

The Australian Government, Department of the Prime Minister  
and Cabinet

# Dignity, Diversion, Home and Hope:

A Review of Interventions for Volatile Substance Misuse in  
Regional North Queensland.

Johanna Karam, Genevieve Sinclair and Lisa Rackstraw 2014

Youth Empowered Towards Independence

# Contents

<b><u>ABBREVIATIONS</u></b>	<b><u>1</u></b>
<b><u>ACKNOWLEDGEMENTS</u></b>	<b><u>1</u></b>
<b><u>INTRODUCTION</u></b>	<b><u>11</u></b>
<b><u>1 INTRODUCTION</u></b>	<b><u>1</u></b>
<b><u>BACKGROUND OF THE REPORT</u></b>	<b><u>3</u></b>
<b><u>2 VOLATILE SUBSTANCE MISUSE – AN OVERVIEW</u></b>	<b><u>4</u></b>
<b><u>3 CAIRNS VSM-CAP (COMMUNITY AND PRACTICE) PROJECT</u></b>	<b><u>5</u></b>
3.1 Youth Empowered Towards Independence (YETI) .....	5
<b><u>RESEARCH METHODOLOGY</u></b>	<b><u>7</u></b>
<b><u>4 METHODS</u></b>	<b><u>8</u></b>
4.1 Agency interviews.....	8
4.2 Interviews with Inhalant users .....	8
4.3 Inhalant Use Incidence Tracking .....	8
4.4 Literature review .....	9
4.5 Development of Practice Principles .....	9
<b><u>LIMITATIONS</u></b>	<b><u>10</u></b>
<b><u>5 LIMITATIONS OF THIS REPORT</u></b>	<b><u>11</u></b>
<b><u>LITERATURE, BACKGROUND AND CONTEXT</u></b>	<b><u>12</u></b>
<b><u>6 LITERATURE - BACKGROUND AND CONTEXT</u></b>	<b><u>13</u></b>
6.1 Legal Framework .....	13
6.2 National Strategies.....	14
6.2.1 National Drug Strategy .....	14
6.2.2 National Inhalant use Taskforce.....	14
6.2.3 Petrol Sniffing Strategy.....	15
6.2.4 National Clinical Guidelines .....	15
6.3 Queensland approach to inhalant use .....	16
6.4 Inhalant users - Who sniffs? .....	16
6.5 Prevalence and patterns of inhalant use .....	16
6.5.1 National Drug Strategy Household Survey' (NDSHS).....	17
6.5.2 Australian School Students Alcohol and Drug (ASSAD) survey .....	17
<b><u>7 OVERVIEW OF THE SERVICE SYSTEM AND SERVICE CONTEXT</u></b>	<b><u>18</u></b>
7.1 Cairns.....	18
7.1.1 YETI's work with vulnerable young people who engage in inhalant use.....	18
7.1.2 Youth Substance Misuse Service .....	19
7.1.3 Coordinated Care Panel for Vulnerable Young People .....	19
7.2 Mt Isa.....	20
7.2.1 Young People Ahead (YPA) .....	20
7.2.2 Mt Isa Substance Misuse Action Group - MISMAG .....	21

7.3	Rockhampton .....	21
7.3.1	Darumbal Community Youth Service.....	21
7.4	Townsville.....	21
7.4.1	Townsville Aboriginal and Islanders Health Service (TAIHS).....	21
7.4.2	The Youth Network NO Inc.....	21

**DISCUSSION OF RESULTS AND FINDINGS** **23**

**8 DISCUSSION OF RESULTS AND FINDINGS** **24**

8.1	Inhalant use patterns reported by practitioners .....	24
8.1.1	Inhalant use amongst Aboriginal and Torres Strait Islanders .....	24
8.1.2	Cairns.....	24
8.1.3	Mount Isa.....	26
8.1.4	Rockhampton .....	27
8.1.5	Townsville .....	27
8.2	Preferred inhalants .....	27
8.3	Inhaling methods.....	28
8.4	Reasons and correlates for inhalant use.....	29
8.5	Drug of Choice?.....	33
8.6	How does sniffing begin?.....	33
8.7	Young People’s Perceptions of the Effects of Sniffing .....	34
8.8	Issues faced by young people using inhalants .....	38
8.9	Stopping sniffing.....	40
8.10	Perceptions of Inhalant use.....	42

**9 INTERVENTIONS TO ADDRESS INHALANT USE** **44**

9.1	Demand Reduction .....	45
9.1.1	Awareness-based approaches .....	45
9.1.2	Counselling .....	46
9.1.3	Activity-Based Approaches .....	47
9.1.4	Family Support .....	48
9.1.5	Case Management.....	49
9.1.6	Residential Rehabilitation .....	50
9.2	Supply Reduction.....	51
9.3	Harm Reduction.....	53
9.3.1	Rest and Recovery Services.....	53
9.4	Local Action – Interagency cooperation .....	54
9.5	Specific Strategies/Frameworks for working with Aboriginal and Torres Strait Islander Young People .....	55
9.5.1	Return to Country and Culture .....	56
9.5.2	Services and Interventions in Remote Communities.....	59
9.6	Barriers to Addressing Inhalant use.....	60
9.6.1	Isolating VSM Services.....	61
9.6.2	Release from detention or residential rehabilitation .....	62
9.6.3	‘Captains’.....	62
9.7	Inhalant use and residential care .....	62

**PRACTICE PRINCIPLES** **64**

<b>10 YETI'S APPROACH – THE DEVELOPMENT OF PRACTICE PRINCIPLES</b>	<b>65</b>
10.1 The Interplay of Principles .....	65
10.2 Hope.....	65
10.3 Dignity .....	67
10.4 Home.....	68
10.5 Diversion.....	69
<b>CONCLUSION AND RECOMMENDATIONS</b>	<b>71</b>
<b>11 CONCLUSION</b>	<b>72</b>
<b>12 RECOMMENDATIONS</b>	<b>74</b>
<b>13 BIBLIOGRAPHY</b>	<b>76</b>
<b>APPENDICES</b>	<b>80</b>
Appendix 1 - Cairns Service Chart for Inhalant use.....	80
Appendix 2 – Interviewees.....	82
Appendix 3 - Agency Interview Questions .....	83
Appendix 4 - Guiding Questions for Interviews with Young People.....	84
Appendix 5 - Coordinated Care for Vulnerable Young People Model .....	85
Appendix 6 - Intake Form .....	86

## Abbreviations

Abbreviation	Description
ASSAD	Australian School Students Alcohol and Drug Survey
ATODS	Alcohol, Tobacco and Other Drug Services
CCYP	Coordinated Care for Vulnerable Young People
Child Safety	Queensland Department of Communities, Child Safety and Disability Services – Child Safety Services
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
IGCD	Intergovernmental Committee on Drugs
LPA	Local Partnership Agreement
MCDS	Ministerial Council on Drug Strategy
MISMAG	Mt Isa Substance Misuse Action Group
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NIAT	National Inhalant Use Taskforce
PCYC	Police-Citizens Youth Club
PSS	The Australian Government's Petrol Sniffing Strategy
TAIHS	Townsville Aboriginal and Islander Health Service
VSM	Volatile Substance Misuse
YETI	Youth Empowered Towards Independence
YPA	Youth People Ahead (Mt Isa)
YSMS	Youth Substance Misuse Service, Anglicare (Cairns)

## Acknowledgements

Thank you to the former Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs for providing funding to YETI to support our ongoing work with vulnerable young people and allowing us to take some time to explore the range of interventions which are being implemented to address volatile substance misuse. We would also like to extend our warmest gratitude to all those people working in the community sector in Regional Queensland who made the time to talk to with us about their experiences of working with young people. Finally, we would like to thank the young people at YETI who agreed to be interviewed for this research. Despite histories of immense trauma and sadness, these young people make us: reflect on the community we live in; provoke thoughtfulness and empathy; and bring joy, laughter and hope to those of us who share their lives.

# Introduction

# 1 Introduction

Volatile substance misuse (VSM) refers to the practice of deliberately inhaling volatile substances for the purposes of bringing about a change in mental state. Rates of inhalant misuse in Australia are difficult to determine but are generally thought to be increasing (Usher et al. 2005). Whilst there is a growing body of literature about VSM, many papers recognise the lack of empirical research investigating the effectiveness of interventions (Skellington Orr & Shewan 2006; Konghom et al. 2010; Ridenour et al. 2007; Ridenour 2005; NHMRC 2011b; S. J. MacLean & d'Abbs 2011; CCYP 2002; d'Abbs & S. J. MacLean 2008; S. MacLean et al. 2012; NIAT 2006). Research into inhalant use interventions in Australia is dominated by investigations of petrol sniffing and other inhalant use in remote Aboriginal and Torres Strait Island communities (e.g. Cairney and Dingwall 2010; James 2004; S. J. MacLean and d'Abbs 2002; Midford et al. 2010) or capital cities (e.g. Ogwang et al. 2006; Hancock 2004; Takagi et al. 2010).

In the regional cities of Central, North and Far North Queensland, young people from Aboriginal and Torres Strait Island backgrounds overwhelmingly dominate the statistics of inhalant users. This necessitates a targeted, culturally appropriate place based response, as reflected in Australia's National Drug Strategy Complementary Action Plan for Aboriginal and Torres Strait Islander peoples (Ministerial Council on Drug Strategy 2006). Outbreaks of inhalant use are often highly localised and spasmodic. The episodic nature of outbreaks means that often *place based* strategies and responses are the most appropriate (NIAT 2006). Criteria outlined by d'Abbs and MacLean (2008) included '*research and consultation to determine specific features of VSM within the local area*' as a specific component of any successful intervention. Examination of interventions and applicability within the regional context was therefore deemed warranted.

In April 2012, Cairns based government and non-government agencies participated in a one-day forum, facilitated by state-wide capacity building organisation Dovetail, to discuss regional VSM issues and develop an action plan to improve strategies and collaboration. Following the forum, Youth Empowered Towards Independence (YETI) received funding from the former Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to undertake a 12-month VSM-CAP (Community and Practice) project to help strengthen interventions and supports for inhalant users in the local area.

YETI is a not-for-profit non-government organisation that supports young people aged 10-25 years old residing in Cairns. YETI primarily works with vulnerable young people who are at risk of, or are already engaging in the use of illicit drugs and/or alcohol. Approximately 85 per cent of clients accessing services at YETI identify as Aboriginal or Torres Strait Islander. YETI recognises the importance of research and evaluation for strengthening collaborative interventions and the documentation of VSM practice responses, which are relevant to the local context. The funding ensured that research and documentation of best practice place-based interventions was able to occur.

Aims of the VSM-CAP Project included; *direct intervention* - to reduce harms associated with VSM in the Cairns region and to provide individual support to young people of Aboriginal and Torres Strait Islander background to reconnect with country, family and community, and; *coordination and collaboration* - to build community systems capacity in relation to responding to inhalant use in Cairns and Far North Queensland. This research constituted the third aim of the project.

This research examined current regional VSM interventions and collated qualitative and statistical data to develop *evidence-based locally responsive* interventions to address VSM. The subsequent report also documents a set of practice principles, which underpin YETI's VSM response within the local context. The project identifies, explores and reports some of the issues associated with inhalant use in regional centres of North and Far North Queensland. Most importantly, the report and the associated project give a voice to the 'grass roots' people at the 'coal face' of sniffing in regional Queensland. That is, the voices of young people engaging in VSM and local place based practitioners who work with them.

Issues associated with inhalant use in our communities are extremely complex and it is unlikely that a single agency or approach will adequately address all needs. The findings and subsequent recommendations, which are presented in this report, are therefore aimed to assist in outlining the suite of services, and collaborative processes that were found to more effectively address inhalant use within our community.

# Background of the report

## 2 Volatile Substance Misuse – an overview

Volatile Substance Misuse (VSM) refers to the deliberate self-administration by inhalation of solvents in order to achieve intoxication. Other terminology to describe VSM includes chroming, sniffing, inhalant use and inhalant abuse. The young people interviewed for this report use the term 'sniffing' and so this will be used interchangeably with 'VSM' and 'inhalant use' in this paper.

Rates of inhalant use are generally thought to be increasing in the developed world (Usher et al. 2005). As a rule, prevalence of use generally peaks during early adolescence (Drugs and Crime Prevention Committee 2002b) and the largest cohort of users is in the 12-14 year age group (White & Bariola 2012). Despite the serious potential health risks of inhalant use (see Ridenour 2005), historically it has generally not been viewed with the same level of concern as other forms of illicit substance use, except perhaps amongst the practitioners who support young people involved in VSM.

For a variety of reasons the growing body of literature fails to efficiently document the effectiveness of interventions, particularly relevant to the context of use in regional cities. Investigations of petrol sniffing and other inhalant use in remote Aboriginal and Torres Strait Island communities (e.g. Cairney and Dingwall 2010; James 2004; S. J. MacLean and d'Abbs 2002; Midford et al. 2010) or capital cities (e.g. Ogowang et al. 2006; Hancock 2004; Takagi et al. 2010) dominates the research in Australia. This is also true for Queensland where there are various reports addressing inhalant use in inner city Brisbane (e.g. Hancock 2004; Ogowang et al. 2006; Butt 2004; Cheverton et al. 2003).

A review of studies into VSM published between 1980 and 2009 was unable to find any randomized controlled trials and studies generally had low evidentiary levels (S. J. MacLean 2012). Some literature providing guidance for clinical management of VSM does exist, however there are often conclusions warning of poor outcomes when compared to the management of other substances (d'Abbs & S. J. MacLean 2008). This lack of research into inhalant use compared to other drug issues in Australia may be partly due to: a lack of funding because inhalant use is often viewed as not of serious concern (NIAT 2006; S. J. MacLean 2003); a lack of recognition of inhalant use as a problem amongst users, resulting in low rates of users seeking treatment; inhalant use frequently being associated with the use of other substances and hence difficult to isolate from poly drug issues and; use rates being the highest amongst young people thus introducing a complex set of ethical issues around conducting clinical trials (Konghom et al. 2010).

