You are stoned, you are high ...*
Tam Stewart (1987), p 29.

Tam Stewart has powerfully written of how the heroin high placed her in a different reality, an intensely personal experience where all the problems of this world recede. In contrast, amphetamine (a stimulant drug) users are seeking a very different experience of heightened sociability, energy, confidence and personal power.

2.2 Young people and intoxication

It is not surprising that alcohol and other drug intoxication is so commonly sought. Whatever problems and risks are associated with being intoxicated, there is also much pleasure to be gained. This is an important principle to remember 'n our work with young people, as it will help us to understand their motivation for drug use and intoxication. Life is difficult for many young people as they struggle to define their identities and cope with myriad pressures and problems. Intoxication can provide 'time-out', immediate and temporary relief and release. And essentially, there is no difference between the motives for drug use at any age or with any drug; an altered state of consciousness is desired (Well, 1972). Additionally, using drugs and sharing an intoxicated time with friends can be a bonding experience. It can heighten a sense of group membership, of belonging. For example,

"Young people who smoke dope...see themselves as belonging to part of a group that has fun smoking dope. And in some cases, smoking dope is what gets them into that group - it is indeed their rite of passage. But ask them why they smoke dope and the will *tell you quite clearly that their were initially curious and now they enjoy getting stoned. "* Palin & Beatty (2000), p 25.

This perspective on drug use and intoxication should help ensure that we never sit in judgement on the drug, use and intoxication that young people are prone to experience when they experiment with drugs.

"Try and imagine what it must feel like from the teenager's point of view to have your recreational activities (in this case your drug taking) constantly criticised by other people. Imagine how you would feel if someone was constantly moralising to you about …..lawn bowling or gardening, and sailing what ridiculous activities they are, (as some people do). Imagine also that these were important sources of entertainment and satisfaction for you. It wouldn't take very long to switch off would it? And it doesn't take teenagers long to switch off either." Palin & Beatty, (2000), p 25.

However, while we should have a non judgemental attitude towards an intoxicated person, - we should not become blase about intoxication just because it is so very common (as common as every episode of drug use). It would be a grave mistake to only get concerned when really gross and blatant intoxication is "in-our-face". It is important to recognise that a huge proportion of all alcohol and other drug, related problems are due to intoxication. Intoxication related death (accident, overdose, self-harm) and injury is very high in young persons. (NHMRC, 2001).

SUMMARY

- Essentially, there is no difference between the motives for drug use at any age or with any drug; an altered state of consciousness is desired. (Weil, 1972)

- Using drugs can sharing an intoxicated time with friends can be a bonding experience for young people.

- A huge proportion of all alcohol and other drug related problems are due to intoxication.

- Intoxication related death (accident, overdose, self-harm) and injury is very high in young persons.

Exercise: A young person's experience of intoxication

Task 1

Talk to a young person about their experiences of intoxication. List both the positives and the negatives of the experience. **The** *young person may evpect that you only really want to hear* **about** *the positives, so.vou may need to* **assure** *him or her that the negatives are valid and - vou do indeed want hear them. If possible, get the young person to contrast different intoxication experiences (either with the same drug orfor different drugs), as intoxication is a highly variable experience.*

W - write

If the nature of your work makes such a discussion with a young person difficult or compromises your role (eg. Some police personnel may feel this exercise is inappropriate), then conduct the exercise using your own (or a friend or relative's) experience of intoxication.

A young person's experience of intoxication

Positives	Negatives

Task 2

Write about 300-400 words on your response to the young person's account of their intoxication. You may wish to consider the following questions in formulating your responses.

> *"What is your response to the young person's account of their intoxication experience?*
> *What feelings did you experience?*
> *What thoughts did you have in response?*
> *Did you form any judgements about this young person's experience?*

NOTE: This is a good point at which to examine your values and beliefs regarding intoxication. It is possible that some of your responses have been shaped by negative experiences you have had of intoxication and that these experiences form an impediment to your interviewing appropriately with a young person. There is also a vital distinction between accepting a young person's intoxicated state but not tolerating harmful behaviour associated with intoxication.
(There are no set expectations as to what you will discover from this exercise. It is designed to put you closely **in** *touch with -your feelings, values and beliefs regarding intoxication in young people.)*

Topic 3: Understanding -intoxication - related problems

Key Issues to be covered in this topic:

- Understanding intoxication
- Social setting, expectations and intoxication
- Individual differences
- Intoxication and the "e of drug(s) taken

3.1 Understanding intoxication

You may, by now, be familiar with Thorley's (1982) model of alcohol-related problems, which also applies, more or less, to most other drugs.

Thorley's model draws our attention to the fact that problems can be usefully thought of as resulting not only from dependence (the traditional, narrow, way of identifying a 'drug problem'), but also from the regular use of a drug at hazardous levels (without necessarily having any critical signs of dependence), and *from intoxication.* Indeed, one could make an argument that the bulk of drug-related problems in young people occur due to intoxication. (See Figure 1, based on Thorley's model, drawn to reflect that problems of intoxication and regular use dwarf those problems relating to dependency from a broader societal perspective)

Thorley's model of harm relating to intoxication, regular use and dependency

1. Intoxication

2. Excessive regular use

3. Dependency

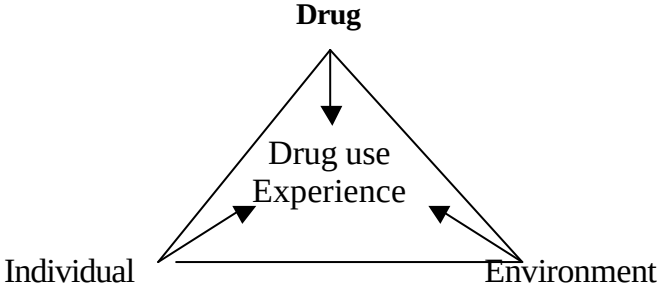
Younger people tend to engage in more adventurous and risky behaviours, whether drug-related or not, so the risks are elevated considerably when a young person ' intoxicated. It is not hard to compile a list of intoxication-related harm (and I'm sure you could add to this list)

- Drink/drug driving charges and accidents (Including pedestrians)
- Water-related accidents (particularly diving accidents)
- Workplace accidents and absenteeism
- Accidents when operating machinery
- Aggression and violence
- Relationship and domestic difficulties
- Impulsive crime
- Unprotected sex
- Further unsafe drug use (e.g. sharing a needle)
- Overdose
- Choking on vomit when unconscious
- Anxiety/Panic attacks, and less commonly, a psychotic episode
- Acting on suicidal impulses

The likelihood of harm resulting from intoxication is a consequence of multiple factors associated with:

- properties of the drug(s) consumed
- the individual characteristics of the usei
- the environment in which the intoxication is occurring.

The drug, individual, and environment model (Zinberg, 1984) is another useful guide that you may have already encountered, but it is worth revisiting the model solely in the context of intoxication-related harm.



Interaction model

SUMMARY

- Drug use and intoxication can never be fully understood in isolation from the characteristics of the individual user and the environment in which they have been using drugs.

