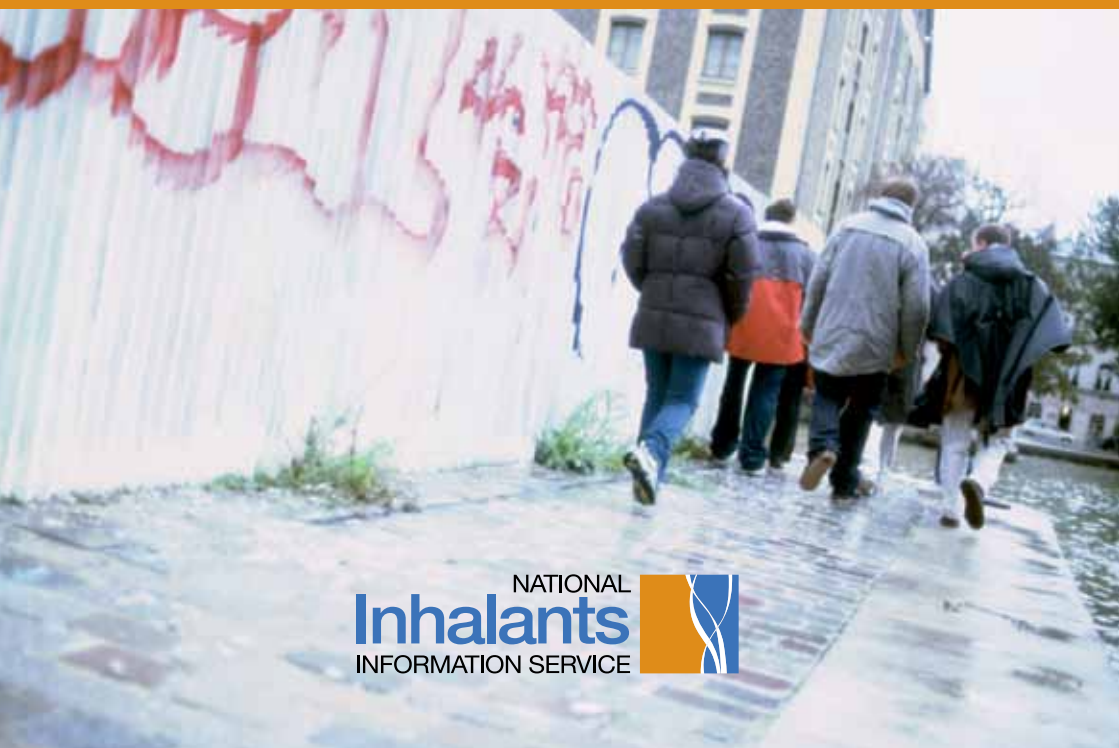


Developing an Inhalant Misuse Community Strategy

By Sarah MacLean,
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& Centre for Health and Society,
University of Melbourne

Second edition



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**A message from the President of the
Alcohol and other Drugs Council of Australia,
Professor Robin Room**

Inhalant misuse is one of many alcohol and drug problems that occur within Australia. Inhalants are easily obtained and are predominantly misused by young people and by people who are socially or economically marginalised. Inhalant misuse can result in impairment and death and can be very distressing for families and communities.

This publication aims to assist local communities to address inhalant misuse. The first edition of the booklet has been used by communities and community workers across Australia. This second edition contains updated advice; I recommend it to you and commend Sarah MacLean for her work.



Professor Robin Room

Inhalant misuse (IM) involves breathing vapours from intoxicating substances into the lungs. Products subject to IM, such as petrol, spray paints and glues, are often widely available. IM is also commonly known as volatile substance misuse, solvent misuse or by names that refer to the products involved, such as 'petrol sniffing'. IM is a difficult problem for any community to tackle. It tends to occur cyclically, that is it becomes highly visible for periods of time and then dies down, often to re-emerge at a later date. Many people may find the thought or sight of people using products such as spray paint or petrol to become intoxicated very distressing. This can make a calm and rational community response difficult to achieve. Local community responses can be labour-intensive to implement. Nonetheless, there have been many community campaigns that appear to have been successful in reducing IM. A community development approach to IM can also build local capacity and equip people with skills to deal with other alcohol and drug (AOD) related problems.