The data regarding levels of inhalant use in Australia, used in this study, is mostly derived from the National Drug Strategy Household Survey (NDSHS), which forms part of the National Drug Survey and the Australian School Students Alcohol and Drug Survey (ASSAD). The most recent Household Survey was conducted in 2010 and included data from 26,000 people. However, the sampling method presented some limitations as data was only collected from those aged 14 years and over and only included data from households (Australian Institute of Health and Welfare 2011). This meant that anyone who was homeless or in any form of institution or detention facility would not have contributed information. It is reasonable to assume that people in these categories would likely have a greater representation in regards to substance use. The Australia School Students Alcohol and Drug Survey also has similar limitations as it only targets young people who are at school and does not count disengaged students.

In reality, the prevalence of young people engaging in heavy inhalant use is often not comparatively high, but the support needed by these young people can be very resource intensive as a result of many complex issues accompanying VSM. Additionally, it is not only inhalant users who are impacted by their substance use. Issues often extend to affect their families and the broader community (d'Abbs & S. J. MacLean 2008). Australia's National Drug Strategy incorporates a Complementary Action Plan for Aboriginal and Torres Strait Islander peoples in recognition of the overrepresentation of Aboriginal and Torres Strait Islander populations within the statistics of use (Ministerial Council on Drug Strategy 2006). This is presented further in this report.

Whilst it is recognised that data on prevalence of use is inadequate, a distinction is normally made between 'occasional' (or 'experimental' or 'recreational') and 'chronic' or 'heavy' VSM with a likelihood of occasional users experiencing fewer problems than regular heavy users who experience significant

disadvantage. Reasons for sniffing are many and linked to prevalence, however poverty and marginalisation are widely recognised as contributing factors (Ogwang et al. 2006; NIAT 2006). The well-established correlates of inhalant use include many issues associated with disadvantage such as alcohol or other drug dependence, household violence, physical or sexual abuse, homelessness and overcrowding (d'Abbs & S. J. MacLean 2008; Butt 2004). In addition to this issue, young people from Aboriginal and Torres Strait Island backgrounds may also experience problems associated with a lack of a sense of belonging and loss of connection to culture (Butt 2004). The causal relationship between all these issues is not clear, however is particularly relevant for any form of practice.

### 3 Cairns VSM-CAP (Community and Practice) Project

This research constituted one part of the Cairns VSM-Community and Practice (CAP) Project, which also included the following broader aims:

1. Direct Intervention
  - To reduce harms associated with VSM in the Cairns region;
  - To provide individual support to young people of Aboriginal and Torres Strait Islander background to reconnect with country, family and community;
2. Coordination/Collaboration
  - To build community/systems capacity in relation to responding to inhalant use in Cairns and Far North Queensland; and
3. Research
  - To collate qualitative and statistical data to develop evidence-based locally responsive interventions to address VSM.

In April 2012, Dovetail facilitated a Local Action Plan for responding to inhalant use in Cairns. The plan indicated a need for further research to develop a local evidence base in relation to inhalant use. Following the forum, the former Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) provided funding for the VSM – CAP project with the purpose of strengthening interventions and support for inhalant users in the local area. This research project thus aimed to identify, explore and report some of the issues and interventions associated with inhalant misuse in regional centres of North and Far North Queensland. The project was primarily informed by interviews with young people of Aboriginal and Torres Strait Islander backgrounds and community sector practitioners.

Many of the findings of the research were consistent with published literature on inhalant use but aimed to add 'grass roots' views to the discourse. That is, the voices of young people engaging in VSM and practitioners at the 'coal face' who work with them. This report is not intended to provide assessments of any existing VSM or alcohol and drug programs providing services to young people who are using inhalants. Such evaluations are beyond the scope of the research.

A number of reports have already addressed inhalant use interventions in Australia over the past decade such as the comprehensive *Volatile Substance Misuse: A review of interventions* (d'Abbs & S. J. MacLean 2008); *Review of First Phase of the Petrol Sniffing Strategy* (URBIS 2008); *Inquiry into the Inhalation of Volatile Substances* (Drugs and Crime Prevention Committee 2002b) and *Policing, volatile substance misuse, and Indigenous Australians* (Gray et al. 2006) among others. We will not repeat the results of these reviews in detail here but will include an overview of the literature throughout the report to provide context to this study.

#### 3.1 Youth Empowered Towards Independence (YETI)

Youth Empowered Towards Independence (YETI) is a not-for-profit non-government organisation that supports young people aged 10-25 years old residing in Cairns. YETI's mission is 'to provide a community-based, empowering, supportive, responsive and healing environment that meets the needs of vulnerable young people through the provision of holistic services that foster social, emotional, spiritual and physical wellbeing.' The agency facilitates a range of programs focussing on

the needs of vulnerable young people, including: a day program; case management; crisis intervention; therapeutic counselling; outreach; and research and evaluation.

YETI primarily works with vulnerable young people who are at risk of, or are already engaging in the use of illicit drugs and/or alcohol. Young people include those who are wishing to reduce, cease or become safer within their alcohol and/or drug use. The target group includes young people relocating to Cairns and/or engaged in transient lifestyles between Cairns and outside communities.

Much of YETI's initial engagement with young people is achieved via attendance at YETI's day program centre where approximately 85 per cent of clients accessing services identify as Aboriginal or Torres Strait Islander. The organisation values cultural safety, empowerment and harm minimisation with service delivery approaches that aim to engage young people and encourage their participation.

YETI employs a multidisciplinary team of teachers, social workers, community development workers, counsellors and a registered psychologist. YETI endeavours to ensure that significant proportions of practitioners are from Aboriginal and Torres Strait Islander backgrounds.

It should be recognised that much of the information provided in this report is skewed towards the particular young people who access services with YETI and is hence inherently biased.

# Research Methodology

## 4 Methods

The methodology used in this research consisted of the following components:

- Interviews with practitioners from youth support agencies in Cairns, Mount Isa, Rockhampton and Townsville;
- Interviews with current and former inhalant users who accessed services at YETI;
- Data collection of all observed and indicated incidences of VSM;
- Review of relevant research and literature; and
- Critical review and analysis of interim findings with YETI practitioners to develop a series of Practice Principles.

These are explained more fully in the sub-sections below.

### 4.1 Agency interviews

In preparation of this report, semi-structured interviews were conducted with seven practitioners from YETI and 22 practitioners from other service providers in Cairns, Mount Isa, Rockhampton and Townsville. The lead author also attended a Mount Isa Substance Misuse Action Group (MISMAG) meeting in October 2012, which was attended by various youth support agencies and members of the Queensland Police Service. A full list of services visited is provided in Appendix Two.

By speaking to agencies in each of these regional cities we were able to get a snapshot of the current VSM situation in each location and collated practitioner impressions on suitable interventions for supporting inhalant users within the local context. Visits generally took place over one or two days and were limited by the availability of individuals working in various services at the time of the visit. Guiding questions for agency interviews are provided in Appendix Three.

### 4.2 Interviews with Inhalant users

Eleven young people who currently or have previously inhaled volatile substances were interviewed between August 2012 and February 2013. All of these young people were current clients at YETI. Eight people were interviewed individually and two were interviewed together. A group discussion was held with four young people, three of whom were interviewed individually and a fourth who was not. This group discussion aimed to further explore issues young people faced as a result of their inhalant use, the associated stigma and whether they had got into trouble with the law and their families.

Of those interviewed, six young people were known to regularly use inhalants at the time of their interview, four had ceased use and the status of the final young person interviewed was unclear (Table 1); definitions of levels of use are discussed later in this paper. Six of the young people identified as Aboriginal and the remaining five identified as Torres Strait Islander. All interviews were semi-structured, following guiding questions as presented in Appendix Four.

Table One describes the characteristics of the eleven young people who were interviewed as part of the research project. The inhalant use status of the young people interviewed was: six currently using; four young people who have ceased use; one young person whose status was unclear. The cultural background of young people interviewed was: six from Aboriginal backgrounds and 5 from Torres Strait island backgrounds. Two males were interviewed and nine females. The age group of participants was as follows: one was aged 12-14 years old; five were 19-21 years old; four were 22 to 25 years old; and one was older than 25 years old.

The purpose of the research was explained prior to interviews and with the written consent of the interviewee; interviews were recorded on a digital voice recorder. Young people were given a supermarket voucher for their participation.

### 4.3 Inhalant Use Incidence Tracking

Throughout the 12-month period of this research, YETI staff recorded all incidences of indicated inhalant use in Cairns. This information included data regarding young people accessing services at

YETI as well as incidental observations outside of the context of service provision (i.e. witnessing inhalant use on the street). Data were recorded when clients displayed physical signs of inhalant use (e.g. paint on body/clothing, smell of inhalants on breath), signs of intoxication amongst known inhalant users and admitted use. Incidences were coded to determine prevalence rates.

Consensual de-identified data was provided regularly to FaHCSIA during the period of this research. The collection of VSM data has become a routine part of data collection within YETI.

#### 4.4 Literature review

A review of literature was completed to underpin this study. The literature search focused in particular on the evidence gathered within the Australian context. The purpose of the review was to examine and summarise the key findings, explore any limitations in knowledge and position YETI's findings and practice response to VSM. The review began by documenting the data context and current national strategies. It summarised what is known about those who sniff and the identified prevalence and patterns of use. Effects and impacts of sniffing are considered followed by a focus on the methods employed for responding to use including supply reduction, demand reduction and harm reduction. Where possible the literature review aimed to examine the Aboriginal and Torres Strait Islander context within Australia in both remote and regional/urban settings and provides some conclusions with regards to best practice responses.

#### 4.5 Development of Practice Principles

Whilst this research project did not adopt a prescriptive action research framework, ongoing data review and analysis assisted YETI in informing a series of practice principles for working with inhalant users. An analysis of practitioner interviews was undertaken to ensure validation. The interim data was analysed and practice approaches undertaken regionally were reviewed providing the evidence base. The literature review also enabled the substantiation of the approach within current VSM practice. This has enabled the authors to articulate the framework and practice principles that underpin YETI's approach to working with young people who sniff. Whilst the principles have been embedded in YETI's approach, this project has ensured that they are named and defined. Authenticating the principles and ensuring they become overt, frames intervention and enables practitioners to reflect on practice and make informed decisions. The principles also enable accountability and act as a future reference point for evaluation. This also allows the promotion of a best practice framework for those who work with young people who sniff. The practice principles are discussed fully within Section nine of this paper.

# Limitations

## 5 Limitations of this Report

By reporting the information provided by young people and practitioners this research does not purport to represent all young people who use inhalants or their families. Young people who attend YETI and the workers who support this vulnerable group of young people are the key sources of primary information. The individual experiences of inhalant users as well as those who work with them vary dramatically and are shaped by individual situations and backgrounds. In particular, it is critical to note that these findings focus on the needs and experiences of very heavy and/or chronic inhalant users. The research does not focus on the issues of experimental inhalant users, in particular those young people who remain engaged in education and training and may use inhalants sporadically.

Literature and evidence indicate that heavy VSM is symptomatic of intergenerational disadvantage and trauma (Denov & Campbell 2002; Toumbourou et al. 2004). All of the young inhalant users attending YETI come from families of low socioeconomic backgrounds and often experience high levels of unemployment, homelessness, family violence and other intergenerational issues. For the purposes of this report, such issues are discussed only with the aim of giving context to the situations experienced by vulnerable young people. It is outside the scope of this report to attempt to suggest solutions to such systemic problems. Likewise for issues such as cultural disconnection, dispossession and disadvantage specific to Aboriginal and Torres Strait Islander people in Australia.

Quantitative analysis of the success rates of VSM interventions in Cairns is not possible, as the numbers of people engaging in these activities are too small for meaningful statistical analysis and longitudinal tracking of outcomes are difficult. This is a common challenge when trying to measure the effectiveness of VSM interventions. Dealing with relatively small numbers of people using inhalants inevitably means that the changing behaviour or attitude of one or two individuals may have a disproportionate impact on rates of VSM overall.

An additional difficulty when trying to compare success rates of particular interventions is the fact that many people experiencing chronic inhalant use are also engaging in other risk-taking behaviours and are frequently engaged with multiple services. Attributing changes in inhalant use to a single intervention is therefore problematic and the complexity of the issue prevents the formulation of definitive solutions.

We also acknowledge that data from interviews with young people are limited because of a relatively small sample size (11 individuals interviewed) and limited representativeness, as all of the young people interviewed were recruited from among the YETI client base.

Inhalant use incidence data collected throughout the period of this research is limited to observations made by YETI staff and is therefore biased toward the cohort of young people accessing services at YETI. However, as indicated previously, no individuals not yet known to YETI were witnessed to be using inhalants during the data collection period. Data are collected by YETI practitioners during working hours within service target areas and hence only intended to provide an indication of prevalence of inhalant use within this timeframe amongst a known cohort, rather than document overall rates of use across the community.

# Literature, Background and Context

## 6 Literature - Background and Context

The following section of the report will examine the existing legal framework and strategies in current operation. The report will review the current approaches to inhalant use nationally and within Queensland. We examine the findings of the research into inhalant use and review prevalence and patterns of use through examining the findings of the national surveys and reports.