- That is to say, we can never understand any aspect of drug use, intoxication included, by just focussing on the drug itself

3.2 **Social** setting, expectations and intoxication

A potentially confusing thing about intoxicated behaviour is that it can greatly vary in a person from one episode to another, even when about the same amount of alcohol and/or other drugs have been used. Intoxication can even change dramatically in the space of a few minutes; a person can seem to sober up or alternatively become much more intoxicated, seemingly on the spot. This is because there is a powerful relationship between one's mood and expectations, and the setting in which the drug use occurs.

On occasions a young person may strongly desire intoxication, and so feel very intoxicated very quickly at low doses. This is all about having time-out from the straight' world. Even the responses of other people, both positive and negative, may be part of the 'fun' of being smashed. **This is** not to say that such intoxication is being deliberately feigned. Rather, intoxication can be exaggerated by expectations, mood and the context in which the episode of drug use occurred. Conversely, if a situation demands a more sober response, say after a mate has had an accident, the euphoria or recklessness of intoxication can dissipate quickly. Of course, the level of drug(s) in the bloodstream does not fall dramatically within minutes; an intoxicated person responding to a crisis may behave more soberly but you would not want them driving their friend to hospital!

Expectations of intoxication may come from many sources within our society, friendship networks, family and our own experiences with a drug. Expectations play a more significant role at lower levels of drug intake where they may be as important, if not more so, than the pharmacological basis of intoxication. On occasions, a person may expect, or want little intoxication to occur and they consequently may hardly feel the impact of a drug (or certainly are determined to moderate its impact). Perhaps they have some work to complete before they can really let themselves go and get fully into feeling intoxicated. On another occasion, the same dose of a drug, after work when ready to party, may have that person feeling high and light-headed hardly before the drug has had much time to influence the central nervous system. In other words, just as we can sometimes moderate our intoxicated experience and behaviour, at another time we may choose to exaggerate our state of intoxication.

There is much cross-cultural evidence, collected by anthropologists from the early 1900's, that alcohol intoxicated behaviour varied enormously from one society to another (MacAndrew & Edgerton, 1969). In some societies, such as the Papago of southern Arizona, violent mayhem resulted from drunkenness. But the elders of the Pagago indicated that this violence began to occur only after colonisation by 'white men'. Before colonisation, wine ceremonies (at which a very potent cactus cider was consumed), resulted in peaceful behaviour only ("Drink friend. Grow beautifully drunk", they exhorted each other). This is an example of where the *meaning* attached to drug-use changed greatly, resulting in a very different type of intoxicated behaviour.

The Camba Indians of Bolivia would sit in a circle drinking a brew that was almost 100% alcohol (so strong it would strip the lining from their mouths), yet no rowdy drunkenness ever ensured. They simply joked and exchanged pleasantries, until becoming quiet with the stupor of advanced intoxication and falling off their stools to sleep off their binge. Where is the disinhibition of behaviour that is supposed to come with extreme intoxication? Obviously we humans can exert more control over intoxicated behaviour than is often thought to be the case, particularly when the social controls on our behaviour are well understood and enforced.

Edgerton recounts the story of a tribesman who was renowned for his violent drunken 1

behaviour, but whenever he happened upon Edgerton in the midst of one of his rages, he became subdued, polite and friendly. As soon as Edgerion was out of sight, his drunken rage would return. This last example is a clear case of intoxicated behaviour following a pattern that the intoxicated person thinks is expected and, to an extent, excused because of the drug use.

A more recent example of intoxication being influenced by the situation in which it occurs comes from the writer of this module's own experience at a party when himself a young man.

> *After much drinking and other drug taking, by 2 am. intoxicated - young people were staggering off into the bushes in twosomes, in some cases with their friend's partners. Presumably, in the morning when the recriminations would start, cross intoxication would be used as an excuse for people doing what they had fancied doing. Unfortunately, or perhaps fortunately for the survival of some relationships, a young woman then ran from the house to dive into the pool, and in doing so ran straight through a glass door that had been shut while she was changing. Shrieking with pain until she quickly lapsed into unconsciousness. Her friends emerged from the bushes in an instant. Seeing that she was badly cut, they appeared to sober-up on the spot. She was placed in the recovery position, her pulse monitored, blankets fetched to keep her warm, tourniquets applied to stem the blood-flow, and an ambulance called. When the ambulance departed, no one felt like resuming the party,. They sheepishly said their good-byes and drifted off into the night…..*

A contextual understanding of intoxication **is** important **in** two ways.

1. It will help you to not overreact to provocative intoxicated behaviour, when handled in a firm but non-defensive and non-confronting. manner, aggressive, antisocial or disruptive behaviour may vanish on the spot. While drug intoxication does impair judgement and decision-making, leading to impulsive action, drugs do not control behaviour. Unless grossly intoxicated, or in a drug induced psychosis, people still retain some control over their actions (but they may choose not to exercise that control).

2. If extreme intoxicated behaviour persists for a lengthy period, despite intervention and a chan(,e in circumstances, then you will suspect that the person

3. has taken a very large dose of drugs and/or is suffering from a physical and/or mental illness. Under those circumstances, the young person must be monitored very closely and medical attention sought (more of this later in the module).

SUMMARY

- The setting in which drug use and intoxication occurs is critically important to outcomes.
- A calm, consistent and orderly approach to intoxication in accordance with your organisation's policy and procedure will help ensure that intoxication does not result in harm.

NOTE: This is a theme we will return to in this module when considering the management of an intoxicated young person

3.3 Individual differences

We have been discussing the role of expectations and social setting on intoxication. There are also large *individual differences* in the mental state of young drug users, which greatly influences intoxication. Those with very stable mood and anxiety states may experience remarkably uneventful intoxication, with little risk of problems, while others prone to high levels of anxiety and mood instability may experience a chaotic, unpredictable, intoxication. Young people who have mental health problems (particularly severe conditions such as manic-depressive disorder and schizophrenia) may greatly exacerbate their symptoms when taking drugs (we return to this difficult area later in the module). Those who have a tendency towards impulsive risk-taking behaviour or aggression when sober, are far more likely to have an accident or be involved in a criminal act when intoxicated.

There are also individual differences at the basic level of physiological functioning that influence the degree of intoxication experienced. Regular, heavy, use of a drug(s) over a prolonged period will result in less intensely experienced intoxication. This is because the central nervous system adjusts to having drugs 'on board' frequently, so much so that 'a person will only feel ‘normal’ after using alcohol or other drugs. This effect is known as drug *'tolerance'*. A lack of tolerance in young naive drug users can result in very dramatic intoxication at quite low levels of intake, and make them more prone to overdose.

Tolerance occurs when a person needs to have increased doses of a drug to obtain the same effect. Tolerance is a state of progressively decreasing responsiveness to a drug,' as the body adapts to the presence of the drug.

There are also basic differences in the rate at which drums are processed (or metabolised) in large and small people, and in males and females. Smaller people will generally become more intoxicated at lower doses because they have less body fluid in which alcohol can be diluted. Females, with a higher body fat to fluid ratio than males (as well as generally being smaller), tend to get considerably more intoxicated than males at comparable doses. An empty stomach also produces more intense intoxication, as food will slow-down the rate of absorption of alcohol, and other orally administered drugs, into the bloodstream.

