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INHALANT SUBSTANCE ABUSE IN THE NORTHERN TERRITORY

Young People and Family Support

This paper proposes that young people and family support is the most critical element of a strategic and coherent response to petrol sniffing.

Prevalence and Patterns of Use

Inhalant Substance Abuse (ISA) is not confined to Aboriginal communities, however petrol sniffing is a particularly harmful form of inhalant substance abuse, which is practiced primarily by young Aboriginal people. There has been significant research into petrol sniffing during the last 50 years, since its apparent introduction to Aboriginal communities during World War II. The research indicates that responses to petrol sniffing and other inhalant substance abuse lie in a coordinated and sustained effort by government departments and community agencies in partnership with affected communities.

ISA is most entrenched in the Western corridor of Central Australia and the Tri State region of South Australian, Western Australia and the Northern Territory. ISA is also practiced in the East Arnhem region and communities east of Katherine. The Barkly tablelands and communities west of Katherine are not affected.

In 2000, twenty-three remote aboriginal communities reported that ISA was a current or persistent problem. In the same year in remote central Australia, communities reported 350 sniffers; made up of 160-255 individuals spread over 14 communities and approximately 100 individuals in communities on the border of South Australia, Western Australia and the Northern Territory.

Sniffing was reported as an endemic practice in at least four communities, including Alice Springs town camp communities.

In the Top End, seven communities reported sniffing in numbers ranging from 10-30 sniffers each. Of this number four communities experienced persistent occasional outbreaks, generally coinciding with the Wet Season and school holiday periods.

A comparison with prevalence figures collated in April 2002 (see Attachment A) show an increase in ISA use in the region, particularly by older and more chronic users. In Central Australia, 15 communities reported petrol sniffing; made up of 320 individuals across the region. Of this number 130 were identified as chronic sniffers and 190 were identified as occasional sniffers.

In the Top End the sporadic nature of use appears to have become more entrenched over the last two years. ISA has spread to communities previously unaffected in both the East Arnhem and the Katherine region although numbers in individual communities remain small (less than

10). Notably, a small number of communities have eliminated petrol sniffing over the past two years through a concerted community approach to prevention.

A recent study of substance misuse in the Top End found that ISA is being practiced interchangeably with other substance use, notably cannabis, kava and alcohol and that past ISA use is a predictor of other substance use (Clough, Cairney, Maruff and Parker, unpublished paper). This finding suggests that in the Top End, ISA use is linked to the availability of substances in the community and that a community wide prevention approach which addresses risk and protective factors for substance misuse may be more effective than a singular focus on specific substances.

Costs of Inhalant Substance Abuse

Whilst the overall numbers of people who abuse inhalant substance is small compared to other substance related harm, particularly alcohol and tobacco, they have an effect on community life, far beyond their numbers. This effect is partly due to community damage, violence and ill health associated with ISA and partly from the sense of despair and shame experienced by families.

Petrol sniffing admissions to hospital are most frequently a result of burns and other injuries and mental and behavioural disorders. Over the last three years fourteen people were admitted to Territory hospitals for injuries sustained as a result of ISA. Petrol sniffing injuries are usually life threatening, requiring airlifting to acute specialist care in either Territory or interstate hospitals. Since 1999/00, two hundred and fourteen people were also admitted to Territory Hospitals for mental and behavioural disorders as a result of sniffing. Of this number 76% were from the Central Australian region.

Apart from the health effects on the user, ISA can lead to social disruption, family stress and aggressive and violent behaviour which can cause injury to users and others and can result in property damage, including community infrastructure. Often behaviour can transgress Aboriginal customary law and mainstream Australian law leading to contact with law enforcement and the justice system. This type of outcome exacts costs on the individual, families, communities and the Government. Because of these costs, issues around petrol sniffing are generally seen to require a health and/or law and order response.