### 6.1 Legal Framework

It is very difficult to legislate against the use of volatile substances as these substances have a legitimate function and are accessed by the broader community for many different purposes. Unlike other drugs it is not possible to ban the sale of products used for inhaling and even if some substances are banned, users can simply move to another. Another difficulty in regard to controlling substances is that restricting sale of a substance can draw people's attention to the fact that it has psychoactive properties and may make it more popular (Henry-Edwards 2003). Similarly, including warning labels on potentially dangerous inhalants may introduce people to substances of which they were not previously aware.

Nonetheless, since the beginning of this century, governments around Australia have endeavoured to introduce legislation that can reduce the harm associated with inhalant use. The primary objective of legislation is to protect the health and welfare of inhalant users and the National Drug Strategy stresses the need to provide treatment services for people who have drug related problems or are drug dependent (NIAT 2006).

The use of inhalants is not illegal in any state or territory in Australia (ADCA 2010) though police have increasingly been given powers to confiscate inhalants from users and to move users to a safer location. In some states and territories, including Queensland, retailers are prohibited from selling materials to people if they have reason to believe they will be used as an inhalant (ADCA 2010, Australian Drug Foundation 2010).

The Queensland VSM Report (CCYP 2002) describes three categories of legislation:

- **User-based** legislation such as that giving police the power to take inhalant users to a 'place of safety', as well as move-on powers to order inhalant users away from declared areas, which are generally public spaces such as malls, shopping centres and parks.
- **Product-based legislation**, which allows police to confiscate substances that are currently being used, or are suspected of being used, for inhaling.
- **Supplier-based legislation** making it illegal for retailers to sell volatile substances if they have any reason to believe they will be used for inhaling.

Police in the Northern Territory, Queensland, Western Australia and Victoria all have 'search and seize' powers, allowing them to remove substances being used as inhalants and in some jurisdictions, equipment being used to inhale (NIAT 2006). The Northern Territory is the jurisdiction with the most interventionist approach, with legislation giving authorities the power to compel those engaged in VSM to undergo treatment (S. J. MacLean & d'Abbs 2011).

In Queensland the *Police Powers and Responsibilities Act (2000)* provides police with the power to move people on from declared localities, generally malls, shops and other public areas. This allows police to act when they find a person in *circumstances that lead to a reasonable suspicion that the person has, is, or is about to, ingest or inhale a potentially harmful thing*. Amendments were made to the Act in 2003, which allow police to remove substances if there is reason to believe they are currently being, or will be used for inhaling. Initially, these amendments were trialled in five selected sites, including Cairns and Mount Isa (Gray et al. 2006). These amendments also give police officers the right to detain a person for the purpose of taking them to a 'place of safety'.

Despite some obvious benefits to this legislative approach, it has been argued that these increased powers have eroded relationships between police and inhalant users, further cementing their status as 'outcasts' (Ogwang et al. 2006). Ogwang et al. (2006) suggest that the fact that the powers only

relate to certain declared locations demonstrates that the aim of the legislation is to remove the problem of inhalant use from public view, rather than address VSM itself (Ogwang et al. 2006).

The second piece of legislation addressing inhalant use is the *Summary Offences Act (2005)*, which makes it an offence to sell *potentially harmful things* to any person if the seller reasonably believes that they might misuse the product (by ingesting or inhaling). This law also made it illegal to sell spray paints to young people aged less than 18.

## 6.2 National Strategies

### 6.2.1 National Drug Strategy

Australia's National Drug Strategy (NDS) was developed in 1985, based on an overarching approach of harm minimisation. The aim of the *National Drug Strategy 2010–2015*, is '*to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities*'.

The Strategy is built upon the three pillars of demand reduction, supply reduction and harm reduction, all of which seek to minimise the harm caused to Australian individuals, families and communities by substance abuse (Ministerial Council on Drug Strategy 2010).

In recognition of the significance of this issue for Aboriginal and Torres Strait Islander communities the strategy includes a complementary plan. This Complementary Action Plan stresses the importance of comprehensive, culturally valid actions covering '*physical, spiritual, cultural, emotional, and social wellbeing*'.

The Complementary Action Plan structured around six key result areas focuses on:

- 1. Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.*
- 2. Whole-of-government effort and commitment, in collaboration with community-controlled services and other non-government organisations, to implement, evaluate and continuously improve comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.*
- 3. Substantially improved access for Aboriginal and Torres Strait Islander peoples to the appropriate range of health and wellbeing services that play a role in addressing the use of alcohol, tobacco and other drugs.*
- 4. A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible.*
- 5. Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.*
- 6. Sustainable partnerships among Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information. (Ministerial Council on Drug Strategy 2006)*

### 6.2.2 National Inhalant use Taskforce

The National Inhalant use Taskforce (NIAT) was established by the Ministerial Council on Drug Strategy, to investigate existing strategies and programs throughout Australia that address inhalant use. This resulted in the development of a *National Framework for Addressing Inhalant use in Australia* which was designed to fit within the National Drug Strategy (NIAT 2006). The objective of the recommended framework was to support an effective collaborative response to inhalant use amongst government departments at different levels. However, this is yet to be fully implemented.

In the Federal Government's report 'National Directions in Inhalant use' (NIAT 2006) recommendations for prevention and treatment of inhalant use focus on a holistic approach which prioritises improving the overall health and welfare of communities, particularly in regard to education and training, employment, recreation and cultural enhancement. The report emphasises the importance of addressing underlying issues of social disadvantage and marginalisation rather than focussing solely on the issue of the substance being misused.

### 6.2.3 Petrol Sniffing Strategy

The most comprehensive national strategy to address the issue of inhalant use has been the Australian Government's Petrol Sniffing Strategy (PSS).

The PSS is a whole-of-government approach, which aims to reduce the incidence and impact of petrol sniffing and other forms of substance misuse amongst young people from Aboriginal and Torres Strait Island backgrounds and communities in specific regions.

The PSS is focussed on four designated zones. They are:

- the remote cross-border region in central Australia, covering the Ngaanyatjarra Lands in Western Australia (WA), the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in South Australia (SA) and the communities of Docker River, Imanpa, Mutitjulu and Apatula in the Northern Territory (NT)
- the expanded Central Australian region, incorporating the Alice Springs township and communities to the west and north of Alice Springs in the NT
- Doomadgee and Mornington Island in the Southern Gulf area of Queensland (QLD), and
- WA East Kimberley region<sup>1</sup>.

Some of the key elements of the PSS to date have been the introduction of low aromatic (Opal) fuel; expansion of youth services and activities; improved support to local communities in dealing with anti-social behaviour resulting from petrol sniffing through the development of restorative justice conferencing models; and diversionary, training and employment programs for young people affected by petrol sniffing and other substance misuse.

### 6.2.4 National Clinical Guidelines

Comprehensive national guidelines for clinical practice associated with inhalant use are available from the National Health and Medical Research Council (NHMRC 2011c; NHMRC 2011b). The guidelines were developed following a systematic review of evidence undertaken by an expert committee of professionals with knowledge and experience caring for people who use inhalants. Of 65 recommendations presented in the guidelines, only one is described as being 'evidence-based' and the evidence is described as being 'weak'. The remaining recommendations are consensus-based or practice points, which cover subjects that were outside the scope of the search strategy used to develop the guidelines. Practitioners interviewed for this report regarded the national guidelines as a very important tool for supporting the management of intoxicated young people.

The guidelines provide comprehensive recommendations relating to:

- Managing acute intoxication;
- Managing withdrawal symptoms;
- Comprehensive assessments after recovery;
- Brief interventions to reduce sniffing risk;
- Case management;
- Education;
- Psychological therapies; and
- Activities.

<sup>1</sup> <http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/communities-regions/petrol-sniffing-strategy> [accessed 11/06/2013].

### 6.3 Queensland approach to inhalant use

At the time of writing there was no current state drug strategy in Queensland however, in the past decade Queensland has enacted legislation to address inhalant use as described in Section 6.1. Legislation allowing police to move inhalant affected people to a place of safety is supported in the Queensland Drug Strategy 2006 - 2010 with a commitment to:

*Provide VSM safe recovery services (formerly known as place of safety services) in areas with high levels of inhalant use (inner Brisbane, Logan, Townsville, Mt Isa and Cairns) and develop appropriate responses in two new locations. Safe recovery services will provide a safe place for young people affected by VSM to recover as well as a coordinating point from which to address the underlying complex needs of the young people who engage in VSM (Queensland Health 2006).*

As such, the Queensland Government funds dedicated VSM services in the listed locations. Staff members from these services in Cairns, Rockhampton, Mount Isa and Townsville were interviewed as part of this research.

### 6.4 Inhalant users - Who sniffs?

Inhalant use in Australia (and internationally) is most common amongst adolescents, with use generally peaking at around 12-14 years of age (White 2006; White & Bariola 2012). The Victorian Parliament's Inquiry Into the Inhalation of Volatile Substances (Drugs and Crime Prevention Committee 2002b) lists a number of different categories in which VSM occurs:

1. 'Average' young people who experiment with VSM;
2. VSM associated with delinquent behaviour and low socioeconomic status;
3. VSM in urban and rural Aboriginal communities;
4. Petrol inhalation in remote Aboriginal communities;
5. VSM amongst disadvantaged and homeless adults;
6. Abuse of anaesthetic gases by professional groups; and
7. Abuse of amyl and butyl nitrites by those in the gay community.

The Australian Drug Foundation describes three broad categories of inhalant users<sup>2</sup>. These are:

- **The experimenter:** The majority of teenagers fall into this category. They try it once or twice, and then stop by themselves.
- **Social user:** Usually done with a group of friends. The amount of using varies, depending on what else is going on in their lives. These users often develop other interests and move out of this practice.
- **The long-term dependent user:** A small number of inhalant users go on to use on a regular basis over a long time. They generally have other major problems in their lives. They may use inhalants alone, or with other people who use regularly. They may feel bad about using, but feel unable to give up. For some it is one of their few pleasures.

Despite the usefulness of these definitions, most of the literature defines a more complex range of use patterns within each of these categories. Young people from any social background may experiment with using inhalants at some stage in their life but longer term use tends to occur amongst people who are in some way marginalised from mainstream community (S. J. MacLean 2012). Regular use and potential movement into chronic inhalant use are frequently associated with low socio-economic backgrounds, childhood neglect, families that are chaotic or disrupted, physical and emotional abuse, and antisocial behaviour (Dinwiddie 1994; d'Abbs & S. J. MacLean 2008; CCYPCG 2011). Unsurprisingly, it seems that young people who use VSM to cope with negative emotions are more likely to use at higher levels (Butt 2004).

### 6.5 Prevalence and patterns of inhalant use

Incidence of inhalant use in Queensland is not well recorded and actual rates of inhalant use within Australia are difficult to determine. Reliable or consistent data on VSM is rarely collected

<sup>2</sup> Source: 'Inhalants: How drugs affect you', brochure from the Australian Drug Foundation

systematically as VSM is not illegal and it is often a clandestine activity to which people may not want to admit (d'Abbs & S. J. MacLean 2008).

Prevalence of inhalant use within a community can fluctuate dramatically, often over relatively short periods of time such as weeks or months (Henry-Edwards 2003; S. J. MacLean & d'Abbs 2002) and evidence suggests that generally outbreaks of VSM are cyclical (Cleary 2001). Inhalant use can become a highly visible issue because it often occurs in public spaces, and attracts much negative attention. However, it does not necessarily involve large numbers of young people so small increases in numbers of young people engaging in VSM can dramatically change the impacts on other young people, families and the wider community. A specific trigger for increased levels of sniffing at a community-level is the return to town of particular sniffers. Generally these people are returning from visiting family in other locations or periods in detention or rehabilitation services. This is not a new phenomenon and has been discussed in a range of reports and papers (e.g. Gray et al. 2006; James 2004).

National data regarding inhalant use primarily comes from two main sources. These are the 'National Drug Strategy Household Survey' (NDSHS) and the 'Australian School Students Alcohol and Drug (ASSAD) survey', both of which are conducted every three years. Despite the fact that the most recent of each of these surveys included around 25,000 respondents, both sources of data have limitations in regard to providing an accurate picture of inhalant use rates. The National Drug Strategy Household Survey likely misses many people most at risk of inhalant use due to homelessness (Lubman et al. 2006) and school based surveys exclude cohorts who have disengaged from education. Both of these surveys and some of their limitations are described further below.

#### 6.5.1 National Drug Strategy Household Survey' (NDSHS)

Despite concerns over inhalant use, all available information suggests that only a small portion of the population of Australia ever engages in VSM. Results from the 2010 NDSHS found that less than four per cent of the entire population report having ever used inhalants, with only 0.6 per cent having inhaled in the past year. This is consistent with longer term results which show that in every survey since the NDSHS began in 1993, the overall percentage of the population over 14 years of age who report having used inhalants in the past 12 months has been less than one per cent (Australian Institute of Health and Welfare 2011).

Table Two describes various inhalant use statistics from the 2010 National Drug Strategy: Household Survey Report. Recent use (used in the past twelve months) was described as 0.6 per cent; Lifetime use (have inhaled at least once in their life) was 3.8 per cent; Average age of initiation was described as 19.5 years old; young people offered inhalants in the past twelve months was 3.0 per cent. The percentage of recent inhalant users who had also used cannabis in the past 12 months was 62 per cent.

The number of people who were offered inhalants to sniff in the past 12 months was five times higher than the number who actually used. This was highest within the 18-19 year old age group, where 7.2 per cent of people reported having been offered inhalants (Australian Institute of Health and Welfare 2011). It should be noted however, that evidence indicates that young people may commence using inhalants during their younger adolescent years. With results of the NDSHS only including data for individuals aged 14 years and over the total proportion of users may not be reflected. Additional inaccuracies may result from a reluctance of some individuals to reveal their actual substance use habits/experiences and higher levels of non-response from certain subgroups in the population (Australian Institute of Health and Welfare 2011).