You can see, then, that it is important to see the whole picture to understand how 1'll unfold. Keep in mind that all drug users (which includes most of us) are individuals, unique in the way we see, feel and think about our drug use and experience intoxication. The setting in which drugs are used, and the situations young people find themselves in when intoxicated, has a profound impact on whether harm results or not. Additionally, you need to know what kind of intoxication to expect from the use of different types of drugs, and how the drugs were administered.

SUMMARY

- All drug users are individual and unique in the way they see, feel and think about their drug use and experience intoxication.

- The degree of intoxication experienced is influenced by differences in a Young person's mental state, physiological functioning and metabolism

3.4 Intoxication and the type of drug(s) taken

As indicated earlier:

Intoxication ranges from mild to extreme. In more mild cases, the signs of intoxication may be quite hard to detect unless you know what to expect in relation to the use of different drugs.

Extreme intoxication will also vary considerably depending on the nature of the drug used (notwithstanding that the characteristics of the individual drug-user, and the immediate setting of intoxication, will influence the signs of intoxication).

The type of drugs a client has used is of critical importance. The physical signs of intoxication that result from the three major pharmacological classes of drugs (depressants, stimulants and hallucinogens) are somewhat predictable (see Table on the next page). However, if the young person has been mixing various drugs (polydrug use), as is increasingly the case, the resulting intoxication is far less predictable and can be extreme and volatile. When various depressant drugs are mixed (e.g. alcohol and tranquillisers or heroin), then you can expect extreme intoxication to occur.

Combining these drugs produces a total effect that is greater than each drug effect simply being added to the other(s). Rather, the effect is more like **multiplication than** addition. This is called a 'Potentiating,' effect, which greatly increases the possibility of chaotic behaviour and overdose.

Potentiation is when the combined effects of two or more substances are greater than the sum of the effect of each used alone.

For example, death by heroin overdose is more likely when a person has also been drinking heavily. If stimulants have been mixed with depressant or hallucinogenic drugs, then the impact on the central nervous system, and resulting intoxication, will be very unpredictable.

The mixing of drugs is an increasingly important issue in the youth scene, with prepackaged 'drug cocktails' now available for sale. The reasoning behind 'cocktails' is that stimulants (and possibly hallucinogens) are used for an energetic good time, followed by depressants to help wind down and get off to sleep many hours later.

Table: Types of Drugs* and their effect (intoxication) on the central nervous system (CNS)

Depressants	Effect	Duration (hours)
Decreased activity of CNS *Examples:* • Alcohol • Benzodiazepines (eg Valium, Serapax, Rohypnol, Temazepam) • Opiates (Heroin, Morphine, Codeine, Methadone) • Inhalants – can also be Hallucinogenic (solvents, Aerosols, Petrol, Glue) • Marajuana (also an Hallucinogen) • Barbiturates	*lower doses:* Relaxation, feeling of well-being Feel less inhibited *Moderate doses:* • More intense moods: • Excitable • Europhoria or depressed • Quick to anger • Impulsiveness • Loss of co-ordination • Slowed reflexes and reaction time • Impaired attention *Higher doses:* • Slurring of speech • Unsteady on feet • Light-headeed • Drowsiness • Blurred vision • Nausea/vomiting • Unconsciousness and possible death if overdose	• Tranquillisers 12-24 • Opiates 4-24 • Cannabis -5 • Inhalants/Solvents -6 • Alcohol (dose related, liver metabolises on drink per hour)

Stimulants	Effect	Duration (hours)
Increased activity of CNS *Examples:* Amphetamines (Speed) Caffeine Cocaine MDMA (Ecstacy)	• Arousal, alertness • Excitability • Boost in energy • Hyperactivity • Talkative • Europhoria • Feel less inhibited • Overconfidence • Insomnia • Dehydration (potenially fatal) • Anxiety, agitation • Delusions/hallucinations	• Caffeine 2-24 • Speed 4-8 • Cocaine - 4 • Ecstasy - 6

Hallucinogens	Effect	Duration (hours)
Disturbance of perception Examples: PCP LSD (Acid or Trips) Marijuana (also Depressant) Inhalants (also Depressant) Mescaline (Peyote Cactus) Psilocybin (Magic Mushrooms) MDA (Adam)	• Impaired co-ordination • impaired attention • Visual and auditory hallucinations • Altered time perception • May be religious-like experiences • Anxiety from 'bad trips'	Most varieties 6 - 12

+ This is a slightly modified version of a table, prepared by the author, included in the ARRTS student handbook, *Provide Alcohol atidlor Other Drug Withdrawal Services* (2001).

* Nicotine is not included, as most users have high tolerance, and intoxication is not readily
discernible

** Some depressant drugs tend to produce such deep relaxation that exaggerated sociability, impulsivity and aggression are not likely (e.g. tranquillisers, opiates).

Exercise: Case studies - Intoxication

Task

Consider two different drug-taking intoxication scenarios in terms of low-risk and high-risk factors.

Analyse the cases using the drug, individual and environment model.

***Read* the following**

Nick

Nick has been , drinking and smoking marijuana with friends at his flat while having a jam session on guitars. Nick is generally prettv relaxed about things and chooses friends who also like to chill-out, with no dramas. Nick is a third year University student with little cash, so he has limited supplies of alcohol and other drugs on hand. He prefers to take his time using drugs, spacing his supplies out over many hours, so that he doesn't totally lose control. He has an assignment to complete the next day, and is determined to graduate this year. However, some of his best mates (who are employed) like to get drunk/stoned quickly and bring ample supplies, which they insist Nick share with them. His friends will crash at his place for the evening. A neighbour, who has repeatedly complained about the noise from the jam sessions, has threatened to "take the law into his own hands "

Heather

On the other hand, Nick's younger sister Heather (in Year 12) is a far more extraverted (a 'pocket-sized' dynamo), risk-taking, person than her brother and likes nothing better than to 'rave' always in the presence of two of her best friends. She has had a cocktail of drugs (she is not even too sure what, and how much she has had, and has swallowed pills, injected speed and drunk some alcohol). She is now roaming the streets with her friends (with some other people who have latched onto their group, including a guy who seems determined to 'hit on' Heather despite her apparent lack of interest), looking for further action in the early hours of the morning. Heather hates 'mindless authority' interfering with her good times and an argument with a bouncer is ensuing. Heather always carries a mobile phone with her with her parents and Nick's phone numbers on 'speed dial'. Her parents also stress to her to take a taxi (with a friend) whenever there is a problem and they will pick up the lab on the night. She does understand the reasons for their concern.

Fill in th efollowing tables (an example has been given to get you going).

Don't worry if you are not sure which category (Individual, setting, **drug)** a particular issue **fits** neatly into. There is overlap between the categories, and the important thing is that you have recognised relevant factors. Also feel free to use your imagination to speculate on any other factors that might be relevant that weren't mentioned in the scenarios. Not every box has to have an entry (although this should be possible in Nick's scenario, as it is a mix of low and high-n'sk factors).