Further costs arise from the care of severely disabled ex sniffers. One brain damaged ex sniffer requiring full time institutional care costs in the vicinity of $160,000 per year. Typically such people are physically fit, relatively young and can be expected to live for many years with little or no improvement in their condition. It is estimated that there are currently 15 disabled ex sniffers being cared for in Central Australia alone. It is anticipated that the number of ex sniffers in Central Australia requiring full time care by Government will increase to 60 in the next ten years. These figures exclude numbers being cared for by family members.

Funding for ISA in the Northern Territory

A census of Government funded programs to address ISA identified a total investment of $2.16 million. The Department of Health and Community Services contributes $400,000 and the Commonwealth Government, through the Department of Health and Ageing and the Office of Aboriginal and Torres Strait Islander Health contributes $1.8 million. (see Attachment B) The Commonwealth allocation includes the $1million committed by the Prime Minister in 2001 for prevention programs which was allocated to the Northern

Territory under the National Illicit Drug Strategy. In order to ensure speedy distribution to the community, the Northern Territory Government advocated that allocation be handled through Northern Territory Office of the Commonwealth Department of Health and Ageing, rather than the more lengthy and stringent contractual process involved in transferring the funds to the NT Government and thence allocated to the community. This allocation for petrol sniffing was specifically advocated for by the Department of Health and Community Services.

Although this figure may seem significant, the majority of funding is being applied for short term pilot programs (approximately $1.1million) and for outstation programs in remote areas of Central Australia and the cross border region of Western Australia and South Australia (approximately $550,000). These programs are not universally accessible because they are confined to particular communities and language groups.

Whilst alcohol and other drug treatment programs claim to be available for ISA affected people, these services are predominantly used by people who are affected by other substances. Government resources in remote communities, such as police, health and education professionals, may contribute to prevention and management of ISA, but it is outside the scope of their core business and actual contribution is difficult to verify.

Young people and petrol sniffing are also identified as a priority area for the Alcohol Education and Rehabilitation Foundation (AERF). The Foundation is incorporated as a charitable trust and has $15million to acquit Australia wide, over the next four years.

In reality, there have been very few initiatives and programs specifically for ISA. Program initiatives are further limited, because responsibility for ISA and resulting funding is not clearly aligned to a single Commonwealth or NT Government Department. The result is a lack of critical thinking and planning for ISA, poor coordination and monitoring, little emphasis on prevention, and programs that are funded on an ad-hoc and intermittent basis.

Responses by the Department of Health and Community Services have tended to focus on managing outbreaks or dealing with chronic use, an approach which is resource intensive and without prevention. In recognition of the limited emphasis on prevention, the Department of Health and Community Services strongly advocated that the $1million Commonwealth allocation be specifically targeted to broad based prevention activities in those regions most severely effected by ISA.

The reliance on pilot funds has been a well documented stumbling block to achieving sustainable outcomes to address ISA. Both individual communities and ISA consultation processes have consistantly identified that pilot funding has undermined community involvement and impact on ISA (d'Abbs and Maclean, 2000; Mosey, 1997; CARIHPC, 2001). It is evident that the expectation of communities to recruit staff, plan interventions and evaluate their effectiveness in a one-year period is unrealistic.

YOUTH (DEVELOPMENT) AND FAMILY SUPPORT STRATEGIES

Inhalant Substance Abuse strategies need to have a range of targets, many of which have nothing much to do with ISA specifically. Long term ISA interventions have wider impacts and are more cost effective when considered within the context of youth health and wellbeing and developed to ensure a holistic response to the psychosocial needs of young people rather

than that a singular emphasis on ISA and the young people who abuse petrol. Over the years there has been a great deal of documented evidence of the most effective approaches to preventing harm and promoting youth well being. In sum, the evidence suggests that long term success is dependent on:

- Engaging young people to be actively involved in identification, planning and implementation of services, strategies and activities;
- Community and family support and involvement;
- A range of strategies that are available for a different age, peer and interest groups;
- Involvement of capable and caring adults to mentor and support young people and who are sensitive to the needs of the Community, and
- Activities that are purposeful, exciting and educational to the target group (d'Abbs and Maclean, 2000; Roche A, 1999; Garrow and Mosey, 1999).