#### 6.5.2 Australian School Students Alcohol and Drug (ASSAD) survey

Surveys regarding inhalant use that are conducted through schools are also likely to present underestimates of actual prevalence given that many inhalant users are disengaged from education or employment activities (Midford et al. 2010; Skellington Orr & Shewan 2006; CCYP 2002; White & Smith 2009).

In the 2011 ASSAD survey of around 25,000 Australian secondary school students, 17 per cent of students reported having ever used inhalants. When disaggregated by age, the prevalence of having

ever used was highest amongst 12 year olds. Similar results have consistently been obtained since the schools surveys began in 1996 (Drugs and Crime Prevention Committee 2002a), suggesting that either younger people are falsely reporting having tried inhalants or older students were no longer admitting to previous use. For example, 20 per cent of 12 year olds reported having ever used inhalants – including 10 per cent who had used in the previous month - compared to 11 per cent of 17 year olds – of which 4 per cent had used in the past month. This is also at odds with 2010 household survey where the average age respondents reported having initiated inhalant use was 19.5 years (Australian Institute of Health and Welfare 2011).

The majority of students who admitted to having used inhalants did not report regular use, with around half who had used in the past year saying they had only used one or two times. Among urban young people VSM appears to involve a relatively large number of experimental or occasional users and a smaller number of the long-term dependent users (d'Abbs & S. J. MacLean 2008).

## 7 Overview of the Service System and Service Context

Having explored the broader context we now introduce the study area. The following section will give a brief overview of VSM funded services within the study area and any collaborative case management models operating across agencies within each region. Practitioners interviewed within the study were selected from these agencies or from agencies participating in the collaborative processes in order to improve their work with young people who sniff.

### 7.1 Cairns

With a population of more than 224,000 people (ABS, 2011), Cairns is a large regional centre and the capital of Far North Queensland. The region provides services to remote Aboriginal and Torres Strait Island communities throughout Cape York. According to the 2011 Census data (ABS, 2011) (of those who stated) 10.3 per cent of the population of the Cairns region were from Aboriginal and Torres Strait Island background and young people (5-24 years) comprised over 42 per cent of this population, with the older cohort (16 years and older) representing a significant proportion of participants at YETI.

#### 7.1.1 YETI's work with vulnerable young people who engage in inhalant use

As a youth support agency, YETI engages with a broad range of vulnerable young people, including many currently or previously using inhalants. When necessary, the service provides interventions to directly address inhalant use, such as: information; education; intensive case management support and assisting young people to access counselling or rehabilitation services. Whilst not funded as a rest and recovery service, young people are able to access YETI when intoxicated and allowed to recover in a safe and calm environment.

As an organisation, YETI encourages staff to openly discuss VSM with young people who use inhalants. The objective is to develop trusting relationships with young people where practitioners can provide frank and honest support and advice based on harm reduction frameworks. As these discussions are only with chronic users there is little chance of encouraging increased use or bringing new substances to the attention of the young people, as is often the fear when trying to do education activities relating to VSM (e.g. in schools).

YETI's organisational policy on drug use states that the service is informed by a harm minimisation approach. However in regard to inhalant use, YETI takes a cautious approach to discussions with clients around harm minimisation strategies with inhalant users given that there is no safe level of inhalant use. When working with chronic inhalant users, staff may assist them to develop safety plans regarding how to look after each other and how to keep themselves safe. Staff reported additional concerns about the wellbeing of young people using inhalants during the hottest months in Cairns. During this time, all young people were encouraged to drink plenty of water to avoid dehydration and advised not to run or walk too far.

When dealing with someone in the service that is obviously intoxicated, staff members remove the substances or paraphernalia (where present) and encourage the young person to rest in a calm

setting. If they are extremely intoxicated and incoherent or displaying other complications or danger signs, as described in the National Clinical Guidelines (NHMRC 2011b), staff will call an ambulance for assistance. When a young person aged less than 17 years presents and is assessed to have no apparent immediate need for medical attention, YETI will call the Youth Substance Misuse Service (YSMS) to collect the young people for rest and recovery services.

YETI has a close working relationship with Dovetail, the state-wide support agency for youth alcohol and drug services across Queensland. During early 2013, YETI and Dovetail collaborated to provide VSM training to YETI staff and representatives from other agencies in Cairns and in Weipa.

In September 2012, YETI commenced outreach activities through a program for young people in public spaces. Activities undertaken through the Young People in Space (YPIS) program are designed to support vulnerable young people in Cairns to build better connections with their families, schools and community services and reduce negative behaviours in public space. The program provides outreach, diversionary activities and public space interventions. These activities connect to a strong case management framework whereby vulnerable young people are linked to ongoing, multiagency support.

Through YPIS, YETI provides evening outreach to the West Cairns Area and other areas where key stakeholders including the Department of Communities, Cairns Regional Council and the Queensland Police Service have identified public space issues with young people. These activities encourage young people to engage in a range of entertainment and skills development activities, as well as providing a soft entry point for young people who may require additional case management support services offered by YETI. YETI has also engaged with family homelessness, youth justice and domestic violence services to develop clear referral pathways for vulnerable young people and families who need additional support.

#### 7.1.2 Youth Substance Misuse Service

The Youth Substance Misuse Service (YSMS) of Cairns is a dedicated VSM service, with a target age range of 12-17 years of age. YSMS also provides some support to siblings of clients who are slightly either side of this age range as they were considered highly vulnerable to inhalant use and may influence or be influenced by, the treatment of those within the target age group.

Services include:

- Rest and recovery - providing a space for young people to spend up to six hours in the service to recover from severe intoxication.
- Case Coordination/Case Management – one-on-one counselling and interventions, advocacy and education regarding risks of inhalant use.
- Outreach – involves going out to meet people in their 'space'. This allows the service to access young people who may not come into the service of their own accord. Services provided include information provision regarding the dangers of inhalant use and providing transport to assist young people at risk to get to a place of safety.
- Planned diversion activities – holiday programs, days out for young people such as fishing trips, go karting etc.
- Unplanned (responsive) diversion activities – in response to calls from police or Cairns Regional Council to address VSM issues or hotspots.

Education in the current program was limited to information provision for known users. This included small group information sessions with clients that came through youth justice or residential services for young people, where an existing VSM problem has already been identified. There is also some community awareness raising through discussions with families of known inhalant users.

#### 7.1.3 Coordinated Care Panel for Vulnerable Young People

In recognition that effective case management for vulnerable young people (including those engaged in VSM) requires an inter-agency response, government and non-government agencies in Cairns collaborate through the 'Coordinated Care for Vulnerable Young People' (CCYP) panel. The panel was formed in 2010 after a period when YETI staff were particularly concerned about the wellbeing of a

group of young people aged less than 15 years old who were accessing the service and were involved in increasingly serious risk-taking behaviours. Most of this group were also known to be using inhalants.

This collaboration has been formalised in a Local Partnership Agreement (LPA). The parties to this LPA are:

- § ACT for Kids
- § Anglicare North Queensland
- § Department of Communities, Child Safety and Disability Services
- § Queensland Health
- § Department of Education, Training and Employment
- § Department of Justice and Attorney-General
- § Queensland Police Service
- § Youth Empowered Towards Independence
- § YouthLink
- § Wuchopperen Health Service

The LPA is intended to facilitate local collaboration between parties and formalise the commitment of service providers to actively participate in care coordination. The agreement involves a commitment to work in a spirit of goodwill and mutual respect to achieve common goals in providing effective support to vulnerable young people. The panel aims to coordinate support around the complex-needs of young people and their families, to reduce duplication of services and to identify gaps in service provision.

A CCYP Reference Group is responsible for overseeing the implementation of the CCYP Model, developing monitoring and evaluation processes and reporting outcomes to the Homelessness Project group annually. The Department of Communities supports the CCYP Reference Group by providing secretariat assistance.

The CCYP currently meets monthly to share information and develop action plans to address the needs of particularly complex young people. Prior to each meeting, panel agencies can refer young people aged 10-17 years to the panel. The young person's details are emailed to members of the group and each agency searches their database for details of any contact they have had with that person. These individuals are assessed against the panel's agreed criteria and, if they are deemed suitable, all agencies that have had contact with that young person will bring relevant information for discussion. A young person or their guardian must provide consent for this exchange of information to occur.

At the panel meetings, one agency will take on the role of Care Team Leader and they then become responsible for organising Care Team Meetings to develop collaborative plans to directly support that young person.

## 7.2 Mt Isa

Mt Isa is a large regional city with a population of over 21,000 people (ABS, 2011). Over 3,000 identified as Indigenous within the 2011 census, over 15% of the population. Almost half of that total falls within the 5-24 year age categories. Mt Isa covers an area of over 43,310 square kilometres. A significant part of industry in Mt Isa is mining employing 26% of the population. A significant proportion of young people are considered vulnerable within Mt Isa.

### 7.2.1 Young People Ahead (YPA)

Young People Ahead (YPA) runs a dedicated VSM service in Mount Isa, including providing the city's only place of safety for intoxicated young people. Other services provided by YPA include a drop-in centre, crisis accommodation and regular outreach activities in public spaces. The Volatile Substance Misuse Initiative "Place of Safety" provides support and assistance to young people aged 12 to 17 years, who engage or are at risk of engaging in volatile substances i.e. Alcohol, Cannabis, Petrol/Glue/Deodorant sniffing and or use. The service works from a harm minimisation model.

In the past, VSM within Mt Isa has received significant negative coverage in the local media, increasing the stigmatisation of young people involved. As part of efforts to address community concerns and address VSM issues more broadly, fortnightly events known as “Thursday Night Live” are held in public spaces. These activities are organised through the Mount Isa Substance Misuse Action Group (MISMAG) in conjunction with the Mount Isa PCYC and were originally established in response to community concerns about public space issues.

### 7.2.2 Mt Isa Substance Misuse Action Group - MISMAG

MISMAG is a group of government and non-government agencies that meet monthly to exchange information about inhalant use in the region and to collaborate on activities and interventions to address these issues.

## 7.3 Rockhampton

The census population of the Rockhampton Region in 2011 was 60,216. The Aboriginal and Torres Strait Islander census population was 3,836. According to the 2011 census nearly 1,700 were in the 5-24 year age categories. The region spans an area of 18,300 kilometres. Grazing is still a dominant industry in the region.

### 7.3.1 Darumbal Community Youth Service

Targeted VSM programs are currently delivered by Darumbal Community Youth Service which provides support services to young people who engage, or are at risk of engaging, in VSM or other substance misuse. The service also works from a harm minimisation model. The service is open during office hours and also conducts outreach activities four nights a week at school and community locations. The service has established a number of personal development and skill based activities, which are provided both at school and community locations. Activities include young men’s and women’s groups, art and painting workshops and regular participation in touch football competition. These activities are also offered as a way to engage young people due to changes in funding which mean that a drop-in centre is no longer offered. Previously the drop-in space provided a soft entry point for engagement.

Agencies in Rockhampton cooperate through complex case management meetings organised by Youth Justice. Agencies identified the ongoing importance of developing the coordination framework to ensure streamlined approaches for young people.

## 7.4 Townsville

Townsville city has a census population of nearly 175,000 (ABS, 2011). Indigenous persons account for 10,703. A total of 4,882 fall within the 5-24 years age categories constituting 45% of the Indigenous population a markedly younger age structure than the non-Indigenous population. The local government area covers 3,736 square kilometres. Townsville has a diverse economy acting as a hub for the mining and agricultural industries.

### 7.4.1 Townsville Aboriginal and Islanders Health Service (TAIHS)

Townsville Aboriginal and Islanders Health Services (TAIHS) provides a 24 hour rest and recovery service which can be accessed through self-referral or referral from another agency. The service is currently endeavouring to get the rest and recovery component separated from their other support and diversionary activities so that inhalant use is not seen as a desirable pathway to access complementary support services. Likewise, the TAIHS VSM service offers a broad range of activities to siblings and family members of inhalant using young people so that sniffing is not seen as a pathway to accessing services. TAIHS also offers individual support, holistic health support, transport and supervision, educational and motivational programs as well as their rest and recovery and outreach and diversionary activities.

### 7.4.2 The Youth Network NQ Inc.

The Youth Network NQ Inc. is a not-for-profit organisation based in Townsville which hosts monthly meetings for youth service providers to meet and network with other youth services. There have been various collaborative panels discussing specific young people in Townsville but at the time of interviews, none of these were active. The collaborative youth panel was due to recommence in the

near future and was an added session linking in with Youth Network meetings. Whilst individual cases were discussed in the meetings, individuals were not named and the process was not formalised as in Cairns. Practitioners reported that there was generally a good sense of cooperation between agencies in the youth sector, although collaboration was sometimes difficult due to the large geographic area covered. In the past there had been a VSM Reference Group, however it was cited that due to distance it was logistically difficult to get people together and now there are several smaller groups, which discuss issues in different parts of Townsville and responses are subsequently more discrete and place-based.

# Discussion of Results and Findings

## 8 Discussion of Results and Findings

This section of the report will examine the findings of the research in order to document inhalant use patterns and current interventions utilised within Northern Queensland. We examine the findings of interviews with practitioners who work within services operating in the regional townships of Rockhampton, Mt Isa, Townsville and Cairns. The report will document preferred inhalants and inhaling methods most commonly observed by those practicing within these services and analyse reasons and correlates for use. Most importantly the voices of young people interviewed will be heard in this section of the report. This section will discuss some of the reasons why young people commence sniffing and the effects reported by those who work with them. We consider issues faced by young people using inhalants as well as the factors, which may influence any decision to cease use and the barriers, which may prevent this.