The purpose of this booklet is to provide information to support professional staff and people for whom English is a first language. A booklet developed by the Aboriginal Drug and Alcohol Council of South Australia may be more useful for Indigenous community members (Aboriginal Drug and Alcohol Council (SA) Inc, 2000).

A review of interventions addressing IM (d'Abbs & MacLean, 2008) argues that successful community strategies have involved two elements, each of which is discussed in more detail below.

- A. They have widespread support from community agencies and community members, with participants working cooperatively together. Particularly where Indigenous communities are involved, support from influential community members is critical. Developing and fostering community cohesion and agreement on proposed action is therefore a critical part of any IM strategy.
- B. They are multi-pronged, including a range of individual interventions. Zinberg (1984) has argued that drug and alcohol use is influenced by three factors: pharmacological-toxicological properties of the substances concerned; attributes of individual users, such as their personalities, physical health, and expectations associated with drug use; and characteristics of the environment in which use takes place, such as availability of the substance, legal sanctions or opportunities for other activity. Where possible, strategies should include interventions addressing each of these factors.

Before making a decision to initiate a community campaign it is important to be sure that the problem is sufficiently widespread to warrant collective action. Where only a few individuals are involved it is probably sensible to attempt to engage them in alcohol and other drug services and/or alternative activities as a first measure. This is because any community campaign carries the risk of attracting media attention that may publicise and hence encourage IM and at the same time exacerbate community fear and anxiety.

This document shows firstly how a community strategy might be developed. Next, case studies illustrating action taken in five localities in the Northern Territory, Queensland and Western Australia are provided. It concludes with a list of useful resources and references.

A. Generating and maintaining community support for a strategy

The development of a cohesive and well-supported strategy involves a number of steps:

1. Form an action group or steering committee

Groups are generally initiated by a small number of concerned people. In some instances responses to IM have been developed with the support of local governments as part of drug action plans. On other occasions they have been initiated by health and welfare agencies or family groups. Successful action groups have included a range of representatives of agencies working with or in contact with people who misuse inhalants. This may include local government, welfare agencies and protective authorities, police, schools, youth agencies, drug treatment centres, sporting, recreation or religious groups and retailers of inhalants. Families and users themselves should also be invited to participate. If IM is occurring among members of a particular cultural group it is essential that agencies, workers or representatives from the community concerned be involved.

2. Decide how to deal with media interest

One of the key difficulties in addressing IM is its newsworthiness and the possibility that media coverage of your efforts might serve to publicise the potential to use household products as intoxicants. Action groups should familiarise themselves with available recommendations for reporting IM and disseminate these to local media outlets when it appears that media interest in the issue is likely. The National Inhalants Information Service (NIIS) website has information about other guidelines that might be useful (www.inhalantsinfo.org.au/media.php).

Recommendations for media reporting of IM (Commonwealth of Australia Senate Select Committee on Volatile Substance Fumes, 1985, paraphrase of p. v)

- Products subject to misuse and methods for inhaling products should not be described or shown in pictures.
- Reports of inhalant abuse deaths should be factual rather than sensational.
- Articles should depict the causes of IM as complex and acknowledge that people's reasons for using inhalants are diverse.
- Stories should include a local contact telephone number for further information and support.

Recommendations for community agencies to reduce the negative impact of sensational stories about IM (Drug and Alcohol Office, 2008)

- Appoint a media liaison person to manage media requests.
- Ensure all staff are aware of the agency's media liaison procedures.
- Provide the media with the above Senate Select Committee guidelines.
- Develop a positive relationship with editors and reporters.
- Provide human interest, good news stories about young people and agency work.
- If necessary prepare a media statement which should be approved by the agency's management prior to release.
- Provide training in media management including: how to provide a well-balanced, informative interview; how to get your message out there; and how to write effective media statements and responses to enquiries.