The value of prevention strategies such as employment and education projects, community events and activities and recreation programs are well recognised. However, implementation in Aboriginal communities has been limited by a reliance on a visitor led model of service delivery, an emphasis on sport and recreation rather than youth development, ad hoc funding and responsibility for funding not being clearly aligned to any single Department or program.

It can also be argued that ISA and other substance abuse is symptomatic of a lack of community cohesion, poor relationships with families, schools and other community institutions and limited opportunities for recreation, education and employment (d'Abbs and Maclean, 2000; Hommel, 1999; Spooner et al, 2001). The failure to effectively monitor and contain ISA represents a real failure to provide practical and safe alternatives for young people experiencing desperate problems. Solutions to ISA are therefore inextricably linked to improved social and economic outcomes for Aboriginal people.

Remote communities have limited support to develop health promotion and prevention activities and are often reliant on 'visitor led' approaches which exploit the cultural notion of 'community' rather than appropriately resource interventions (Office of Aboriginal and Torres Strait Islander Health, 1998). These responses are often applied without due regard for site specific family and community dynamics and a genuine acknowledgment of the capacity of Aboriginal people to generate effective problem solving ideas. Government priorities, which have been traditionally linked to outcome specific health or social issues, are not necessarily the priorities of Aboriginal families and communities.

Fundamentally, responses to and engagement with Aboriginal people need to be cognisant of the way that community problems are identified and addressed from within a cultural context. In practice this means that identified ISA strategies should be integrated within community structures and systems (such as the Community Development Employment Program) that are underpinned by social and cultural obligations. Situation specific programs developed on the basis of cultural obligation and existing community partnerships are more likely to be effective in the long term.

- **Funding for Youth Workers in Remote Communities**

Establish a Youth Development Program to resource and support communities to develop and sustain prevention activities and programs and to integrate health education and recreation services.

There are limited strategies to address risk and causal factors relevant to substance misuse in remote communities (CARIHPC, 2001), and the relatively small numbers of people who abuse inhalant substances make justification of significant resources difficult. However, programs promoting meaningful occupation for young people are few and have been undervalued as preventative strategy for substance abuse and anti social behaviour, even though they are particularly effective in preventing sniffing outbreaks, because they involve young people in community activity and they target the most commonly identified reason for inhalant substance abuse – boredom (d'Abbs and Maclean, 2000). It is important to note that many communities have small numbers of sniffers (less than 10), but that the practice can grow rapidly and spread from community to community (Mosey, 1997). It is therefore more cost efficient to resource youth strategies at a community level to order to prevent ISA, rather than as a result of it.

Community consultations have highlighted the value of skilled youth workers in the community as a means of preventing a range of harmful and problem behaviours (CARIHPC, 2001; Mosey, 1997; McFarland, 1999). Common themes drawn from research outcomes and advice to the Department include; funding youth workers to advocate and link young people to health, education, training and recreational services; build on school and after school activities including sport and recreation; link management, treatment and referral activities to health clinics and services; aid access to brokerage programs; seek involvement of ATSIC; link health promotion and health literacy to substance misuse programs; and involve Aboriginal Student Support and Parent Awareness (ASSPA) committees in each community.

Youth workers also have an important role to foster young people's involvement in activities and strategies and to develop a range of sustainable skills in the community. This could be achieved through training and employing young people from the community as part of the (Community Development Employment Program) CDEP to advise and support youth workers in individual communities. One innovative model being developed in the Central Australian region through the Commonwealth Department of Family and Children's Services uses funds allocated through the National Children's Services Program for community youth programs. 10 remote communities are block funded $65,000 to provide after school care to children and to develop youth activities and programs identified by the community. Additional support and resourcing is available through CDEP positions, Bachelor College funded sport and recreation apprenticeships and through childcare training provided through Waltja. Any proposal to fund youth workers in Central Australia should enhance this approach.