### 8.1 Inhalant use patterns reported by practitioners

Practitioners in all locations included in this research reported obvious cyclical patterns of inhalant use rates within their respective communities (and thus reported here geographically). Much of this observed change was attributed to the presence or absence of certain 'ring leaders' or charismatic individuals who influenced others and encouraged others to use inhalants with them. One worker described these individuals as having *'an amazing power to draw people in with a seductive, manipulative control which allows them to coerce people into doing what they want'*. The influence of these individuals was reflected in some of the stories young people told of leading a crew of younger inhalant users and looking after them, whilst encouraging them to steal for them in return for support and inhalants.

The level of inhalant use of these key individuals often fluctuates in relation to stress levels associated with their relationship, family or accommodation status. It therefore follows that rates of inhalant use within communities may vary depending on nothing more than levels of stability or stress within the lives of a few key individuals.

The other factor determining prevalence is the availability of volatile substances. As retailers in certain areas take measures to restrict access to substances, practitioners reported changes in VSM behaviour. On some occasions, such as in Mount Isa, the overall prevalence of VSM temporarily decreased after concerted efforts to work with retailers to prevent the theft of deodorant. However, sometime later VSM prevalence once again increased, though the preferred substance shifted to petrol.

#### 8.1.1 Inhalant use amongst Aboriginal and Torres Strait Islanders

Whilst inhalant use in Australia is an issue for both young people from Aboriginal and Torres Strait Island backgrounds and non-Indigenous people, rates per population are higher amongst Aboriginal and Torres Strait Islander young people (NIAT 2006). These higher rates are partly attributable to petrol sniffing in remote communities. The context of this petrol sniffing differs greatly from inhalant use in urban settings because of different cultural contexts, geographical isolation and lack of access to other legal or illicit recreational substances preferred in other regions. It therefore follows that the lessons learned about inhalant use in urban populations and remote Aboriginal and Torres Strait Island communities are not interchangeable (Cairney & Dingwall 2010).

The disproportionate use of substances by Aboriginal and Torres Strait Islander young people was noted by all those interviewed for this report. For example, all of the young people accessing programs at YETI who are known to regularly use inhalants are of Aboriginal or Torres Strait Islander background. Likewise, the Youth Substance Misuse Service (YSMS) in Cairns estimated that in the previous 12 months approximately 85 per cent of their clients identified as Aboriginal or Torres Strait Islander.

#### 8.1.2 Cairns

In Cairns, practitioners refer to at least two distinct cohorts of young people engaged in VSM. The first of these cohorts is typically younger and often describe using inhalants as a fun 'social' activity with friends. This cohort may reside with family albeit most with significant current or recent exposure to family and domestic violence; heavy parental substance use; and often histories of family

homelessness. As a general rule, this group inhale glue and deodorant and may go for periods of months without using inhalants. This group were reported to have the potential to (though often do not) progress to more frequent sniffing and use of paint. They are more likely to reduce/stop inhalant use if separated from VSM peers. This group would be categorised in the Drugs and Crime Committee definitions as Category 2 – whereby their inhalant use is associated with delinquent behaviour and low socio-economic status. These young people, tend to sniff 'on and off' over many years and may have binge periods where they engage in heavy inhalant use (e.g., use inhalants daily or periods of weeks).

The second cohort consists of individuals who are often older (20 years plus) and demonstrate signs of physical and psychological dependence upon inhalant use. Members of this group tend to experience extensive disadvantage and demonstrate high rates of co-occurring mental health issues. They are more likely to continue using inhalants even if no longer associating with inhalant using peers. Paint and glue are the preferred inhalants for this group. Some of the young women accessing YETI services who fall into this cohort are frequently experiencing varying degrees of homelessness. These adults could be regarded as Category 5 in the Drugs and Crime Committee definitions. In Cairns, there appears to be little mixing between the two groups, aside from interactions focussed on interpersonal conflict and fighting.

In addition to the cohorts engaging in regular or semi-regular sniffing there are also ongoing reports of young people sniffing deodorant or other substances at school or in residential group homes. It appears that for many of these young people inhalant use does not progress beyond the experimental stage and they are less likely to come to the attention of youth services, thus prevalence is harder to estimate.

Practitioners interviewed in Cairns all highlighted the high number of female inhalant users compared to males, noting this was a phenomenon that had evolved in recent years. This appears to differ somewhat from the other regions covered by this report. The average inhalant user who accesses services at YETI is aged anywhere from 10 to 25 years old, female and from an Aboriginal and/or Torres Strait Island background.

At the time of writing, most of the young people regularly attending YETI who are known to be using inhalants are aged 18 years or over, and tend to be chronic users. At different times there have been cohorts of younger people as well, of whom there was a mix of occasional and chronic users. Amongst those 17 years or under, some attend the dedicated VSM service, Youth Substance Misuse Service (YSMS). According to YSMS the majority of their clients are in the 13 to 14 year age bracket. In the preparation of this report, we did not have access to their recorded data so the number of individual clients they are dealing with was unclear.

Currently in Cairns, younger users tend to inhale glue and aerosols, whilst the older, chronic sniffers seem to prefer paint, but use glue when paint is not available. Glue is generally inhaled from plastic bags and paint from plastic bottles. As plastic bags are easier to hide in pockets or clothing, it means that sometimes inhalant users may choose to inhale glue when they want to be able to carry substances with them and potentially conceal it to avoid detection.

The most commonly inhaled substance amongst young people accessing youth services in Cairns is spray paint. At times there have been spikes in glue sniffing but paint has generally been the most prevalent substance. Petrol sniffing was virtually absent in Cairns at the time of this research, and only a small number (i.e., between five and ten individuals) of young people with a history of petrol sniffing were known to have accessed the service in the past two years. Several young people interviewed knew of individuals sniffing petrol in Cairns, but agreed that this was not a common practice and tended to be undertaken by young people who were briefly visiting Cairns or occurred amongst an older rough sleeping cohort (although both occasions were considered rare).

Practitioners at YETI reported that several young women in Cairns had spoken of engaging in opportunistic sex work in return for inhalants and sometimes for accommodation. Some of these cases involve ongoing arrangements with certain individuals as described later in this report in the section on 'Captains'.

Many of the inhalant users who access YETI services originate from outside of Cairns. Some come from remote communities on Cape York, the Torres Strait and others from regional cities such as Rockhampton. Others have been born and raised in Cairns but retain family connections with other communities.

Throughout the period of this research project, YETI staff recorded all observed incidences of inhalant use. This included observing evidence of inhalant use, such as substances spilt on the clothing of young people, the smell of inhalants on known users as well as direct observation of inhalant use amongst non-clients outside of the work context. Between July 2012 and June 2013, there were 235 recorded incidences of inhalant use. The highest monthly figure was recorded in January 2013, when 67 incidences involving 11 individuals were recorded (Figure 1). It should be noted that figures for the twelve-month period involved only 21 individual inhalant users, with four female individuals accounting for 82 per cent (n=193) of incidences.

Figure One describes the number of sniffing incidents and number of individuals involved as recorded by YETI staff between July 2012 and June 2013. The data refers to the sniffing patterns of 11 individuals. In July 2012 there were 4 individuals reported sniffing in 6 incidences; in August 2012 there were 6 individuals reported sniffing in 11 incidences; in September 2012 there were 5 individuals reported sniffing in 10 incidences; in October 2012 there were eight individuals reported sniffing in 34 incidences; in November 2012 there were 6 individuals reported sniffing in 19 incidences; in December 2012 there were 4 individuals reported sniffing in 21 incidences; in January 2013 there were 11 individuals reported sniffing in 67 incidences; in February 2013 there were 6 individuals reported sniffing in 34 incidences; in March 2013 there were 3 individuals reported sniffing in 5 incidences; in April 2013 there were 4 individuals reported sniffing in 16 incidences; in May 2013 there were 3 individuals reported sniffing in 9 incidences; in June 2013 there was 1 individual reported sniffing in 3 incidences.

### 8.1.3 Mount Isa

In Mount Isa, practitioners interviewed indicated that at times petrol sniffing had been a highly visible problem, causing considerable community concern. All those interviewed described cycles of different substances being sniffed, with key groups generally moving from one substance to another depending on what was available at any given time. The two main substances identified as the biggest problem were deodorant and petrol. Some workers said that they had observed predominantly males using petrol, whilst females preferred deodorant. However, workers at other services did not agree with this analysis.

It was reported that deodorant was often stolen from local shops and as a result, several of the larger supermarkets have installed video camera monitoring in the deodorant sections of their stores. Several young people from Mount Isa have been given lifetime bans from particular shops or shopping centres.

Inhalant use in Mount Isa was reported to be restricted to young people aged 10 to 16 years old. Local practitioners attributed the cessation of sniffing at 16 years of age to young people becoming eligible for financial support and therefore largely able to purchase other substances, particularly cannabis and alcohol. Of the few individuals who continued, use was generally only occasional and perceived as a means of staying connected with friends or family members who used inhalants.

Service providers interviewed in Mount Isa all said that boredom was a major factor contributing to inhalant use in the area. This is consistent with a decade old report from the Queensland Commission for Children and Young People which stated that young people in Mount Isa reported boredom due to a lack of free recreational activities as a major reason for inhalant use (CCYP 2002).

Workers highlighted the links between homelessness and inhalant use, noting that many young people ceased their inhalant use once they had stable accommodation. The lack of affordable housing in Mount Isa was also seen as a key contributor to homelessness amongst young people. As a mining town, rental properties are very expensive and vacancy rates are low so that it is often difficult for young people to rent houses.

There was also a perception that in general, the prevalence of inhalant use increased during the colder months of winter and that this was perhaps linked to trying to reduce feeling cold. Inhalant use rates were also observed to spike during periods of household overcrowding, as occurs around the time of special events in the town such as the annual Mount Isa Rodeo, which attracts tens of thousands of visitors to town.

#### 8.1.4 Rockhampton

Some agencies working in Rockhampton reported that inhalant use was not particularly prevalent at the time of the interviews. Amongst practitioners working with vulnerable young people, some had not yet encountered inhalant use amongst their client group.

However, at the time of the researcher's visit, Darumbal Community Youth Service reported working with a core group of around ten young people who were known to be regular sniffers. Glue has generally been the most prevalent substance used by young people in Rockhampton, with some reports of paint use. Workers were not aware of any petrol sniffing but reported an apparent increase in cannabis use in the past few years.

Of the young people known to use inhalants in Rockhampton, practitioners reported that most were male, and the average age of users was estimated to be around 14 years. Like in Mount Isa, services in Rockhampton observed that the majority of young people's inhalant use would cease or decrease when they reached 16 years of age. Again practitioners attributed this to young people reaching an age where they were able to receive income support with which they could buy other substances such as cannabis or alcohol.

#### 8.1.5 Townsville

The VSM service Townsville Aboriginal and Islander Health Service (TAIHS) provides substance misuse support for young people aged 12-17 years. At the time of discussions for this report, approximately 70 per cent of clients attending the VSM service were male and deodorant (specifically Rexona) was the most commonly used substance amongst inhalant users. Workers also reported that there had been an increase in petrol sniffing in recent months and some cases of young people inhaling glue.

The majority of inhalant users in Townsville were reported to be in their early teens, though there were also a few young people who were known to have continued their inhalant use until the age of 16 or 17 years of age. The VSM service has approximately 90 current and former inhalant users engaged with the service. Amongst these approximately 15 were considered to be regular or chronic sniffers.

Practitioners in Townsville expressed concerns that some inhalant using young people who had spent time in the Cleveland Youth Detention Centre were deliberately committing offences to be detained as the detention centre provided education and training opportunities that were otherwise inaccessible to them. It is possible that this situation is unique to Townsville because the proximity of Cleveland to the city means that while in detention young people are still able to be in close contact with family.

## 8.2 Preferred inhalants

The following section will report on the results from the interviews with both young people and with practitioners. As there was commonality across the regions this is reported by topic.

Most of the young people interviewed for this research would be categorised as long-term dependent users, as per the descriptions given in Section 6.4. Amongst these chronic users, all reported having inhaled paint on a regular basis (i.e. at least several times a week, or daily use). For some, paint was the first substance they had ever tried, whilst others had commenced sniffing glue, deodorant or other aerosols and moved onto paint as their levels of use increased.

*'Just paint and then glue and then back to paint all colours all different sorts...some of them have chemicals they're the ones you can't sniff'*

Interviewees expressed preferences for particular colours of paint with different colours appearing to have different levels of toxicity. Silver (chrome) and black paints were reported as producing the

highest levels of intoxication, dark colours were also favoured but reported to have less intense effects. Preferences for particular paint colours were based on the effects that they produce as well as some differentiation based on the different tastes.

*'Chrome makes me more higher than any of the colours of paint that I've sniffed in my life'*

*'Different colours can get you different, yeah make your moods different ways. Some are really strong, like black. Black gets you wiped out of your head. I used to sniff black in [my home town]. I didn't even know what I was doing. People used to come up and tell me the next day and I was like I don't even remember, ay. Yeah cause it's real strong the black. It's the strongest paint you can sniff.'*

*'The main colours I was only sniffing was plum purple and navy blue. And when they didn't have that on the shelf, that's when I would've went for the other colours. Every other colour that smelt good. I used to spray paint into the lid before I buy it. Cause, if it's got a yucky smell to it, I wouldn't buy it.'*

*'I asked for paint the colour was black I liked the black one because it's stronger than all the other paints'*

Young people in Cairns did not report inhaling lighter coloured paints saying that the effects of these were not strong enough. One interviewee told of a friend in Cairns who was a 'white fella' and sniffed fluorescent coloured paints but nobody else liked these colours because they tasted like 'cockroach bombs'. Inhalant users who access services through YETI are frequently seen with silver paint on their clothing and bodies. Differentiation between the effects of intoxication achieved through inhaling different coloured paints is consistent with research done with young inhalant users in Melbourne who reported experiencing visual hallucinations from chrome paints, an effect not felt when using non-chrome paints (Takagi et al. 2010).