Nick's experience of intoxication:

Factors relating to the:	Low-risk factors	High-risk factors
Setting	At home (no driving, machinery, water sports, crowds)	
Individual (Nick)		
Drug(s)		

Heather's experience

Factors relating to the:	**Low-risk factors**	**High-risk factors**
Setting	Sticks with her close friends	
Individual (Heather)		
Drug(s)		

It is not hard to determine who is at greater risk of experiencing intoxicated related problems, and we can easily imagine what other disasters await Heather and her friends as the night unfolds. And yet, despite the differences **in** temperament and drug use, a switch of drug-taking environments could make a large difference. If Nick and his mates were jamming at the beach and someone got the idea of a moonlight swim, a fatal tragedy is lurking. Conversely, if Heather and friends had gone straight to Nick's place from the rave (in a taxi), the risks for her may have been greatly diminished.

Sample responses.
Nick's experience of intoxication:

Factors relating to the:	Low-risk factors	High-risk factors
Setting	At home (no driving machinery, water-sports, crowds) Close group of friends will help each other in a crisis	Volatile situation with neighbour could lead to an argument/violence Sharing of drugs (use gravitates towards heavier users)
Individual (Nick)	Prefers relaxed time with no drama Dedicated to his studies	Easily swayed by his mates into heavier use.
Drug(s)	No intravenous use Supplies limited to those brought along to Nick's flat	Mixing drugs – potentiating effects Not able to keep count/estimate of drinks or joints with pooling of drugs

Heather's experience of intoxication

Factors relating to the:	Low-risk factors	High-risk factors
Setting	Sticks with her close friends Has ready phone contact with family Has plans of escape (parent endorsed taxi)	Wandering the streets (unpredictable events) Interacting with strangers Risk of sexual assault Volatile interaction with bouncer
Individual (Heather)	Acknowledges there are risks associated with drug use	Youjng, still naïve drug user with low tolerance female with small build Seeks high arousal and stimulation Fiesty, anti-authority stance
Drug(s)		Unpredictable drug interactions (dose and type of drugs unknown) Prolonmged intoxication with extreme moods Overdose potential Possibly shared a needle

SUMMARY

- **Intoxicated behaviour can vary greatly in a person from one episode to another, even when about the same amount of alcohol and/or other drugs have been used.**

- **Intoxicated behaviour is influenced by:**

    - The type of drug taken (eg nicotine vs heroin)

    - The amount of drug (1 0OmI of wine vs 1,50OmI of wine)

    - The time taken to consume the drug (1 0 minutes vs 1 0 hours)

    - The user's tolerance (eg regular cannabis smoker and naive smoker)

    - The user's gender, size and amount of muscle

    - Other psychoactive drugs in the person's bloodstream

    - The mood or attitude of the user (eg angry vs calm, confident vs fearful)

    - The user's expectation of the drug effect (eg expecting powerful drug effect vs expecting modest drug effect)

    - The setting or environment in which the drug was consumed (eg wild party vs quiet night at home)

Topic 4: **Assessing the immediate needs of the young intoxicated person**

Key Issues to be covered in this topic:

- Which drug(s) have been used? Physical and mental health issues
- Recognising and responding to overdose Potential for self-harm and harm to others
- Detecting any other relevant factors
- What does the client want?

This section includes the essential assessment and monitoring requirements for a successful harm reduction intervention with an intoxicated young person. Additionally, it advocates an attempt to assess and respond to the individual wishes of the young person where appropriate.

4.1 Which drug(s) have been used?

An attempt should be made to determine which drugs have been used immediately prior to the episode of intoxication, the amount of drugs used, how recently they were taken, and the route of administration. This will help you to estimate the chances of adverse drug interactions, the potential for overdose, and therefore whether medical attention is urgently required (as indicated earlier in this module). It will also provide an estimate of the expected duration of the intoxicated state, and thus help you to plan your strategy for managing the situation. Route of administration will also provide some clues as to likely peak intoxication. If drugs have been intravenously injected, the effects are more immediate and peak intoxication can be expected to occur sooner rather than later. Oral ingestion of drugs results in slower absorption into the bloodstream, and so alerts you to the possibility that intoxication has yet to peak. Route of administration will also **raise** the issue of potentially life-threatening harm (HIV and Hepatitis C) from the sharing of needles, with implications for management post-intoxication (and withdrawal management 1 if necessary).

So, if the young person can understand your questions and are they are coherent and cooperative, then conduct a recent drug taking assessment by inquiring as to:

- **Which drugs were used**

- **Time since last dose**

- **Quantity and purity of drugs.** Greater purity than usual is a high-n'sk factor for overdose, even in experienced, long-term, drug users.

- **Is this typical use?** If it is typical, the client may have high tolerance that minimises the impact of intoxication. However, typical heavy use may also indicate dependency on the drugs, and therefore drug-seeking and withdrawal may commence after sobering-up. If the binge was unusually heavy, then you can expect extreme intoxication and greater potential for overdose (due to low tolerance).

- **Is the** level **of intoxication consistent with the drugs used and the time since last use?** Use may have been under-reported, so err on the side of caution and assume greater quantities were taken). An inconsistent level of intoxication will also raise your suspicions that some other medical or psychological crisis is occurring (see below).

If the young person is not able to respond to your questions, then:

- **Have they still got drugs or empty alcohol containers in their possession** that allows you to estimate possible drug interactions?

- **If a friend or family member is present (and not highly intoxicated),** they may be able to help with your inquiries (attempt to get **client** consent to talk to others, although in a life-threatening situation. any source of information should be accessed).

- **Seek medical assistance immediately**

SUMMARY

- Determining which drugs have been used immediately prior to the episode of intoxication, the amount of drugs used, how recently they were taken and the route of administration, will help you to estimate the chances adverse drug interactions, the potential for overdose and therefore whether medical attention is urgently required.

4.2 Physical and mental health issues

It is important that you recognise the signs of potential health complications or mental health problems.

Assessment of possible physical and/or mental health issues is necessary to:

- **Establish likely problems and complications** (Including any physical or mental illness - is there any history of complications with this person?)

- **Make appropriate referrals or call for appropriate aid**

- **To predict the likely course and effects** of this episode of intoxication

- **To predict likely withdrawal**

You should not convey an overly clinical approach to young people, particularly when you are meeting them in an informal setting. But neither should you be so informal that they cannot distinguish you from any other member of the public. So:

· Clearly introduce yourself and the organisation you represent

· Explain simply and concisely what your role is

You need not necessarily conduct a full assessment yourself - if it is outside the area of your expertise you should call in a health professional with specialised skills. But certainly, the obvious signs of distress must be recognised and addressed immediately, and all workers having regular contact with intoxicated people should have basic first-aid skills.

Never assume from a person's appearance, social circle and usual drug using patterns that they are definitely intoxicated, even when they appear to be. An assumption of intoxication may be particularly likely in a heavy drug-using youth culture.

You may well be able to think of other medical conditions to add to this list. It is obviously critical to differentiate these conditions from intoxication, as they can be life threatening.