Employing resident staff is generally acknowledged to be a more amenable to developing effective working relationships than using visiting personnel. There are however costs to communities in accommodating and resourcing staff in remote

communities that needs to be factored into the funding allocation (CARIHPC, 2001). In 1999, the then Department of Sport and Recreation identified a total allocation of $80,000 per annum to meet the real costs of employment, accommodation and operating expenses for a trained recreation officer working in a remote community. Similar costings could apply to youth workers.

The Alcohol Education and Rehabilitation Foundation (AERF) in partnership with the NT Government is a possible funding source for this strategy for the next four years. A longer term commitment from Government would be required after four years to avoid a reliance on pilot funds.

- **Implement a Youth Grants Program**

Develop a process that includes young people from remote communities in prioritising, planning and implementing prevention projects.

Grants programs are available for remote communities and alcohol and other drug agencies to implement a range of substance misuse programs including education, treatment and care options. These programs are not targeted to young people and there are barriers to their application to broad prevention strategies such as employment, recreation or cultural events.

Ideally, a Youth Grants Program would allocate funds for youth activities and be distributed in a way that is relevant to young people, involves them in the decision making process and that develops skills in planning and evaluating projects. Grants should be necessarily be small to enable them to be manageable and well targeted. A variety of approaches could be explored in consultation with young people in communities, community leaders and regional staff. Possibilities include establishing regional or local committees of young community members, able to be supported by youth worker positions.

- **Training and Support for Youth Workers**

Enhance existing prevention strategies targeting young people and families through the provision of training and support opportunities.
A barrier to recruiting youth workers will be finding staff with the requisite skills in youth development strategies. Preliminary evaluation of the Commonwealth's Community Youth Program in Central Australia (that funds up to 10 youth workers in remote communities) has identified that there is a need for training and support skills to be provided to the range of community based youth workers employed through CDEP, apprenticed through Bachelor College, or funded by Commonwealth or Government Programs.

In Central Australia an opportunity exists to use the range of youth expertise in the non-government sector to build on the strengths of an existing (and well funded) Commonwealth program. A Youth Support and Training Program for Central Australia could be purchased through an accredited training provider able to service remote areas and should be factored into costings for youth workers.

- **Family Support Strategies**

Develop models to provide family support and resourcing in remote communities

Improve access to crisis intervention, counselling and respite services.

Regardless of the cultural context, families are a site for learning, growth and development. Strong family attachment, effective parenting skills and positive role modelling have consistently been identified as protective factors against drug misuse (Spooner, Mattick and Howard, 1996). Roche (1999) argues that a strong relationship with a caring capable adult (usually a parent) is the single most important protective influence on normal psychosocial development. This supports a focus on parents but also suggest that mentoring and extended family involvement should be fostered where parental involvement is not possible.

Aboriginal young people in remote communities were more influenced by family attitudes and modelling (to alcohol use) than peer influence, a finding that is contrary to findings for non indigenous adolescents (Jesson, 1999). Research evidence suggests that strong sanctions against ISA and clear boundaries on behaviour are an important deterrent to use beyond the experimental stage (d'Abbs and Maclean, 2000; the Victorian Alcohol and Drug Association, 2002). Family members often describe the grief and shame of ISA and resultant damage to their families and their communities (Osland, internal THS document) leading to recommendations for family counselling and crisis intervention to be more accessible to Aboriginal people in remote communities.

A recurrent theme in Government and independent reviews of ISA is the suggestion that Aboriginal people need to be more involved in family and cultural obligations to children. Across the NT support and counselling strategies for Aboriginal families are non existent or in embryonic (and often experimental) forms (CARIHPC, 2001). This is a gap in service delivery and research knowledge that warrants urgent investigation.

SPECIFIC INTERVENTIONS FOR INHALANT SUBSTANCE ABUSE

Specific responses to ISA have been the subject of a number of research and review processes conducted over the last four years, including the deliberations of the Chief Executive Officer level Interdepartmental Committee for the Prevention of Petrol Sniffing. Each review has included extensive community consultation, analysis of available funds and services and has identified a range of strategies and gaps in services. The following list is not inclusive of the full scope of ideas and interventions proposed. Instead, it identifies strategies which are relatively cost effective or cost neutral and which are : 1) consistent with a preventative focus, 2) facilitate community action to prevent worsening of current problems, and 3) improve interventions for people affected by inhalant substance abuse.