3. Identify and describe the problem and why it occurs

As it is often hidden, IM is difficult to measure or count. There are various ways to identify and describe the problem, and the approach taken will depend on time and resources available. Past efforts have included networking, community forums or meetings, consultation with professional staff and other affected people, or more formal needs assessment including surveys and interviews with users and their families. A useful list of questions to answer in determining the local profile of IM is included in a report prepared by the Queensland Government Commission for Children and Young People (2002).

Once the extent and patterns of IM have been described (how many people are involved, who are they, where are they accessing products and where does IM occur) reasons for the practice should also be considered. These may include boredom, lack of alternative activities, family breakdown or other problems, easy availability of IM products or changes in supply of other drugs. Other problems such as lack of knowledge about IM within the community, in schools or among professional staff may also be identified.

4. Consider what has worked in other community campaigns against IM

It is worthwhile considering what interventions other communities have implemented. Effective community campaigns in urban and rural locations have included, for instance: research and consultation to determine specific features of IM within the local area, improvement of communication mechanisms between local service providers (for instance, police and welfare agencies), community education to increase parental and worker sensitivity to the issue, retailer education, targeting IM 'hotspots' through outreach visits, and efforts to engage inhalant users in AOD treatment and activity-based programs such as drama or sporting opportunities.

For community-based interventions in remote Indigenous communities it is essential that interventions proposed by the community complement those of families and vice versa. Support is required from agencies such as police, clinics and schools, as well as Indigenous groups and individuals. Supply reduction, through substituting conventional fuels with Comgas and then Opal, has been a particularly successful strategy in remote Australian Indigenous communities, with one study finding that petrol sniffing had reduced by 70% in communities where Opal had been introduced as a substitute for conventional petrol (d'Abbs & Shaw, 2008).

While many young people try inhalants, ongoing IM tends to occur among people who are marginalised in some way from the mainstream community. They may live in an area of poverty, may come from conflicted or abusive families, may have mental health problems, may have left school early or may be a member of a disadvantaged ethnic or Indigenous community (research from the US suggests that socio-economic disadvantage rather than cultural factors accounts for most IM among Indigenous people) (National Institute on Drug Abuse, 2005). Some responses entail sending influential inhalant misusers away from their community or locality. This may be to protect other people from commencing IM, to give respite to both the user and community, or to provide the user with treatment or new experiences. In general, however, strategies should avoid any measure that will exacerbate the sense of exclusion from family and community already experienced by many people who misuse inhalants (d'Abbs & MacLean, 2008). Interventions therefore should be designed to positively engage and care for people involved.

5. Identify the community's resources and strengths

This stage of the process entails determining what existing resources in the community can be used in the strategy. For instance if an outreach team is available, youth workers could visit young people at identified locations where IM occurs and speak with them about what might help them. An already-established recreation program might be adapted to provide alternative activities for people using inhalants.

AOD services provide individual and family programs that may assist people who use inhalants and referral of users and their families should always be considered. While the evidence for IM treatment is not rigorous, available studies show some support for cognitive behavioural therapy (CBT), family therapy, activity-based programs and Indigenous-led residential approaches (MacLean, Cameron, Harney, & Lee, 2012; Ögel & Coskun, 2011).

Recommendations for health workers are available in the *Consensus-based clinical practice guideline for the management of volatile substance use in Australia* (National Health and Medical Research Council, 2011).

A community group is unlikely to be able to address all the identified reasons for IM on its own. Some community responses have entailed lobbying governments to fund programs (such as recreation or employment schemes) or to bring in new legislative responses.