Intoxication can be *mimicked by:*

- Concussion
- A bleeding brain
- A brain tumour
- A stroke
- Lack of oxygen to the brain
- Dehydration
- Shock
- Diabetes
- Blood poisoning
- Urinary tract infection

It is also vitally important to detect whether a *mental health* problem may exist. It **is** a dangerous situation when it appears the client is experiencing when in fact the symptoms are the result of mental illness and are *mimicking* intoxication. The issue here is that the client may need urgent attention for psychiatric problems, and that attempting to manage their intoxication may not only delay their need for psychological and medical intervention, but also increase the client's level of distress and anxiety.

A difficult area is the distinction between a paranoid psychotic state that is due to mental illness, and paranoia that is due to excessive use of amphetamines (an amphetamine psychosis). On some occasions the correct diagnosis is made only after the client has not used amphetamines for several days. If the delusions continue, then it may be a schizophrenic-related episode. Whenever delusions are apparent, close medical supervision should be occurring.

When assessing **for** the possibility of a mental health **problem consider the** following:

Has the young person:

- been previously diagnosed as having any psychiatric condition
- seen a health professional for psychological issues
- been on medication for a psychiatric condition
- shown symptoms of depression, extreme anxiety, or psychotic thinking and behaviour during assessment
- family or friends who are concerned about their mental state?

The Child and Adolescent components of the National Survey of Mental Health and Well-being (Andrews et al., 1999) were documented **in** a report entitled 'The Mental Health of Young People in Australia' (Sawyer et al., 2000). The survey found that 19% of young people reported mental health problems, and among that group, a high rate of suicidal ideation and behaviour was also reported. Adolescents with self-reported mental health problems were much more likely to smoke cigarettes (54% as opposed to 11 % with no problems). They were also more likely to drink alcohol and use marijuana, as well as use painkillers for non-medicinal purposes (Sawyer et al., 2000).

The following table lists common symptoms of psychiatric conditions. You are not required to reach a firm diagnosis in the context of dealing with intoxication, but rather make sure that there is medical and/or psychological assessment of the client if these symptoms are in evidence. You should also know what your organisation's policy is for managing clients with mental health problems.

Symptoms of psychiatric conditions+

Condition	Symptoms*
Anxiety	Fearful, intensely worried, sense of dread, palpitations, sweating, shaking, shortness of breath, chest pain, dizziness, nausea, feelings of unreality (detached from oneself), panic
Depression	Feeling hopeless, worthless, sad, tearful, guilty, possibly imtable, loss of interest in usual activities, poor appetite (or overeating), difficulty sleeping or sleeping too much, low energy and slow movements (sometimes agitated), poor concentration, indecisive, *suicidal thoughts/plans.*
Mania	Decreased need for sleep, more talkative than usual, racing thoughts, inflated ideas of self-worth and abilities, unrealistic plans, increased energy, dramatic increase in goal-directed behaviour (either socially, at work or school, sexually), agitation, excessive pleasurable behaviour (e.g. buying sprees, gambling, investments, inappropriate sexual behaviour)
Psychotic behaviour (could be due to a schizophrenic type disorder, a brief psychotic disorder, or substance induced)	Delusions, hallucinations, disorganised speech and/or behaviour, inappropriate emotional responses, disorientated

+ This table, prepared by the author, was included in the ARRTS student handbook, *Pi.ovide Alcohol atidlop. Othet- Di-ug Withdp-awal Sep-vices, (200* 1).

* Not all symptoms need to be present to suspect that the person needs to be assessed for psychological and/or psychiatric intervention. These symptoms are based on those given in the American Psychological Association's DSM - IV-R, but without the full criteria (i.e. required number of symptoms over a designated interval) for diagnosis.

Exercise: Drugs that can produce symptoms of mental illness

Task

Using the table of mental illness symptoms, list the type of drugs (depressants, stimulants, hallucinogens) that can be associated with these conditions.

Symptoms of psychiatric conditions +

Condition	Symptoms*	
Anxiety	Fearful, intensely worried, sense of dread, palpitations, sweating, shaking, shortness of breath, chest pain, dizziness, nausea, feelings of unreality (detached from oneself), panic	
Depression	Feeling hopeless, worthless, sad, tearful, guilty, possibly irritable, loss of interest **in** usual **activities,** poor appetite (or overeating), difficulty sleeping or sleeping too much, low energy and slow movements (sometimes agitated), poor concentration, *indecisive, suicidal thoughts/plans*.	
Mania	Decreased need for sleep, more talkative than usual, racing thoughts, inflated ideas of self-worth and abilities, unrealistic plans, increased energy, dramatic increase **in** goal-directed behaviour (either socially, at work or school, sexually), agitation, excessive pleasurable behaviour (e.g. buying sprees, gambling, investments, inappropriate sexual behaviour)	
Psychotic behaviour (could be due to a schizophrenic type disorder, a brief psychotic disorder, or substance induced)	Delusions, hallucinations, disorganised speech and/or behaviour, inappropriate emotional responses, disorientated	

Symptoms of psychiatric conditions +

Condition	Symptoms*	Type **of drugs that can produce these symptoms**
Anxiety	Fearful, intensely worried, sweating, shaking, shortness of breath, chest pain, dizziness, nausea, feelings of unreality (detached from oneself), panic	Stimulants Hallucinogens Tranquillisers
Depression	Feeling hopeless, worthless, sad, tearful, guilty, possibly irritable, loss of interest in usual activities, poor appetite (or overeating), difficulty sleeping or sleeping too much, low energy and slow movements (sometimes agitated), poor concentration, indecisive, *suicidal thoughts/plans*.	Depressants – particularly excessive alcohol Rebound effects (coming down) from stimulants
Mania	Decreased need for sleep, more talkative than usual, racing thoughts, inflated ideas of self-worth and abilities, unrealistic plans, increased energy, dramatic increase in goal-directed behaviour (either socially, at work or school, sexually), agitation, excessive pleasurable behaviour (e.g. buying sprees, gambling, investments, inappropriate sexual behaviour)	Stimulants To a lesser extent from an alcohol binge
Psychotic behaviour (could be due to a schizophrenic type disorder, a brief psychotic disorder, or substance induced)	Delusions, hallucinations disorganised speech and/or behaviour, inappropriate emotional responses, disorientated	Hallucinogens

+ This table, prepared by the author, was included in the ARRTS student handbook, *Provide Alcohol and other Drug Withdrawal Services, (2001).*

* Not all symptoms need to be present to suspect that the person needs to be assessed for psychological and/or psychiatric intervention. These symptoms are based on those given in the American Psychological Association's DSM - IV-R, but without the full criteria (i.e. required number of symptoms over a designated interval) for diagnosis.

Because of large individual differences and setting influences on intoxication, most of these 'symptoms' can occasionally be found in states of intoxication and post intoxication ('coming down') across depressant, stimulant and hallucinogenic drugs. Did you also conclude that there is much overlap, reinforcing the need to be carefully attuned to the possibility of mental health problems in intoxicated young people?

4.3 Recognising and responding to overdose

Very severe intoxication that is life threatening is known as an overdose (i.e. the dose is more than the persons acquired tolerance for the drug).