Most of the young people reported experiences inhaling glue; large tubes of sealant were the most popular amongst both chronic and occasional inhalant users. Glue is relatively easy to obtain, as it is available from most supermarkets and hardware stores and can be purchased or stolen. One interviewee explained that she preferred to inhale paint but the purchase of spray paint required proof-of-age which she did not have. This meant that she was reliant upon others purchasing paint or she sniffed glue instead. Some young people reported adults purchasing paint on their behalf.

Some interviewees said that they preferred sniffing glue to paint, as the effects were similar, though stronger, to cannabis. Another interviewee reported sniffing glue rather than paint because she did not like the taste of paint or 'sprays', admitting she sniffed glue as a substitute for cannabis. Many of the young people interviewed had previously sniffed deodorants or other sprays but tended to 'move on' to paint sniffing.

There appears to be very little petrol sniffing in Cairns, though several respondents said that they had experimented with it or knew of other people who had used petrol. One respondent said that she had briefly inhaled petrol over several days as a teenager, when she returned to her home community in the Torres Strait but didn't like it because it was too strong and made her hallucinate.

Whilst it is generally accepted that petrol sniffing is not a widespread issue in Cairns, a couple of the interviews with young people indicated that it is not completely unheard of. Two interviewees knew of at least one person in Cairns who was known to sniff petrol. Practitioners also reported the recent identification of two adult males sniffing petrol in town camps in Cairns.

### 8.3 Inhaling methods

Young people generally reported inhaling paint by spraying it into a plastic bottle then breathing in fumes from the opening. Glue was generally sniffed from a plastic bag, whilst deodorant was sprayed into a cloth. Only one respondent said that she preferred to sniff paint from a plastic bag because the effects were stronger.

*'Plastic bags is better. You get high quick. You get high real quick. When you sniff through plastic bags, you see different colours. Like rainbows everywhere. That's how high and how quick you get high.'*

*'I sniff out of coke bottles some people sniff out of plastic bags some people do it out of anything cask packets could be a cask packet could be milk bottle I used to spray it in all that.'*

## 8.4 Reasons and correlates for inhalant use

First of all it must be acknowledged that, like much drug use, young people often use inhalants because of the pleasant or euphoric feelings they produce. Most volatile substances reportedly cause feelings of euphoria and an initial and rapid 'high' that may resemble alcohol intoxication, followed by a light headedness (Drugs and Crime Prevention Committee 2002a; S. J. MacLean 2005).

*'I sniffed cause I liked the feeling of it...it made me feel high like it wasn't me here'*

Throughout history, feelings of intoxication, whether caused by drugs or behaviour (e.g. gambling), have been sought after and valued specifically because they are different to everyday consciousness (Palmer 2003). Young people may be particularly attracted to inhalant use as their source of intoxication due to the ease in which substances can be accessed (Drugs and Crime Prevention Committee 2002b). Volatile substances are not illegal and many household substances can be sniffed. Inhalants are often cheap to buy compared to other drugs or can quite easily be stolen from a wide range of retail outlets. Also, in contrast to illegal substances, users do not need to know a dealer to obtain substances for sniffing.

We know that the family plays a key part in substance misuse, whether this be in terms of inducing risk, or in providing support and imparting increased resilience (Velleman et al. 2005). Risk factors such as family alcohol or problematic drug use, high levels of family conflict and experiences with the statutory child protection system have all been linked to inhalant use (Gutierrez & Vega, 2003). Practitioners interviewed consistently identified intergenerational trauma and family dysfunction as predominant contributing factors.

*'My mum knows my dad he knew. My dad was sniffing for a bit and then he became a Christian he died in the park.'*

*'Lately I've been thinking of sniffing I'm so stressed out and the only way people will leave me alone is if I'm sniffing. I'm talking to a worker cause of problems in my family they aren't helping and the way they're going they will make me turn back to my spray tin again.'*

Domestic and family violence and substance misuse related violence was identified as a common factor when assessing a young inhalant user's family background. Young people interviewed also described sniffing as a tool for getting a break from family.

*'I left home when I was thirteen I just decided to run away I think I was a slave for my family that's how I felt. I ran away from home to my granddad's I had a lot of big cousin sisters there who used to roam the streets. I started following them till I met up with the little sniffing crew. I was there with my other cousin sisters and they were just charging up and then I just hung around with the others then I didn't go home ever just for more clothes.'*

*'My mum went right off she growled at me what are you doing that for you don't need to go the same way your sister went. I thought you had better brains and then she told me I had to go or she was ringing the police cause I had a tin of paint on me she still growls me.'*

*'My uncles and cousins just kept telling me to stop and what is it doing to your brain and then I got sick of them and I just stopped, they told me to go far away don't do it here.'*

Emotional deprivation and inability to form strong attachments due to childhood physical or sexual abuse have been noted as a possible correlate by practitioners interviewed in this study. Separation from home and family was also cited as a stressor by the CCYPCG (2011). Where parents and families are still present in a young person's life, practitioners observed a lower risk of inhalant use. One

counsellor said that she believed that intensive sniffing behaviours are linked to a yearning for family and attention.

*'I felt like I wasn't wanted and that's why I sniffed'*

Inhalant use is both a resultant and causal factor in homelessness. A lack of housing was a common feature in the lives of the young people we interviewed, for most the lack of safe housing was a precursor to their inhalant use. In some cases people were homeless due to family circumstances and then began sniffing while living on the streets. For others there were problems at home, which meant they spent large amounts of time away from the house, began to sniff and were then kicked out of home because of their sniffing.

*'When I was sniffing I was sniffing everyday I didn't drink or smoke cones just sniffed. I was staying on the streets at that time I tried all sorts of things but I stuck to paint. I sniffed a lot with friends and by myself'*

*'I was homeless and I got evicted and I had nowhere to go. I didn't want to depend on anyone else. I just was sniffing the whole three days and then my friend found me and took me to her home'*

Inhalant use is also often depicted as a means of coping with stresses or trauma, providing an escape from difficulties being faced by young people (CCYPCG 2011). Individual levels of inhalant use increase and decrease in response to the personal stressors of individuals at any given time. Particular triggers for increased inhalant use included homelessness, pregnancy and grief. This was supported by interviews with young people, where coping with stress was commonly cited as a reason for inhalant use. Several young people discussed using inhalants as a way to escape problems.

*'When your head is like full of everything and like when you sniff then after, like when it's all finished and the highness has run out, it's like you're not worried about that thing anymore, the problems and that.'*

*'It eases your mind. Clears out my mind, everything that's there. Sometimes when I have everything in my mind and it's hard to come out, I just sniff. Then when I have the glue feeling, things just gonna come out of my mind. Then when I finish sniffing, I just gonna think about something else. Not think of anything.'*

*'When I'm stressed I'm a very stressful person I've always got stress on my mind from someone when I don't have my drugs that's what makes me look for paint'*

Practitioners associated high levels of trauma and grief with inhalant use. Many young people engaged in VSM have been victims of sexual abuse and this abuse has led to dislocation from family and country. Older female clients (i.e. over 18 years) often openly discussed histories of sexual abuse with their caseworkers. In general, the younger clients were less willing to talk about such abuse.

Practitioners noted that most of the young people using inhalants have had some association with the child protection system and many had been removed from the care of their parents. Conclusions from 'The Chroming Report' produced by the Commission for Children and Young People and Child Guardian (CCYPCG 2011) highlights this connection between out-of-home care and inhalant use as follows:

*"Children who have not been involved in healthy and attached relationships and who are living in care have a very high risk of adopting dysfunctional and destructive coping strategies such as chroming and VSM" (p60)*

'The Chroming Report' focuses on Aboriginal and Torres Strait Islander young people who come from families experiencing intergenerational trauma and disadvantage. Many of these young people have experienced abuse and neglect in the family home. Despite these strong links between young people's involvement in the child protection system and inhalant use, the causal nature of this correlation is not immediately evident although there appears to be a strong correlation between initial abuse or neglect in the home, suitability of placement and smooth transitions from care.

The level of family dysfunction that necessitates the need for intervention by the child protection system is likely to be a significant initial contributor to a young person's inhalant use. In many cases a

young person will have been exposed to domestic or family violence and substance misuse at a young age; this and the subsequent separation from family may be considered contributing factors to the development of psychological or behavioural issues. These in turn impact upon child development and functioning and create challenging needs and behaviours. A young person will often adopt dysfunctional coping strategies including risk-taking behaviour, which in turn can make placements unworkable and/or unsustainable.

Placement breakdowns both in residential or foster care can decrease young people's feelings of self worth and absconding from placements can increase access and exposure to inhalant use. Additional problems include some residential services providing young people with only emergency overnight accommodation, and young people being further exposed to the risk of inhaling during the day (CCYP 2002).

*'I was staying on the streets for a long time we lived under the bridge cause we were in child safety we ran away and lived under the bridge'*

*'I started moving house to house and someone in the house, was um, one of the cousin brothers was trying to um ask me out and everything so I left the house that's when I found all them young kids and they didn't have anybody older than them so I had to be there for them but they found glue so I just sat there and watched them do it and then I started doing it. It was just like kids that was on the street before I was most of them was in child safety like run away from homes'*

Workers in the non-government community sector raised concerns about the inadequacy of transition from care strategies for young people as they approached eighteen years of age, when they would no longer fall under the responsibility of the Department of Child Safety. The need for such strategies is consistent with recommendations from an inquiry into the inhalation of volatile substances in Victoria, which included the need for a review of service provision for those young people who, having turned eighteen years of age can no longer receive assistance or participate in programmes designed to assist them with their volatile substance misuse (Drugs and Crime Prevention Committee 2002b).

Practitioners interviewed for this research were in agreement with the findings documented in the 'The Chroming Report' and expressed concerns that young people's involvement with the state child protection system may have contributed or exposed them to inhalant use. That said, practitioners also noted that whilst sniffing rates may be higher amongst young people involved in the child protection system, the majority of young people in state care do not use inhalants.

The case of 'Sally' below provides just one example of the family and residential placement instability, which often accompany the lives of young people who use inhalants.

Sally (Please note names and places have been changed)

Sally is an Aboriginal young woman who was born in Western Australia. Sally moved to Cairns with her grandmother when she was eight years old. They came to stay with Aunt Sarah but Sarah did not get along with Sally and did not want the additional responsibility of her care. Sally could not return to Western Australia because her father could not provide suitable living arrangements and her mother had passed away. Sally was thrown out of the house when she was eleven and accessed crisis accommodation. Following an assessment, Sally was placed in a residential care group home. There is no evidence to suggest that Sally was using inhalants at this stage.

Staff at YETI became aware that Sally was using inhalants when she was 12 years old, though initially this appeared to be an occasional, social activity with her friends. Sally's sniffing increased when she was placed into a residential facility with another young girl who was known to be a frequent inhalant user.

When Sally was 14 years old she was sent to a crisis accommodation shelter in another town. Whilst there, she became pregnant to an older man. Sally's sniffing escalated during her pregnancy and her baby was removed shortly after birth.

Following the birth, YETI staff accompanied Sally to Western Australia to visit family and to visit a remote rehabilitation service. Sally was excited by this reconnection with family and after returning to Queensland, she seemed to be coping better with life for a few months before her substance use again escalated.

During the years that followed, Sally moved from one residential facility to another. During this period, YETI assisted in facilitating meetings between Sally and her grandmother. At this stage Sally was attending YETI daily receiving advocacy, accommodation and case management support in cooperation with Child Safety and residential placement services.

YETI staff believe that some of Sally's behavioural issues stemmed from her experiences in residential placements. Changing workers and residences left Sally confused. At 16 years of age and pregnant with her second child, Child Safety said that they were no longer able to find local placements for her as too many of her previous placements had failed. She was offered a placement in the same crisis accommodation shelter where she had fallen pregnant at 14 years old, an hour away from her existing support systems. This placement did not last and Sally returned to Cairns where she was placed into a domestic violence crisis shelter. By this stage Sally was known to be sniffing paint as well as drinking alcohol and using cannabis.

Sally again sniffed heavily during the final stages of her second pregnancy, including openly sniffing in front of YETI, causing great concern to many people who had been trying to support her. YETI staff called for ambulance assistance on several occasions to check on her wellbeing during this time. Sally's sniffing had clearly moved from being a social activity to chronic use, as she was heavily pregnant and sniffing alone and every day.

Both of Sally's children were removed by Child Safety shortly after birth and placed with a non-Indigenous foster family. Sally recognised that she could not look after her children and requested they be placed in the care of her family members. However, this request was denied and Sally was soon denied all visitations with her children due to her behaviour towards child protection staff.

Sally continued to get into a lot of legal trouble throughout this period. By the time Sally turned 18, she was still sniffing heavily and many of her friends expressed concern for her safety.

Shortly after she transitioned from care, YETI staff supported Sally to return to her Western Australian community of origin. Sally's family members stipulated that she would need to spend time at an outstation rehabilitation service to sober up and settle down before she would be allowed to return to the community.

Sally is reportedly doing very well in Western Australia. She has ceased sniffing and had a job for a period of time. Sally continues to contact YETI regularly and staff are assisting her to explore reunification options so that her children can reside in the community with extended family. Sally has participated in women's ceremonies and dance. Sally's grandmother, who is with her now in Western Australia, is proud of her.

Young people interviewed were not always able to identify or articulate the reasons they used inhalants. Whilst practitioners frequently referred to trauma amongst inhalant users, the young people interviewed did not use such terminology, instead making references to using inhalants because they 'had problems'. Several young people said that they started sniffing regularly when they became homeless. One young woman told of living on the streets with a large group of children, most of who were in the custody of the child protection system but absconded from placement.