6. Clarify and prioritise objectives and interventions

Programs are best developed to suit specific contexts and therefore cannot be exactly reproduced elsewhere. Shaw and colleagues (2004, 64) stress that the best way to determine the most appropriate approach for any particular community is through a process of consultation: 'it is the community itself that works this out most efficiently'.

Objectives should address the problems identified at step 3. For instance, if spray paints are being accessed through a particular retail outlet it will be important to work with that supplier; if young people are using largely because they have little else to do, developing recreation opportunities will be a critical part of the response. Based on an understanding of the problem, a list of objectives should be developed that the steering or advisory group believes is likely to impact on IM.

Objectives should be linked with interventions; the actions that will be taken to implement changes identified as objectives. Where possible, interventions should be aimed at influencing the three domains of drug use identified above: individuals and groups who misuse inhalants, the nature and availability of the substances misused and the physical and social environments in which inhalants are misused. Suggestions about how to do this are provided in the next section of this document.

7. Implement the interventions

Ongoing communication is recommended between all partners involved in implementing the interventions. Protocols which clearly state each participant's role and responsibly will help parties to be clear on who is doing what (Commission for Children and Young People, 2002). Unforeseen difficulties may arise during implementation. For instance, managing media interest in IM and related responses may become important to ensure that alarmist coverage does not inadvertently serve to publicise the possibility of IM or add to the excitement associated with it.

8. Modify the strategy in light of information gathered and plan an ongoing response

Very few campaigns will eradicate IM completely or for all time and efforts should not be judged on this criterion. Campaigns should be monitored to determine whether individual elements are working. They should also be flexible and open to modification if new ideas or opportunities emerge. It is really important that strategies be documented and evaluated so that other people can learn from what you have done.

Campaigns are dependent on the energy of working group participants and project officers. Difficulty in securing funding, alongside the often episodic nature of IM, means that it is hard to implement ongoing preventive strategies when IM declines in the community concerned, and people's attention will likely turn to other issues. Some action groups have broadened their brief to addressing other problematic drug use or risky behaviour. Ongoing monitoring of IM is required to ensure a speedy and coordinated response if it re-emerges within the community.

B. Developing a multi-pronged strategy

Many successful strategies against IM have entailed interventions that work on three factors identified by Zinberg (1984); the users and their families, the nature of the drug, and the environments in which drugs are used. For example, if you take away the drug (e.g. by substituting Opal fuel for conventional petrol) without considering the environment in which IM takes place (e.g. alternative activities and opportunities for young people) then it is likely they will look for another drug. Similarly, drug treatment programs focus on reducing demand for IM on the part of users and may provide temporary respite for families and even the community, but they do not, in themselves, address any of the problems in the community that contributed to IM in the first place. No individual intervention will effect change in all of Zinberg's drug use factors and this is why a multi-pronged approach is required.

Examples of IM interventions targeting each of Zinberg's three substance use factors are provided below. The table on page 12 shows how various interventions may be put together as a strategy.



Examples of interventions reducing availability of or altering the properties of inhalants

- substituting Opal for conventional petrol
- encouraging retailers to stock 'low-toxicity' spray paints
- in urban or rural areas where inhalants are accessed from retail outlets, measures to restrict the availability of products subject to IM have been effective. For retailer information kits see the Target Groups - Retailers section of the NIIS website (www.inhalantsinfo.org.au/retailers.php)
- encouraging contractors conducting work in communities to use low-toxicity products and store any product that may be intoxicating securely.

Examples of interventions targeting users and their families

- outreach to 'hotspots' where people are using inhalants
- individual counselling and family therapies
- residential rehabilitation and outstation treatment centres
- harm reduction education
- drug education for users and families.

Examples of interventions altering the environments in which IM occurs

- providing youth and recreation programs that offer attractive alternatives - programs need to be easy to access and exciting in order to offer a credible alternative to IM and should be open to all disengaged young people
- providing alternative activity through training and employment opportunities
- working with schools to help young people stay engaged
- establishing community by-laws against IM
- establishing places of safety for people who are intoxicated
- providing education for professional staff dealing with users of inhalants.