Overdose is very severe intoxication that is life threatening. (ie. The dose 's more than the persons acquired tolerance for the drug).

Overdose always requires prompt medical intervention. Many people are familiar with overdose in the context of drugs other than alcohol, but do not think that alcohol alone can lead to overdose (traditionally referred to as 'alcohol poisoning'). Binge drinking frequently leads to overdose, and this claims a number of, (mostly) young, lives each year. A grossly intoxicated person may not respond to questioning in a coherent manner, so your observational skills must be highly developed. You will closely observe:

Signs of physical distress and overdose such as:

- Fever, high body temperature
- Excessive sweating
- Shallow and/or rapid breathing
- Pulse rapid, irregular or slow (<60 or > 1 20 per minute)
- Vomiting/diarrhoea
- Lack of coordination and balance
- Altered and rapidly changing mental state - hallucinations, panic, deep depression, disorientation
- Increasingly agitated
- Severe headaches
- Severe internal pains, such as chest or abdominal pain
- Incoherent speech
- Cannot follow any instructions
- Convulsions, jerky eye movements
- Decreasing level of consciousness, not responding to stimuli Unconscious

Try to determine which drugs have been taken, and amount taken. Remember, a combination of drugs (particularly different types of sedatives such as alcohol and heroin or tranquillisers) can be more dangerous than any one of the drugs taken alone.

This is certainly not a module in medical intervention with intoxicated persons (referral to medical care is expected whenever there are complications), but anyone working **in** an area where they will encounter overdose, must be able to:

- Stay with and observe the client
- Talk calmly and reassuringly to the young, person to reduce anxiety. Anxiety and panic exacerbates the symptoms of overdose
- Place in coma/lateral position and check that the airway is unobstructed
- Observe vital signs (temperature, pulse, respiration)
- Apply CPR (cardiopulmonary resuscitation)
- Arrange for transfer to hospital by ambulance ASAP

- Supply medics with all relevant information that you have been able to ascertain about the client and their drug use (Novak, 1989)

SUMMARY

.Overdose is life threatening and requires early detection and emergency intervention.

Frontline workers should:

- know some of the signs of physical distress and overdose
- know and be able to apply appropriate responses to young people experiencing an overdose (see Novak , 1989)

4.4 Potential for self-harm and harm to others

The risk of self-harm and suicide is higher amongst young people who are highly intoxicated (NHMRC, 2001). You must try to establish whether the client is at risk of immediate harm to themselves or others. Try to determine whether there have been:

- recent attempts at harm to self and/or others
- expressed intentions to self harm or harm others
- possession of, or access to, weapons

All suicide threats must be taken seriously. While contemplating suicide, an adolescent's perception of reality is often quite different from actual reality

If there is an elevated risk of harm, constant supervision is required. Always take the threat of suicide or self-harm seriously. Do not make the mistake of thinking that talk of self-harm is Just idle, intoxicated, babble. On occasions, attempts at self-harm are also preceded by repetitive fixation on a theme of concern (e.g. "Why did they do that to me?").

If a young person seems agitated, depressed or desperate about their situation, they may be at risk of self-harm without declaring their intentions. Intoxication can greatly exacerbate extreme feelings, impair reasoning and judgement, and distort reality. This can lead to impulsive, spur-of-the-moment decisions to harm oneself

Do not be afraid of raising the issue of self-harm with the young person. Ask if they are thinking of hurting themselves and whether they have made any plans for self-harm. Take every precaution to protect the young person from self-harm by notifying other workers and relevant authorities. Potential self-harm or harm to others Justifies breaking confidentiality.

Again, it cannot be stressed enough that you should know your organisation's policy and procedural guidelines for dealing with situations of potential self-harm and follow them closely.

4.5 Detecting any other relevant factors

In addition to a careful physical and mental assessment, there is a need to observe *anything in general* that may influence the course of intoxication and the likelihood of engaging the young person in harm-reduction interventions. Some examples are given below:

- **What is their general condition like?**
- **Can you gauge from their clothing, hygiene and general appearance** whether they are likely to be weak and malnourished?
- **Are they living on the street?**
- **What other high-risk activities are they engaging in?**
- **What is the client thinking, feeling and planning?**
- **If you, or another worker, have had previous contact** with a particular young person, is their behaviour or presentation very different on this occasion?

4.6 What does the young person want?

Part of addressing the needs of a young person is also to determine what it is that they *want* to happen. On occasions, what they want may be so potentially harmful (e.g., more drugs to use immediately) that you may have to override their desires in order to protect them and/or others. But at other times their wants, even **if** quite unconventional, can be accommodated. This will greatly increase the chances that they will engage **in** treatment after sobering-up or in the future. Some examples of a young person's immediate concerns could be:

- Making contact with friends or family members
- A request for a specific staff member already known to them
- Accommodation needs
- Attention to pressing financial or legal issues
- To watch a video or listen to/play music
- Close support and supervision
- To be left alone (with supervision from a distance)

If possible, also talk to the young person about their reasons for having a binge. This may well elicit vital information that will help you to understand their needs and to help plan an intervention with their permission. For example, you may **find** out that the binge was a response to an argument with their parents, and that family therapy may be desirable.

Topic 5 Managing intoxication: a harm reduction emphasis

Key Issues to be covered in this topic:

- Harm reduction response to intoxication
- The sobering-up environment :
- Managing aggressive and disruptive behaviour
- Debriefing critical incidents

5.1 Harm reduction response to intoxication

The focus of this module **is** on an appropriate harm-reduction response to a single episode of intoxication. It is not about counselling or giving advice to an intoxicated young person (usually impossible) or attempting to divert them from future drug use and into treatment. As desirable as longer-term change may be, decisions to change drug use patterns are unlikely to be made when intoxicated, and attempts to do so will more than likely alienate you from the young person. A response to intoxication needs to be concentrated on, and confined to, the period of intoxication. Safely aiding the young person through to sobering-up is a major achievement in itself. However, if you successfully engage with the young person, you may well be able to move her or him towards low-risk drug using practices. After a person has sobered-up, they may welcome counselling by a staff member and/or a referral to treatment.

A goal of harm-reduction arises from a health perspective on intoxication. In recent years in Australia, there have been moves to decriminalise drunkenness. Despite the fact that some intoxication is the result of using illegal drugs, intoxication is not itself a criminal offence. Legalistic, or punitive, responses to drunkenness will only serve to scare young intoxicated people away from receiving help, 'ust when they are perhaps most in need of aid. Imprisoning intoxicated people carries a great risk that they will engage in self-harm.

5.2 The sobering-up environment

A sobering-up environment must be skillfully designed with harm-reduction 'n mind. Young people can sober-up in a variety of settings, depending on supports available and the potential for problems to arise. Whichever setting is chosen, close supervision is required, even when the person seems to be sleeping soundly and deeply. Death from obstructed airways after vomiting when asleep or unconscious is totally preventable. Sobering-up settings may include:

- Their home, or a friend's home in cases of mild intoxication and low risk
- Sobering up services
- Shelters/Accommodation services
- Hospitals

- Police stations
- Sickness bays in the workplace

Exercise: Features of a sobering up environment

Task

List what you consider would be the essential features of a sobering-up environment that would minimise the risk of harm.