Interestingly, two clients interpreted the reason for their addiction to sniffing as an inherited problem passed down from one or both of their parents. One client stated that she used inhalants because her father did. Another supposed that she was a sniffer because her mother had been. This suggests a concerning perception of inevitability in regard to inhalant use.

*'I take after my father, because he was sniffing right up until he died. My mother she's never touched paint, never sniffed in her life but my father was a sniffer.'*

## 8.5 Drug of Choice?

Practitioners interviewed throughout this project reported that inhalants were rarely the first drug of choice, with most young people preferring alcohol and/or cannabis when available. This was supported in many of the interviews with current or former inhalant users and has also been documented in various reports into inhalant use in Australia (CCYP 2002; Drugs and Crime Prevention Committee 2002a; Hancock 2004; Cheverton et al. 2003). Amongst users who said they also used alcohol and/or cannabis, most said that they would prefer one of these substances given the choice.

*'When I'm stressed, it's... I'm just a very stressful person. I've always got stress on my mind from someone. And sometimes if I don't have my friggin drugs, my drugs or a cone just to calm my nerves down, that's what will make me go look for paint then, if I don't have drugs'*

*'We usually sniff when we don't have drugs. Because when you take glue, it feels like drugs, that's why we just take it'*

*'I would sniff if I didn't have marijuana. It was like something would tell me to steal glue and sniff'*

Reasons for choosing to use inhalants rather than alcohol or cannabis were largely related to price and accessibility. Some said that they would buy cannabis or alcohol when they got paid and some spoke about stealing money to access cannabis when they wanted a break from sniffing.

*'They ran in town and they were stealing them jars, the money tips that they put on the desk. They stole one of those and we started smoking marijuana. And we just forgot about the glue'*

Substances such as paint, glue and deodorant were reported as relatively easy to steal as they were stocked in many retailers. For young people relocating to a new town it is generally easier to access inhalants because it did not involve needing to know a dealer.

*'I used to sometimes go in and get it every now and then, I don't steal I buy it, that would get me in more trouble stealing, them others they steal paint but not me. I'm not into stealing'*

Several young people said that cannabis was better for calming nerves and anger.

*'Yeah, it does have different effects. Marijuana it's just like slow you down from thinking. You know cos like before I'm saying like you think about a lot of things. You know, like you're thinking about the traffic, you hear people screaming, birds. When you smoke marijuana you're like just relaxed. Then everything just goes nice and gentle and then you just sit there and just. I mean I can hear like three conversations at once.'*

*'When I am stressed I don't sniff because it makes me more stupid. Though sometimes I smoke drugs because it takes out the stress, but it makes you think a lot. Like it makes you think, why are you stressing and why are you doing this, why you doing that.'*

However, some practitioners said a preference for alcohol or cannabis was not universal and that some young people have expressed a preference for the kind of 'high' they get from inhalant use. Even when alcohol and cannabis were available some would also use inhalants in response to events occurring in their lives.

## 8.6 How does sniffing begin?

Whilst chronic inhalant use may be a response to trauma and grief, workers noted that it generally does not begin that way. Commencement of sniffing may not necessarily be attributed to life events, but associated as a fun social activity with peers, similar to initiation into the use of other substances.

During interviews, young people described being introduced to sniffing by a friend or family member who was using. In one case it was the older brother of a chronic user who introduced her to inhalant use and another was introduced to sniffing at a young age by her aunt.

*'It started when people started sniffing around me and I didn't like the smell of it and I sat around them and they sniffed around me and the smell annoyed me and I asked them one day what it felt like and I asked if I could have a try and I liked it and then on I sniffed glue'*

*'I was fourteen when I first started yeah, a boy he asked me to buy him a tin of paint and I said to him I don't sniff like that there to him and he said well you don't have to sniff you can just buy it for me and I bought it for him and when we got to the park he said to me come on you have a sniff with us and I kept on saying no and he kept on bugging me saying come on have a go and then I had a go and then I just sniffed from then'*

*'The first time I sniffed I was in grade three. When I was sixteen I started again I was with friends who sniffed and then somehow I just joined in. When I came to Cairns I started sniffing with other people. I came for my mum's funeral and then I just stayed'*

*'I was fourteen when I first tried with a friend I asked her for some and she gave me some and we were sniffing paint'*

*'I was thirteen when I first sniffed with a friend, that friend just got back from Brisbane and he learned how to sniff down there he was sniffing for a while and I was following him then I started sniffing. I sniffed just paint and petrol.'*

In Cairns, several people spoke of an older peer openly recruiting adolescents into her circle of sniffing peers. She was also referred to as the first sniffer another inhalant user had contact with when moving to Cairns as a teenager. During the group discussion with inhalant users, a number of young people spoke of this individual meeting up with younger children at the charity food van in the park where she would give them a small amount of paint to sniff. She would then offer to give more paint in return for these children to do tasks for her, such as stealing food or money.

*'One part there, me and her were there at [the park], at the food van and she had a couple of cans on her. We didn't have nothing. She's like, "youse follow me. We're gonna steal something. Follow me and I'll give youse a refill." And we all followed her you know. She's in the front walking. And she's like "Look for your own bottle" So we're all there, looking round for bottles and we're all putting it out and she's like "Only one squirt" and I'm like, "Is that all?" "Yeah if you're gonna do something for me then I'm gonna keep refilling it"... "You gotta do something for me and then I'm gonna keep giving."'*

One of the participants in the group discussion also admitted to encouraging younger children to sniff. The youngest of these was just nine years old at the time.

*'Yes, I had my own crew. And I'm the one who taught all of them. The youngest boy we had was John<sup>3</sup>, he was only nine. He already knew how to sniff. But when he came to Cairns I kept on encouraging all of them, yeah so he got really heavy'*

Practitioners referred to a common pattern where young people commence inhaling deodorant as an entry point into sniffing, and then later progress to stronger substances such as paint. However, when young people were asked about the first substance they ever inhaled, six out of the ten who answered said that they started with paint. Two others reported using other aerosols, namely fly spray and air freshener.

*'When I first started sniff it wasn't paint or glue it was superglue and deodorant, that was the first thing, air freshener and fly spray before paint came involved, cause I seen sniffers and they told me it was like you're stoned'*

Despite published literature generally showing that the majority of inhalant users are in the 12 to 14 year age bracket, one of the women who had previously used inhalants on a frequent basis said that she did not start until she was nineteen years old.

## 8.7 Young People's Perceptions of the Effects of Sniffing

This section will discuss the reported effects of sniffing as perceived by young inhalant users.

<sup>3</sup> Not his real name. Also referred to in previous case study.

The perceived effects of inhalant use vary by substance (see Section 7.2 for paint colour preferences) and include both the intoxicating and/or euphoric effects that are sought by those inhaling them as well as negative physical and psychological effects. Whilst young people discussed some of the negative effects of their inhalant use, they were also quite open about the enjoyable effects they got from intoxication and presumably it is largely these effects that motivate an individual to sniff. There were various descriptions of the general euphoric effects of inhalant use, with several descriptions of heightened senses.

*'You get high, like your brains are sizzling. You can hear better. It's just a good head rush.'*

*'You feel real alive, you feel awake. And you hear more things than you can hear normally. Somehow it just affects your ears. You know, that's what I mean, you're in your own little world and you're constantly thinking this... and that. You can hear people screaming and you can hear the traffic so loud.'*

*'I feel really different and speak different and feel different it's a lot clearer'*

*'Sometimes it calms my nerves down cause like when I'm angry and that it makes me relax and that but with the other girls I hang out with and they sniff and that they get a bit dopey and that they get a real dopey look about them when I sniff I'm still a normal person. I feel calmer'*

When asked to describe the negative physical effects of sniffing, most young people did not specifically identify what they thought sniffing was doing to their body, though some reported that heavy sniffing had lasting effects on their eyesight. One young woman spoke about damage to her eyesight but attributed it to getting paint fumes in her eyes, rather than any suggestion there may have been any effect on her brain. Workers at YETI had been very concerned about the effects of sniffing on this client's eyesight but were relieved that sight seemed to improve again after a period of reduced inhalant use.

*'Sometimes my eyes close up and go blurry that's from the fumes itself that go up under your eyelashes with the paint fumes or the glue fumes everyone gets it'*

*'There is some points when I was sniffing when I would black out and don't even know what I was doing and then it comes out just a little bit'*

Young people reported other physical side effects from high levels of inhalant use including chest pains and blurred vision. Some discussed a loss of appetite when using inhalants and said that they lost a lot of weight when they were sniffing heavily. Amongst young people that were known to engage in frequent inhalant use, some reported suffering strong throat pain if they ceased sniffing.

*'I do get chest pains from the sniffing, makes my eyes are sore and blurry and it does make your whole throat here so sore after a few days or if you haven't done it for a few hours it's painful in your whole throat that's why I lost a lot of weight that's cause of the sniffing I don't eat when I'm sniffing I can't eat'*

*'My friend was pregnant and she died while she was sniffing I know people who've been through it before I know people can even have miscarriages...the paint can effect, the glue can effect or the petrol'*

*'When I sniffed every day all day I would just wake up and sniff. I had bad migraines with my head throbbing and when I sniffed it all stopped'*

*'These new ones they're crazy they're drinking paint and all, you know they get too high they accidentally drink it. I think when they get dehydrated so they need water but they're too high and they can feel that paint in the bottle'*

There were also misconceptions about the risks, such as concern that if you sniffed too much your brain would be physically covered in paint.

Inhalant use dramatically affects temperament and young people who sniff often present extremely volatile and aggressive subsequent to use. Inhalant use differs from the use of other drugs and users may need to 'top-up' more frequently as the intoxication effects are relatively short-lived.

*'There is dramas when you don't give 'em a refill and they go right off their heads. There was things like if you don't shout back you don't get no more'*

Young people who sniff often presented impulsive or reactive. One counsellor hypothesised that the existent culture of some may also contribute to this – such as coming from backgrounds where they had been exposed to violence and being more predisposed to reaching for a weapon when annoyed or frustrated. Young people acknowledged getting aggressive when sniffing and reported getting into trouble with the police as a result.

*'When I was 14 up to 16 I got into trouble. I don't get really into trouble with the police with the paint. But my sister starts on me all the time when she's bombed out. She started imagining the wrong things and then she hits me'*

*'...others are different when they sniff, they gang up on me the others, they get together they whisper like they're going to double me or bash me'*

Paranoia was common and several young people described suspicions others were talking about them and planning to beat them up when they were intoxicated. This sometimes led to fighting within groups of intoxicated young people.

*'You feel like it comes to you, you feel as if you're mental or something. You're getting really low in the brain and you can feel like you're getting really dopey. And you start getting paranoid, your mind gets really paranoid and starts speaking, like speaking to you in your head.'*

*'It was like I could control the police everything that I would say they could hear because I used to get in trouble a lot that was the last time when my mind just blew up and I was thinking weird everytime.'*

Young people were generally very concerned about the effects of using inhalants with cannabis or alcohol. Several young people referred to incidences of memory loss or blacking out when combining alcohol and inhalant use. One interviewee said that when she was a teenager she would get so intoxicated that she would have no memory of what she had done the previous night. During this period she was sniffing and using alcohol and cannabis, which may have contributed to this memory loss. She also spoke of increased paranoia when she was sniffing, certain that the police or others were 'out to get her'. Several respondents said they would not mix cannabis and inhalant use due to prior experience of vomiting and nausea.

Another respondent spoke of memory loss due to sniffing and described a feeling of having water in his head when sniffing paint.

*'I thought that there was liquid in my head, and I seen that there was liquid in my head, like that's what I was thinking. But I didn't think anything about going to the mental health. I was too busy, in sniffing'*

He acknowledged being admitted to the mental health unit and diagnosed with schizophrenia.

*'I ended up going to mental health. Because the doctors wanted to check my head. So I talked about, I think I got a crack in my head. And like I thought I had a crack in my head, but it wasn't a crack. Then I just started talking about, like, I've been sniffing and I've been seeing things and hearing things. Then they just put me on a tablet. And they said that I'm schizophrenic'*

Several young people interviewed, believed that inhalant use was a cause of mental health problems, saying that they knew of people who had ended up in 'mental health' because of their ongoing sniffing. One interviewee believed she was fortunate to have ceased use as she had witnessed her cohort end up with ongoing mental health issues. The interviewee attributed this to sniffing, smoking cannabis and violent partners 'cracking their head'. However, it is not possible based on the information available to us, to determine in these individual cases whether inhalant use was the trigger or if individuals had pre-existing mental health problems.

If someone has been sniffing constantly over several hours, the effects appear to involve hallucinations or 'tripping'. The most vivid discussions around hallucinations whilst sniffing came from a young person whose preference was to inhale glue. This young woman told various tales of group hallucinations with friends whilst intoxicated.

*'Last night when C and I were sniffing, we pulled the Earth close. Like we can draw up on the sky, like draw. We can play love game in the sky. Last night when we were sniffing, we were standing in the park, like on the side of the foot path. And if all friends sniff together, then something's going to come...'*

*'We were standing together and something fell from the sky down to us. C picked it up and she pulled the earth close. There was this orange thing surrounding the oval and us. We was in the middle. There was this orange thing and C was pulling the earth close. And we seen what she was doing. And the sun is that close to the earth. Like we seen what she was doing. We was just standing there and I got panic. As soon as she let the thing go, there was a good sized rock falling down and she said "Watch out from the rock, like run". I slinged the glue bag and started running. As soon as I stopped the rock landed straight side of me. It was a big rock, landed straight at the side of me.'*

One interviewee said that she hallucinated when she sniffed deodorant but not glue. She didn't like the hallucinations, which largely seemed to involve seeing people. She said that she refused to talk to these people.