There are other ways to think about implementing a multi-pronged approach. Mosey (2000) has suggested that a range of strategies should be implemented as part of any one campaign, including both 'sticks' (disincentives against IM) and 'carrots' (positive reinforcement for engaging in other activities).

Example of a multi-pronged community action strategy

Identified problems and reasons for IM	Objective	Interventions		
		targeting users and their families	targeting nature or availability of inhalants	targeting the environment where IM occurs
Young people have nothing to do	Provide accessible alternative activities	Outreach workers to talk with individual users to identify preferred activities and barriers to accessing programs; Outreach workers encourage young people using inhalants to access a local drop in centre and to engage with alcohol and other drug treatment services		Approach local drop in centre to negotiate how people who use inhalants might be included in activities, and establish protocols for dealing with intoxication on premises
Family conflict forces young people out of home in the evenings	Make homes safer for young people	Ask the local community health centre to offer support for families where IM is a problem; Involve protective services if appropriate		Lobby governments for funding for respite and alternative accommodation options for young people
People are stealing paints from a retailer	Reduce easy access to paints and other IM products		Explain sale of products legislation to retailers or notify police if a breach has occurred; Lobby retailers to stock 'low-toxicity' paints	
Media attention has lent a sense of excitement and drama to IM	Encourage media to report responsibly on IM through disseminating IM media reporting protocols			Approach local newspaper outlets to encourage them not to provide detailed reports on IM or sensational coverage

Create your own multi-pronged community action strategy

Identified problems and reasons for IM	Objective	Interventions		
		targeting users and their families	targeting nature or availability of inhalants	targeting the environment where IM occurs

Case studies

Each of the case studies described below demonstrates a multi-pronged approach involving a range of community representatives.

Warlpiri Youth Development Aboriginal Corporation (WYDAC)

The WYDAC was formerly known as the Mt Theo-Yuendumu Substance Misuse Program. It is based in the Central Australian community of Yuendumu, which has for many years been active in addressing petrol sniffing and other forms of substance misuse. Supported by the substitution of petrol with Comgas and then Opal, these interventions have enabled Yuendumu to dramatically reduce levels of petrol sniffing among its young people (for more information visit www.mttheo.org/home/wydac/about/). This success has enabled WYDAC to focus on promoting youth development rather than simply preventing and responding to substance use. WYDAC has now extended beyond Yuendumu to other Walpiri speaking communities at Willowra, Lajamanu and Nyirrpi and is now part of a comprehensive program of care across Warlpiri country.

WYDAC has three components. The first of these is the Mt Theo Outstation where young people are sent to spend time away from the community for cultural respite and rehabilitation. Second, various programs are available in Yuendumu to prevent substance misuse and offer opportunities for youth development. Among these is the 'Jaru Pirjirdi Youth Development Project', established in 2003. The program's name translates to 'strong voices' and it endeavours to help people aged 16-25 find a meaningful activity and opportunities to discuss their concerns and visions for the future. Other programs in Yuendumu include a mechanics training workshop, swimming pool and a counselling service. The third component of WYDAC involves youth development programs at the communities of Willowra, Lajamanu and Nyirrpi.

Cairns Inhalant Action Group

In early 2002 the Cairns Inhalant Action Group (CIAG) was convened by Wuchopperen Health Service, an Aboriginal and Torres Strait Islander community-controlled health service in Cairns, in response to an upsurge in IM. Participants included the Cairns City Council, Queensland Police, non-government and government agencies. A Substance Misuse Worker was employed for four years at Wuchopperen until September 2006 through a grant from the Alcohol, Education and Rehabilitation Foundation. The CIAG met monthly. Measures adopted included:

- working with retailers to restrict product supply – through letters, visits, resource development and distribution of pamphlets
- staff development – including assisting the local council's development of protocols for dealing with street intoxication, a referral flow chart and running education workshops, and discussions on the development of a residential rehabilitation facility for remote-area youth
- interagency case management of known users
- development of an information card and other resources
- conducting needs assessments among service providers and users and monitoring changes in IM prevalence in order to further develop the group's strategies
- educating communities and families about responding to IM, through development of a Streetwork Outreach Program with a focus on building capacity of families advocacy to government to improve service responses for people who use inhalants (Robertson, 2007).