- **Small Grants Programs**

Promoting available small grants as a quick response to communities for planned prevention/early intervention activities in communities and streamlining the application and disbursement process.

Small grants programs provide a flexible funding pool to facilitate case management and prevention and target intervention activities in communities. This approach recognises the

expertise and innovation of communities themselves in identifying interventions most suited to their needs and de emphasises the focus on ISA. An effective grants program is reliant on a balance between accountability and quick disbursement as well as support to communities to develop and implement ideas. Funded youth workers would assist in accessing brokerage funds and aid project development and implementation.

A recent review of the brokerage program funded by the Commonwealth found that it is a useful adjunct to other community development strategies, but that its effectiveness is reliant on dedicated support to communities to plan and implement strategies.

The Alcohol and Other Drugs Program provides a total of $70,000 in brokerage funds to Alice Springs, the Katherine region and the East Arnhem region. Remote Area Alcohol Strategy (RAAS) funds are also available to fund substance misuse interventions in the Central Australian region. The decision to allocate funds through Departmental processes rather than through a community based organisation has created an inevitable hold up in distribution.

- **Monitoring**

Improving detection and understanding of episodic ISA patterns to facilitate early intervention and prevent escalation of core and chronic sniffers.

Identifying the actual numbers of people involved in ISA is problematic, especially as ISA patterns tend to fluctuate widely. Consistent systems for the early detection and monitoring of petrol sniffing outbreaks regionally and cross border are necessary to enable timely interventions and to assist with planning processes across Government.

Opportunities for improved ISA monitoring exist through the Remote Health Information and Community Care Information Systems to primary health care providers and monitoring through the Regional Framework Agreements being explored through the Department of Community Development, Sport and Cultural Affairs.

The Tri State working group/protocol between Health Departments across Northern Territory, South Australia and Western Australia has been established and is being auspiced by the Commonwealth. The intended of this forum are not currently being met because of delays in confirming meeting dates and a lack of clarity regarding the role of the Forum. The Department of Health and Community Services sees the role of the Forum to apply practical strategies to ISA in the region, including funds disbursement.

- **Coordination**

Committing to processes that improve coordination and are responsive to Aboriginal Community needs

Despite the establishment of two whole-of-government Coordination Committees in the last four years, responses to petrol sniffing remain fragmented. This problem is due, in part, to the low priority given to ISA by communities and by Government, the need to prioritise government resources (both funds and staff) for more immediate health and social problems and, the fact that responsibility for youth services is spread across many programs and Departments at a community level.

Experience suggest that high level committees do not improve coordination at the regional level. Useful coordination occurs at the regional and community level closer to the people concerned. The success of programs depends on whether they are aligned to community identified priorities. Coordination of health priorities through the introduction of The Primary Health Care Access Program and the Department of Community Development, Sport and Cultural Affairs, Indigenous Framework Agreements may enhance local planning efforts. These efforts need to be supported through: 1) Clear lines of accountability in Government for ISA; 2) Improved planning between Health, Education and the Office of Aboriginal Development; and 3) Responsive and accessible support to Aboriginal Communities as a Government priority.

- **Youth Link Up Strategy**

Advocating for evaluation and continued funding of the Youth Link Up Service in Central Australia.

The Youth Link Up Strategy was developed by the Central Australian Inhalant Substance Abuse Network (CAISAN) in Alice Springs as a specific strategy for ISA in Central Australia (See Attachment D).

The Youth Link Up Program has been funded $420,000 through the National Illicit Drug Strategy until June 2003. Pending evaluation of the pilot, continued funds need to be advocated for through the Commonwealth or met (or matched) with NT Government funding.

- **Information sharing on ISA**

Funding a biannual newsletter or regional workshop to share ideas and experiences relating to youth services and ISA strategies.