Again, as for other exercises, you may have generated some points not included in our list, or you may have expressed some of the points differently. Any point is relevant if it relates to a safe environment that allows close monitoring of the intoxicated young person. Check with the module facilitator if you are unsure about any differences **in** your responses and the list provided in the text.

Did your list contain some of the following features?

- **Medical attention readily available**
- **Kind, accepting, non-judgemental staff** with a who treat young people with dignity and respect
- **Staff that are sensitive to cultural issues and minority groups**
- **Aversive stimulation reduced to a minimum**
- **Interpersonal contact restricted to a few trusted people**
- **Aggressive persons separated from other clients**
- **A safe and clean area,** minimising the chance of accident or infection
- **An attractive, calming, setting with a range of low-risk activities available to involve the young person** (e.g. music, TV, computers, magazines, etc)
- **Uncluttered and free of sharp or breakable objects to minimise the risk of accident, injury and deliberate harm to self or others**
- **No ready access to elevated areas** from which the client call fall or jump
- **Adequately lit at night** - night lights may need to be used as the dark may trigger fear, anxiety and hallucinations
- **Alarms and on-call back-up service for staff**

SUMMARY

- A sobering-up environment must be skilfully designed with harm reduction in mind.
- Whatever the setting, close supervision is required, even if the *young person seems to be sleeping soundly and deeply*.

5.3 Managing aggressive and disruptive behaviour

Managing an episode of aggressive or disruptive behaviour can be stressful for all concerned, particularly when a young person is intoxicated. The challenge for the worker is to minimise the danger for themselves and the young person (and on occasions for others who are present) and at the same time, maximise the opportunity for a positive outcome.

Firstly, always attempt to establish rapport with the young person. No matter how extreme the intoxicated behaviour, it may quickly subside if the client feels that you pose no threat and that you have their concerns as your priority. Be sensitive to what it is the person is trying to say to you, even if it is largely incoherent. When talking to the young person:

Recognise early signs of aggression such as:

- agitation and intense frustration
- fearfulness
- clenched fists
- invasion of your personal space
- 'eyeballing'
- banging/pushing furniture
- facial muscle tension, furrowed brow, tight and quivering lips.

By seeing the potential for aggression, you may be able to take steps to prevent it

- **Be calm and speak slowly and clearly** (but no need to speak loudly, unless there is background noise), and avoid a patronising tone
- **Do not invade 'personal space'** (the actual physical distance that we all need between ourselves and others in order to feel comfortable, especially with strangers), unless you are applying first aid or you already have a close and trusting relationship with the young person. It **is** very easy to feel threatened and to misinterpret situations when intoxicated
- **Keep other clients from becoming involved**
- **Ensure that You have Your exit strategy determined** in case you need to protect yourself
- **Have appropriate amounts of eye contact.** In everyday communications we do not naturally maintain intense and prolonged eye-to-eye contact (unless newly 'in love'!). In some cultures, prolonged eye contact from strangers **is** perceived as a threatening gesture.
- **Short and simple, to-the-point, communications.** No long-winded explanations. Concentration spans are short when intoxicated, and memory is impaired.
- **Be patient, and repeat information where necessary**

- **Personalise your communications.** Be on a first name basis and try to place information **in** a context with which the young person is familiar. Acknowledge their feelings and needs, and try to satisfy any appropriate desires the young person may have.

- **Don't confront an intoxicated person.** Nobody likes to be confronted at the best of times. Confrontation and intoxication is a volatile mix.

- **Call for help from other staff members**

- **Call the police if the situation is beyond your control**

All these points may seem self-evident. However, when under stress, it **is** not uncommon for health and welfare workers to do and say things that exacerbate tension and aggression, particularly when we take insults personally, or attempt to be authoritarian with young people.

General defusion strategies

Some knowledge of general defusion skills may also be helpful.

Defusion strategies can include:

- When violence is threatened, stop what you have been doing and ACTIVELY LISTEN. Now is not a time for problem solving, reframing, or pointing out irrational thinking.

- Use calm, pacifying language

- Use "I" messages regarding your concern about the potential for someone getting hurt and your need to prevent that.

- Use the young person's name when talking or using active listening responses.

- Model calmness in your voice and movements - deep breathe if you are becoming anxious.

- Reflect feeling and content of what the young person is saying - paraphrasing

- Avoid excessive questioning

- Use self-disclosure "I messages" and inclusive language "we" not ... you"

- Think out loud: "It seems like everyone needs some space right now. Maybe we all could use some time out."

- Attempt to distract the individual if s/he menaces toward another. Consider standing up and saying the individual's name in a loud voice

- Talk to the most upset person first

- Give easy to follow instructions (when appropriate) - step by step

- Take a step back - creating distance between yourself and the young person, so that you are not trapping them

- Be aware of your body language - use non-threatening gestures make eye contact
- Take any other young people away from the situation if you think it is safe to leave the individual
- If the situation has extreme potential for immediate danger or violence to another young person, use an "I" messages to immediately send that young person from the incident

Leave if you assess that your presence is escalating the individual or if you believe the situation will improve if you do so.

Although this will not be an everyday occurrence, there may be times when a situation involving an intoxicated young person escalates to violence.

You must know your organisation's guidelines for dealing with intoxicated people, and follow them to the letter. If there is anything in the policy and procedure that you disagree with, attempt to sort that out with management before a crisis occurs.

Exercise: Assessment event: Organisational guidelines on dealing with intoxicated people

Task

Obtain a copy of your organisation's guidelines **on** *dealing with intoxicated people in a crisis. (If you are not currently working for an organisation, then approach your nearest alcohol and drug service and obtain this information).*
In your response you may wish to consider the following questions..

- What existing systems are in place **in** your agency? Is everyone aware of these?
- How can you get appropriate assistance? eg. speed dial to police, contact numbers are displayed, emergency button, speed dial to ambulance
- Have you established working relationships with other key agency workers eg. mental health teams, police?
- Do you have an understanding of the reasons for aggressive behaviour occurring and the different forms it may take?
- If a young person is demonstrating a tendency towards aggressive behaviour what contingency plans are in place?
- Do you have an up-to-date first aid certificate?

I. Select3-4poititsthatyouthinkarei,italiizthecontextofy,ourpai-ticularrole and comment briefly, on them.

2. Identify 1-2 issues that you believe require clarification (or inclusion if they *are absent) in the context of your particular role and comment briefly on them.*

OR

If your organisation has yet to develop such guidelines, then develop a draft set of 6 key points relevant to your role.

5.4 Debriefing critical incidents

Of course, after an event there are certain tasks that need to be done:

- **Seek medical attention** (this may have been done in the course of managing the intoxication crisis)
- **Contact Manager/Supervisor and debrief**
- **Log actions, Incident reports etc** (you need to ensure that you cover all aspects of the incident, what was said, done etc)
- Legal **Measures** - follow up any legal issues
- **Debrief with young person** (if possible and appropriate) and others who witnessed the event (separately)
- **Look at own work practices to see what may have contributed to the episode.**

(You may also have your own policies regarding the handling of violent or aggressive behaviour as well as those for managing intoxicated people).