Detailed project achievements have been documented (Robertson, 2007). IM prevalence in Cairns reduced during the program's operation. At July 2007 the CIAG had reduced its meetings to twice yearly with a commitment to convene more often if necessary.

The East Kimberley Volatile Substance Use Working Group

The East Kimberley Volatile Substance Use Working Group was established in 2007 to address petrol sniffing and other volatile substance use in the region. Coordinated by the Department of Families, Housing Community Services and Indigenous Affairs (FaHCSIA), the Working Group includes representatives from Commonwealth, State and Local governments; Aboriginal Community Councils; Aboriginal Community Controlled Organisations and local alcohol and other drug and youth service providers.

The Working Group has developed a comprehensive plan with a broad range of supply, demand and harm reduction strategies with a specific focus on young people. Some of the strategies include:

- A volatile substance use (VSU) incident response protocol to ensure a rapid, coordinated response to VSU incidents. The protocol is an agreed response pathway for local services which also allows for the collection of data on VSU incidents to monitor trends and inform future responses. The development of the East Kimberley Youth Services Network which aims to increase young people's access to and engagement in a range of programs and activities. The Youth Services Network services nine communities and supports local Indigenous youth worker trainees and community capacity building to run ongoing youth activities.
- Region-specific resources for retailers and industry to raise awareness of the dangers of VSU and to provide information for local businesses and contractors about reducing access to volatile substances.
- Ongoing delivery of a range of targeted education programs to communities, families and service providers by a regional training coordinator. The training/information sessions educate on the effects and dangers of VSU and effective responsive and preventative strategies to address VSU.
- The Working Group works closely with communities in support of the roll out of Opal fuel across the region.

Similar Volatile Substance Use Working Groups also exist in the Goldfields and East Pilbara regions of Western Australia, coordinated by FaHCSIA and supported by the Drug and Alcohol Office of Western Australia.

AOD Indigenous Communities Project, Amity Community Services

A community based project was established at Amity Community Services in May 2006 to address VSU by Indigenous people in the Darwin area using a community development approach. The project's three objectives were:

1. To develop systems and processes that reduces supply of volatile substances and associated harms in the greater Darwin region;
2. increase the capacity of Indigenous communities, in the Darwin region, to reduce the harms and demands of alcohol, drugs and volatile substances;
3. increase the capacity of Amity and other community service providers, individually and collectively, to work with Indigenous communities.

Activities have included working with retailers to promote the responsible sale of volatile substances. This was done by providing retailers with on-site training and developing and disseminating a resource titled 'Guidelines for Responsible Sale of Solvents.' The program also supports Indigenous community initiatives that aim to promote healthier lifestyles, including working with groups established specifically for men, women and young people, supporting community governance capacity and working with communities to develop AOD action plans. Staff have also worked to increase the capacity of services to respond to VSU through provision of training for workers, establishment of a data management and communications system and improved cross service relationships. Resources for retailers, service providers and Indigenous communities developed through the project are available at www.amity.org.au/AOD-Indigenous/VSM-resources.shtml. The project was evaluated in 2011 (Entwistle, Entwistle, Piper, & Stothers, 2011).

