Developing an Inhalant Misuse Community Strategy

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NATIONAL Inhalants INFORMATION SERVICE

ISBN 978-1-876837-14-3

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Acknowledgements
The National Inhalants Information Service (NIIS) is a result of funding made available through the Ministerial Council on Drug Strategy Cost Shared Funding Model.

Photographs on cover, page 5, and page 22: Patrick Sheandell O'Carroll/Photoalto.
Photograph on page 15: Sarah MacLean

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Inhalant misuse (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 many find the thought or sight of people using products such as 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 drug-related problems.

A review of interventions addressing IM (d'Abbs and 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.

This document shows firstly how a community strategy incorporating these elements might be developed. Next case studies illustrating action taken in four localities in the Northern Territory, Queensland and Victoria 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. Forming 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. Identifying and describing the problem and reasons for the problem

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.

3. Considering what has worked in other community campaigns against IM

It is worthwhile to consider what interventions other communities have implemented and some of the relevant literature. 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, and targeting IM 'hotspots' through outreach visits.

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.

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 new experiences or educational opportunities. 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 and MacLean 2008). Interventions therefore should be designed to positively engage and care for people involved.

4. Identifying 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.

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.

5. Clarifying and prioritising 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 2. 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.

6. Implementing 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.

7. Modifying the strategy in light of information gathered and ensuring 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 below shows how various interventions may be put together as a strategy.

Examples of interventions altering the properties of volatile substances

- Substituting Avgas or Opal for fuels containing greater proportions of intoxicants
- Where they are available, encouraging retailers to stock 'low-toxicity' products
- Although not strictly an intervention that alters properties of inhalants, 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 this website (www.inhalantsinfo.org.au).

Examples of interventions targeting users and their families

- Outreach to 'hotspots' where people are using inhalants
- 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
- 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	Drug treatment officers to work with individual users to identify preferred activities and barriers to accessing programs Outreach workers encourage young people involved in VSM to access a local drop in centre		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 VSM 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 retailer 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 VSM	Encourage media to report responsibly on VSM			Approach local newspaper outlets to encourage them not to provide detailed reports on VSM or sensational coverage

Case studies

(taken from d'Abbs and MacLean (2008)).

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

Mt Theo-Yuendumu Substance Misuse Program

The Central Australian community of Yuendumu has for many years been active in addressing petrol sniffing and other forms of substance misuse. Yuendumu's Substance Misuse Program has three components: the Mt Theo Outstation (where young people are sent to spend time away from the community) a Youth Diversion Program designed to generate regular activities for young people in the community as a preventive measure; and the 'Jaru Pirrjirdi Project', established in 2003 to provide after-care and vocational training for older young people. Supported by substitution of petrol for Comgas and then Opal, these interventions have enabled Yuendumu to dramatically reduce levels of petrol sniffing among its young people (see http://www.mttheo.org/home.htm).

The program at Mt Theo is widely recognised as a unique success story in preventing petrol sniffing. Mt Theo has been taking petrol sniffers since 1994, under the care of Peggy Brown and her late husband and now cares for users of other drugs and young offenders.

Jaru Pirrjirdi was established with the intention of addressing the problems underlying petrol sniffing and other forms of substance misuse. The program's name translates to 'strong voices' and endeavours to help people aged 17–30 find a meaningful activity and opportunities to discuss their concerns and visions for the future. An evaluation (Saggers and Stearne 2007) found that the program had significantly improved young people's sense of connectedness to community. Graduates of the program are now employed within a range of community programs and services including child care and community policing.

In 2000 a football league was established by the Mount Theo-Yuendumu Substance Misuse Aboriginal Corporation. Eight teams from Warlpiri and Anmatjerre communities were formed and games were played seven days a week. So much prestige was associated with playing these games that young men known to sniff petrol had to work hard to convince team mates and coaches that they were petrol-free in order to be allowed to participate (Campbell and Stojanovski 2001).

Sunshine Chroming Awareness Program

Sunshine is a disadvantaged western suburb of Melbourne. In response to community concern about young people chroming in public places, representatives from a range of local agencies met regularly to develop a response. The Sunshine Chroming Awareness Program operated for three years during 2000–2002 through the Salvation Army. It is described in detail by the Drugs and Parliamentary Committee (Parliament of Victoria Drugs and Crime Prevention Committee 2002).

A major focus of the program was on working with retailers to reduce supply of IM products. The project conducted research with school staff and young people to determine the extent of chroming and reasons for this form of drug use. Locations where chroming occurred regularly were identified. Welfare agencies made regular outreach visits to these places. On finding from their research that boredom was a major reason for chroming, the committee shifted its focus from drug use to look more broadly at improving young people's sense of engagement and connectedness within the local community (O'Grady 2001).

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. The coordination of this group has been the core business of Wuchopperen's Social and Emotional Health Service. 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 has met monthly for five years. 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; and
- advocacy to government to improve service responses for people who use volatile substances (Robertson 2007).

Detailed project achievements have been documented (Robertson 2007). Recurrent funding has been obtained from Office for Aboriginal and Torres Strait Islander Health to enhance the Drug and Alcohol Program and secure the future of the Streetwork Outreach Program. IM prevalence in Cairns reduced during the program's operation. As of July 2007 the CIAG had reduced its meetings to twice yearly with a commitment to convene more often if necessary.

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 (Polsen and 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:

- restricting supply through working with local retailers
- training teachers, parents and other community members to recognise IM
- developing protocols between police and the local hospital to ensure appropriate care for affected users
- developing programs to assist young people in developing self esteem and resilience;, and
- 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 volatile substances, albeit only episodically (Polsen and Chiauzzi 2003).

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

Useful resources

The following resources may be useful for those planning a community-level strategy:

1 One of the four volumes 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).

2 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.

3 Chapter 6 of the National Drug Strategy monograph *Volatile Substance Misuse: A Review of Interventions* (d'Abbs and 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)

4 *Guidelines for Community Action on Alcohol and Drug Issues* (Lang, Keenan et al. 1988) is a resource for community groups and local governments developed by Turning Point Alcohol and Drug Centre In Victoria. It provides step by step advice on developing local community responses to alcohol and drug issues.

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The full text of these articles and many more on inhalant misuse can be obtained from the National Inhalants Information Service www.inhalantsinfo.org.au

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