'One of the potential pitfalls of local, community-based action is the risk that each community will be forced to start from scratch, even when they are dealing with very similar problems' (Drug Policy Expert Committee 2000, 165). This highlights the need for a network that links people from remote communities to share information and personal contacts from peers as well as other non-community based expertise. The newsletter produced by Petrol Link Up some years ago proved to be a very effective vehicle for promoting information on ISA strategies and linking communities to support services. This concept could be reinstated by a non-government organisation funded to address ISA, or by regional government staff.

- **Training**

As a matter of urgency, improve the delivery and scope of training in ISA issues to all frontline workers

The Alcohol and Other Drugs Program has recently delivered training in the delivery of the Community Manual on Petrol Sniffing Interventions published by the Aboriginal Drug and Alcohol Council of South Australia, using a train the trainer approach.

The Alcohol and Other Drugs Program has provided $30,000 for additional petrol sniffing training. Services Development Division are developing the tender document.

Despite these initiatives the demand for training in ISA is high. Existing coordination and information networks could be auspiced to coordinate local training activities, including advice on how to manage intoxicated sniffers, develop community interventions and develop programs through outstation programs. For example CAISAN (Central Australian Inhalant Substance Abuse Network) recently arranged for petrol sniffing training to be conducted in Central Australia.

- **Respite and Care for People affected by ISA**

Advocate that Commonwealth funds being allocated to care options in Central Australia are not reduced overall.

The NT Government support existing outstations taking chronic and problematic sniffers by providing access to training, basic telecommunications and medical support if required.

Treatment approaches to ISA are not well documented. There is limited international or national information or evidence on effective treatment for people effected by volatile substances, including petrol.

There is a growing need for 'respite' services in Central Australia in response to the increasing use of inhalants. Whilst there is little community support for urban treatment facilities, there is some support for a range of respite and care options in strategically located remote areas and in Alice Springs. Urban based 'respite' services should provide specialist assessment and case planning and may be linked to new or existing outstation programs.

There are currently three Commonwealth funded outstation programs able to provide care and respite for ISA in the Central Australian region. The Commonwealth has recently reviewed these services. The Department of Health of Community Services is advocating that the pool of outstation funding in the Central Australian Region should not be diminished overall. The distribution of sniffing in Central Australia means that at least two additional outstation programs are warranted to meet the diversity of language and family groups in the region (CARIHPC, 2001). Brokerage funds may be able to meet this need if a suitable location and family or community auspices the project.

Existing outstations have benefited from support from DHCS clinic staff and the provision of first aid and telecommunications systems. This support should be continued and expanded to ensure medical assessment prior to transport to outstations, regular visits by medical staff as well as information and advice from the Challenging Behaviour Team on the management of particular individuals. Outstation staff should also have access to a range of training and support in drug issues.

- **Legislative Reform**

Monitor the outcome of the South Australian Diversion Model through the Tri-State Working Party for consideration in the Territory.

In the Northern Territory, Community Government Councils have the power to make by-laws in relation to the prevention and control of substance misuse under the *Local Government Act*. All by-laws need to be approved by the appropriate Minister and assented by Government

before they can be promulgated. This is a contentious issue and has not been supported by the NT Police because legal sanctions may discourage community action on ISA and enforcement may conflict with the recommendation of the Royal Commission into Aboriginal Deaths in Custody.

The South Australian Government, in partnership with the Anangu Pitjantjatjara (AP), have developed a model for compulsory referral to assessment, education and treatment for people apprehended petrol sniffing in the Pitjanjatjara Lands, using Illicit Drug Diversion Initiative funds. Petrol sniffing is not illegal under General Law in South Australia (or the Northern Territory). However, the AP has argued for petrol sniffing to be illegal under the *Pitjantjatjara Land Rights Act.*

The Department of Health and Community Services has recently finalised negotiations for NT model under the COAG Illicit Drug Diversion initiative. The effectiveness of the Pitjantjatjara Anangu law to coerce petrol sniffers into education and treatment is being monitored as a possible strategy for the NT, pending evaluation of the pilot year.

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