The debriefing process can also be a helpful learning opportunity us to identify what we did well and what we could have done differently. Analysing incident sheets and sharing experiences with others can be a useful team learning strategy if the process is structured and solution focussed. An analysis of our skills, values and self-management skills can help us to identify and address skills or knowledge that we would like to develop further.

Remember: Although often distressing for those involved, a crisis situation can be used for revision of policy and procedure to improve responses to similar situations in the future. Having said that, it is always best to think of ways of managing potentially difficult situations such as intoxicated, and or aggressive young. people PRIOR to that situation arising.

Note on Debriefing:

High rates of bumout in workers in this area can be expected unless they debrief with fellow workers and/or supervisors after critical incidents.

Note: Infection control

There is a high risk of contracting an infectious blood borne disease given the high rate of injury associated with intoxication. Precautions (inoculations, protective gear, isolating the infectious person) must be taken in accordance with policy and procedures.

Topic 6: Beyond intoxication - harm reduction initiatives and brief interventions

Key Issues to be covered in this topic:

- Motivational Interviewing

6.1 Motivational Interviewing

Any encounter with a young Intoxicated person is, potentially, an opportunity to engage in a brief intervention (once they have started to sober-up). Opportunistic harm reduction strategies can have a considerable impact, if not on one occasion, over several encounters with a young person.

The priority for intervention is to reduce the harm associated with drug use. This can be achieved by a combination of.

- Gentle advice
- Instructional materials on low-risk practices
- Access to needle exchange programs
- Self-help manuals
- A brief motivational interview
- Invitations to call at a variety of treatment agencies and support services

A brief motivational interview can be conducted in any location with a young person. The central strategy of motivational interviewing is to get the client to weigh up the *pros and cons* of their drug use and related harm (Miller & Rollnick, 1991). It is important not to focus solely on problems, but also to realistically acknowledge that there are benefits of drug use. The tension between the advantages and disadvantages of drug use means that most users are highly *ambivalent* about their use. They may still find intoxication a highly pleasurable experience, but often will acknowledge that they also suffer 'heaps'. By exploring the discrepancy between the benefits and costs, and between where the young person would like to be in life and where they are currently, you may heighten awareness in the client of the need for change. In motivational interviewing, a client is *never confronted*, as this engenders a defensive response and may serve to entrench excessive drug use. If *resistance* is met, back off and reframe your questions and discussion so that the client does not feel threatened. On occasions, it is best not to pursue the subject of change, as the young person is indicating that now is not the time for a motivational interview.

Change is **often** a gradual **process,** a **spiral** out towards long-term change where typically there are the proverbial two steps forward followed by one step back (Prochaska, DiClemente & Norcross, 1997). Moving a client from being a precontemplator of change through to contemplating change is a significant shift, and from contemplation to taking the first steps in moderating or giving-up drug use **is** cause for celebration. Reinforce decisions for change, *encourage* the young person at every opportunity, and help foster their *self-belief* that they can change their drug use.

Examples of motivational interviewing questions suitable for young drug users are:

- **What do you enjoy about using drugs?**
- **What does it feel like to be 'stoned'/'smashed'/'high'/'out-of-it'/'off-yourface'/'pissed'/'ripped'/'wasted'/'bombed'? (be comfortable with, and use, the same terms as the young person, but substitute another colloquial term for any slang that you find objectionable)**
- **What worries you about your drug use?**
- **What worries you about being intoxicated?**
- **Where do you** see **Yourself in a few years time if You keep using/drinking heavily?**
- **What changes would you like?**

Whenever a young person opens up on any topic, get them to elaborate as much as possi 'ble. The more they hear themselves speak about the need for change, the more likely it is they will take the first steps. So, ask:

- **Can you tell me more about that?**
- In what way does that concern you?
- How do you think you may start to cut-down on Your use of drugs?

You may have encountered 'motivational interviewing' within the context of the 'process of change' in another unit in your studies. A brief summary is included here to remind you that it has universal application. Anytime, anywhere, that a young person is able to concentrate for a few minutes (and that may even include when they are still slightly, but only slichtly, intoxicated), take the opportunity for at least a brief han-n-reduction intervention. This will ideally include a motivational interview (even if only a brief version).

Exercise: Assessment event - Case Study

Task

1. *Describe (600-1000 words) an example of extreme intoxication in a young person, either based on your experience of dealing with intoxication or from talking to a worker who has had such experience.*

2. *List and comment briefly on important assessment issues in this case.*

3. *List and comment briefly on appropriate (and inappropriate if relevant) management strategies used.*

4. *Which harm reduction strategies were employed with the young person* > ?

5. *"at other harm reduction strategies could* **hare** *been employed?*

Selection of a case

Any case is suitable for use in this exercise. It may not necessarily have been a very successful intervention. It may have proven to be difficult to manage. Few harm reduction strategies may have been used. Alternatively, it may be a case where intervention was successful and many harm reduction strategies were adopted. There is scope in the last part of the exercise to cover a broad range of harm reduction strategies that could have, hypothetically, been used with this young person. Think broadly and creatively (perhaps even have a 'brainstorm' with a fellow worker) when dome, the second part of this exercise.

You will not be assessed on how well the case was managed, but on how thorough you are in dealing with relevant issues and generating possible interventions. This exercise ']I reveal your depth of understanding across all the issues addressed in this module.

Topic 7: Summary

It is hoped that you now have a sense that intoxication provides a challenge, an opportunity to help guide a young person into **low-risk** outcomes, and in doing so introduce them to the notion of harm-reduction and eventual moderation of their drug use. The experience of intoxication goes right to the core of our reasons for using drugs, and therefore provides a useful context for decisions to change.

On the other hand, intoxication requires skilled, on-the-ground, management. It is probable that more young Australians are harmed in intoxication-related incidents than by any other cause. Intervening successfully with intoxicated young people requires a firm, considered approach in which you follow recommended procedures to the letter, at the same time as showing that you understand the concerns of the young person and will try to meet **their** needs.

After completion of this module you will be able to provide services to young people who are intoxicated within organisational policy and procedures, and specifically:

- Identify factors associated with the individual user, the setting of drug use and the drug(s) used that are contributing to an episode of intoxication
- Obtain detailed information on recent drug use where possible
- Identify signs of intoxication for different pharmacological categories of drugs
- Identify signs of overdose and know appropriate first aid responses
- Identify signs of physical and mental distress and make appropriate responses (both Erst aid and establishing contact with qualified personnel)
- Assess the risk of self-harm and take preventive measures
- Take appropriate measures to defuse aggression and/or disruptive behaviour
- List appropriate communication skills with intoxicated young people
- Assess the immediate needs and wishes of the young person and respond wherever possible
- Describe a low-risk sobering-up environment
- Explain the need for close super-vision and medical attention for those who are grossly intoxicated

If you have any concerns about meeting these learning outcomes you should speak with your facilitator.

Remember that if you want to know more about Working with Young People who are Intoxicated, a range of references were provided in the beginning of this module.

You could also contact your local health service that deals with drug and alcohol issues for further information.