Mount Isa Volatile Substance Misuse Action Group

Workers in the mining town of Mt Isa in Queensland noticed in early 2000 that the town's previously episodic incidence of IM had become more consistent. Young people's interest in IM was continually reactivated by alarmist media coverage of their activities (Polson & Chiauzzi, 2003). A meeting was convened by Mount Isa Police and the Department of Family Services to address the matter, which led to the establishment of a working group representing government, non-government and community members. The working group identified five areas for action:

1. Restricting supply through working with local retailers.
2. Training teachers, parents and other community members to recognise IM
3. developing protocols between police and the local hospital to ensure appropriate care for affected users.
4. Developing programs to assist young people in developing self esteem and resilience.
5. Establishing a 'Family Healing Program' to engage young people known to be chronic users. The program consisted of bush camps, life skills training, cultural teaching, counselling and family case management. Nine participants were involved in this program.

Eighteen months after this program began all male participants had stopped IM. Some of the young women continued to use inhalants, albeit only episodically (Polson & Chiauzzi, 2003).

Useful resources

Website

- The National Inhalants Information Service provides detailed and up to date information on IM in Australia. The NIIS website (www.inhalantsinfo.org.au) provides links to information for parents, teachers, alcohol and drug workers, police, community groups, young people and others. A database on the NIIS website lists over 800 items that you can request to have sent to you.

Community campaigns

- Booklet 3 in the Aboriginal Drug and Alcohol Council (ADAC) kit *Petrol sniffing and other solvents: a resource kit for Aboriginal communities* (Aboriginal Drug and Alcohol Council (SA) Inc, 2000) provides step-by-step advice on community development approaches to IM. A version of this resource has been produced for use in Victorian Indigenous communities (State Government of Victoria, 2003).
- A report prepared by the Queensland Government Commission for Children and Young People (Commission for Children and Young People, 2002) describes past community-based approaches and outlines a seven step process for communities wishing to develop a coordinated IM strategy.
- Chapter 6 of the monograph *Volatile substance misuse: a review of interventions* (d'Abbs & MacLean, 2008) describes community-based strategies addressing IM in remote Indigenous communities and in urban and rural locations.
- Further case studies of community action are available in Chapter 22 of the Victorian *Inquiry into the inhalation of volatile substances* (Parliament of Victoria Drugs and Crime Prevention Committee, 2002).

Working with retailers

- Several states and territories have produced resources for retailers of inhalants. A list of these can be found on the National Inhalants Information Service website (www.inhalantsinfo.org.au/retailers.php).

Treatment

- The Australian National Health and Medical Research Council have produced a *Consensus-based clinical practice guideline for the management of volatile substance use in Australia* (National Health and Medical Research Council, 2011). This document provides detailed recommendations for healthcare workers including doctors, nurses, Aboriginal health workers, Ngankari, alcohol and other drug workers and allied health professionals including mental health workers. It is available online from www.nhmrc.gov.au.

For information, counselling, referral and advice in your state or territory phone:

Australian Capital Territory

ACT Health Services: Alcohol & Other Drugs

24 hour help line
(02) 6207 9977

Northern Territory

Alcohol & Drug Information Service

24 hour help line
1800 131 350 (free call)

Alcohol and Other Drugs Program
(for information on the NT Volatile Substance Abuse Prevention Act and assistance developing VSA Management Plans)
(08) 8922 8430

South Australia

Alcohol & Drug Information Service

24 hour help line
1300 131 340 (free call)

Queensland

Alcohol & Drug Information Service

24 hour help line
1800 177 833 (free call)

New South Wales

Alcohol & Drug Information Service

24 hour help line
(02) 9361 8000 (Sydney)
1800 422 599 (regional free call)

Western Australia

Alcohol & Drug Information Service

24 hour service
(08) 9442 5000
1800 198 024 (Country free call)

Parent Drug Information service

24 hour service
(08) 9442 5050
1800 653 203 (Country free call)

Tasmania

Alcohol & Drug Information Service

24 hour help line
1800 811 994 (free call)

Victoria

DirectLine

24 hour help line
1800 888 236 (free call)



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Notes

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