*'When I was sniffing deodorant I used to talk to a person that was not real. I would see a person. Glue I never saw anybody, it was something like a game, sniffing deodorant you would actually see people. The others would talk to the people but I would just watch them. I would know they're not there because once it wears out they're not there, once the Rexona wears out I don't know if the others remember what they saw'*

This was only one of several mentions of seeing or talking to people who did not exist as well as the spirits of deceased relatives. Some of the people interviewed spoke positively of such experiences, whilst others did not enjoy this aspect of inhalant use. Other hallucinations were associated with 'games' and premonitions.

*'I used to see things. I used to see a like a game when I sniffed and it all depends on if you win and lose and there's two horns on the side of you and if you lose the horn goes into your head and if you win I think the horn just I don't know I just kept on looking at it but I think the horn goes into your head too'*

*'Me and my friends would play another game when we looked into each others eyes, it wasn't right cause we were sniffing and just looking into our eyes. I would just see a glue bag in their eyes I just imagine you're sniffing it I think it was a hallucination'*

*'when I was sniffing I get really high and I sort of hallucinate and I think all these things are going to happen and I do it a lot when I used to do it a lot I used to hallucinate'*

*'When I started sniffing, I didn't talk. I really didn't talk but the other people who were sniffing paint and all that, they said that you have to talk when you do some things like that. And, um I didn't talk so it was like I was controlling things with my mind. And every time I would sniff alone, I would see the future. Like I would see the future and then it actually happens, like it happens a couple of days or weeks after.'*

One young woman interviewed said that as a teenager she had tried sniffing petrol when she returned to her home community in the Torres Strait. She sniffed by herself over a period of four days but didn't like the feeling of it. It was too strong and made her hallucinate which she did not like. She saw people and objects that were not there, particularly seeing little girls who would speak to her.

*'I only hallucinate with petrol. I just tried it once and sniffed for about four days just by myself and petrol is way stronger and I was hallucinating I saw people or think there's something there and nothing there, like silly girls and people, that was on the islands, there were lots of people sniffing petrol at that time.'*

Young people made several references to the term 'magic' when they recalled experiences sniffing. This included gaining abilities to control people, powers that were used to stop police from coming towards them while they were sniffing and also to prevent shop staff from seeing them when they were stealing glue from shops.

*'I have this thing when, like if we steal and no one wants to get caught, I can blind the workers'*

*'When I first started sniffing she (an older sniffer) has the thing she gives to little kids like us, like when police are coming we can make them go other direction, like if people come our way we can make them go other direction, like black magic, we sniff the glue and put our hands out'*

She would not go into the details of how they do this, explaining that it was something they only discussed within her group of friends.

## 8.8 Issues faced by young people using inhalants

Young people engaging in inhalant use generally face many complex issues, which both contribute to, and result from their substance use. Most of those accessing YETI services experience high levels of stress as a result of family issues, trauma and homelessness. As one practitioner pointed out, not all of the young people coming in to services have family members on whom they feel they can rely for support. Emotional attachments are very important for young people and where family is not able to be supportive, young people need to be given the opportunity to develop positive attachments.

Some young people interviewed reported commencing inhalant use after they became homeless, while others became homeless after their families became aware of their sniffing and evicted them from their accommodation or the family home. Several of those had been told that they were not welcome in the family home while they were sniffing and this has led to ongoing homelessness.

*'My mum said you be sniff paint so don't come home you sleep outside so I lived on the street I choosed paint'*

Whilst experiencing homelessness young people are more likely to congregate in groups for safety on the streets, however this does mean they are more prone to be initiated into sniffing. In several cases young people told of particular members of a group teaching and encouraging younger children to sniff. Young people reported feeling responsible for younger ones, which included helping them to steal food and in some cases helping them to access inhalants.

*'My aunty actually kicked me out and I had to stay on the streets. I had my own big crews. I was the eldest and had to look after all of them. We was actually on the streets and I had to steal food for all of the kids, from [supermarkets].'*

The issue of exposure and subsequent uptake of aggression and/or violent behaviour was also higher in these cohorts. One young person said that when she sniffed she was extremely aggressive and other people were scared of her. She believed that because of her behaviour when she sniffed previously, her brothers were very intolerant of anybody sniffing and would antagonise anyone they suspected of using inhalants.

*'I'm in more fights with my sniffing into more fights than before and that sniffing it's got me into more fights.'*

*'I did them all at the same time (smoking and sniffing). I fought a lot of girls.'*

Whilst some young people reported the distress or anger of parents as being of little influence, others were more concerned with regard to the response of family members to their inhalant use. For example, one respondent said that she would always stop sniffing when her older brother was out of jail. She reported being afraid of him finding out about her inhalant use because he would be angry and had a history of violence.

*'The only time I stop sniffing is when my big brother is out of jail, because there are a lot of dobbbers around. He's in jail at the moment. When I sniff, I don't go around people I know. I*

*don't go where they are, I just stay in the one spot. Then after finishing sniffing, go home have a shower, get the glue smell out of us.'*

*'When my mum hits me, I hit her back. She's shorter than me but she can fight. But I always fight with her back when she grounds me and does this and that to me. But I sometimes listen to my grandmother when she tells me [not] to sniff. When she tells me [not] to sniff I can go like weeks and weeks without glue but then when friends come and get me and they decide to sniff, they force me and I just start sniffing.'*

Young people interviewed generally had histories of family dysfunction including, violence, neglect, and in some cases were quite disengaged from family. Despite this disengagement most young people expressed concern over family perceptions of them.

*'I would sniff in the bush and in the mangroves to stay away from people my family they weren't good about it they would chase me and belt me I thought I'm not part of them but I knew I'm not making good name.'*

It is common for young people to feel stigmatised and alienated from non-inhalant using peers as well as the broader community as a result of their sniffing (Hancock 2004). In guidelines for schools in Victoria it is suggested that the motivation to avoid this stigmatisation may actually be a useful tool for discouraging young people from engaging in VSM (Department of Education and Training 2000).

Unfortunately, it appears that stigmatisation may extend long after a young person has ceased sniffing and people who have a history of inhalant use face being stigmatised indefinitely. A reputation of being a sniffer may persist for a long time after a person has ceased any inhalant use and damage potential trust and relationships both with family members and support agencies. Practitioners identified this as a potential issue when considering encouraging young people to return to their home community.

Most of the young people interviewed spoke about getting into trouble as a direct or indirect result of their inhalant use. This included getting into fights when they were intoxicated, assaulting police as well as being arrested for stealing food.

*'I got into a lot of trouble with the police, I just um used to be really aggressive really really mean. I was mean to all of my friends.'*

Many of the chronic inhalant users in Cairns are well known to the local police. The majority of the young people interviewed for this report had been involved in the juvenile justice system, and later with the adult legal system. The causal relationship between inhalant use and crime is not assessable within the scope of this project, but in general the young people who engage with YETI services are over-represented in the legal system for a range of different offences. Young people's experience with the police varied, although it should be noted that one young person noted that some police were concerned about young inhalant users' welfare.

*'Police just take it and tell us to move on or let us have it or we can even get locked up if we sniff in the city. It's against the law in the city that's what I got told. Now I just walk around or at a friends house. He don't let us sniff there but we do.'*

*'I would run and I would get real paranoid and I don't like the police cause when I was a juvenile I got into trouble I used to swear at them, they used to take our paint from us and spray it out or take it to the police beat and put it in the bin but we used to steal it from the bins. The police used to just pull up even if we're straight'*

*'When me and my boyfriend were on the streets they used to stop and check on us and see if we were alright'*

*'One point I was sniffing me and four younger people we were sniffing and we had lots and lots of glue and we went to sit back at these units and we went out the back and sat there and one of the girls said we should go somewhere else and then two paddy wagons came and found us with all the glue and I was the only one who got put in, they took me to the watchhouse'*

Amongst the long-term inhalant users, there have been historical and recent cases of suicide attempts and ideation. One young woman told of attempting suicide when she was 15 years old after a period of heavy sniffing. Another of the YETI clients frequently phoned the service talking of suicide when she was intoxicated.

Young people attending YETI have told case managers about engaging in opportunistic prostitution in exchange for cash, paint or other inhalants. Cases include one-off situations, as well as ongoing situations where young women receive accommodation and other support from older men. This is described in further detail in Section 8.6.3. Exchanging sex for money or inhalants was not specifically discussed during interviews for this project. Young people coming into contact with the service system are supported to access sexual health services.

Associated health issues noted by practitioners were weight loss, tiredness and lack of energy, irritability and illogical thinking, often warranting immediate crisis interventions. Withdrawal symptoms such as headaches, muscular cramps and pain were cited as less common. Visible signs included rashes associated with substance on skin, red eyes and flu like symptoms. Cycles of depression were also noted however due to the circumstances of young people, it was difficult for practitioners to attribute this directly to use, though noted to intensify during periods of use. Practitioners were aware that many of the young people who they had contact with also had difficulty with memory, attention spans and problem solving issues. These were seen to be exaggerated during periods of substance misuse. Whilst cognitive impairment issues were present in young people using inhalants, they were also significant among young people from low socioeconomic backgrounds accessing the services. Exposure during pregnancy was common. Young people's perceptions of this are discussed further within this report. YETI practitioners voiced most concern about the individuals who sniff alone because they believed it presented a greater risk of suicide and accidental death or injury. Practitioners ensured their harm minimisation interventions incorporated discussing safety plans with young people to negate accidental injury or death as a result of sniffing in unsafe places.

## 8.9 Stopping sniffing

Young people were asked about factors that had previously or would potentially assist them to cease their inhalant use. The answers to these questions included needing to separate from peers, needing to find stable accommodation, finding religion, going to youth services, ceasing due to pregnancy or wanting to gain custody of children who had been removed by child protection services. Amongst young people who were still frequently using inhalants, residential rehabilitation, counselling and diversion activities were also suggested as potential interventions that could support the cessation of sniffing.

During interviews most, though not all, of the young people who admitted to regularly using inhalants said that they would like to stop. Several said that they were currently in the process of giving up and that ceasing sniffing would be 'easy'.

A young person, who had attended rehabilitation on several occasions and temporarily ceased inhalant use each time, said that the most effective aspect of rehabilitation was the lack of access to inhalants. Such services are often located far from easily accessible sources of inhalants and one interviewee said that she would be too '*shame*' to ask workers where she could go to get paint or glue.

*'It messes with my head if I'm not doing nothing. If I'm not doing it and other people are [sniffing] and I've got nothing. But at rehab they got not paint, no glue, no yarndi, no grog, no tawny port, you know'*

One of the younger sniffers, who could be categorised as an occasional social sniffer, said that the best way for her to stop was to stay away from her friends. Several other interviewees reiterated this; they believed that they would not be able to stop sniffing, if they still associated with inhalant using peers. One of the former sniffers said that he had not been associating with any of his former inhalant using friends since his recent release from prison, as he did not want to sniff again.

*'I had new friends and they didn't like me sniffing'*

*'Being away from my friends is enough to stop sniffing'*

The most frequently cited reason for ceasing inhalant use was pregnancy. Two former chronic inhalant users who had stopped sniffing did so when they found out they were pregnant. One of these women said that she was motivated by the fact that she had recently seen another inhalant user give birth to a child with birth defects. The issue of birth defects was mentioned in several interviews with beliefs ranging from a fear of congenital deformities to imagining their child would be born covered in paint.

*'I quit sniffing when I had my baby when I was pregnant because I was pregnant I dropped sniffing when I had the baby I knew I had to stop'*

*'The longest I've gone was probably when I was pregnant, they got to stay in my care for like four months and I never done it once and I came back to town and caught up with my sister and started again'*

*'I stopped for my son's safety I didn't want him to have brain damage or be born with paint on his skin. I was sniffing pregnant I told child safety I won't lie they asked me when the last time I had a sniff before I had that baby and I told them it was only the other night, but it was only glue I refilled the glue bag and then I threw it away cause I was thinking in my head I'm going into labour soon and they asked me the last time I done it, like three days ago I had a tube of glue but I threw it away'*

One woman spoke of ceasing inhalant use while pregnant because of information regarding potential health risks provided to her during antenatal examinations. She said that prior to this she had not really even contemplated ceasing sniffing.

*'I stopped sniffing cause I found out I was pregnant. After I had my baby I had new friends. I stopped cause I had all these check-ups and they told me whatever you're having the baby is having as well. I wanted to go back and sniff but I couldn't. I got put off the taste, it was funny for me'*

*'Because I was pregnant and one of the girls that was sniffing in the group was pregnant and when her baby came out it had problems and I didn't want my baby like that, so I dropped sniffing'*

Another young woman said that she sniffed throughout her pregnancy even though she was worried that the Department of Child Safety would remove her children if they knew. She contemplated stopping while pregnant because she had a cousin who died due to sniffing while pregnant. When asked if there was any type of support that would have stopped her sniffing before her pregnancy she responded:

*'No not really, because I wanted to sniff. Felt like I wasn't wanted, that's why I sniffed. I just sniffed, that's what I did.'*

One interviewee who ceased sniffing during her pregnancy became a Christian after the birth of her child and said she felt that the people in the church group understood her and supported her and that this had helped her sniffing from recurring.

Of the young inhalant users accessing services at YETI, several have young children who have been removed from their care by child protection services. A desire to regain custody of their children was also cited as a motivation for ceasing inhalant use. One interviewee described ceasing inhalant use for some time after the birth of her second child as she recognised her care responsibilities for both of her children. However, after approximately four months she started again and her children were eventually removed. This young woman was exposed to domestic violence and had no stable accommodation at the time.

One of the young people interviewed discussed residential rehabilitation as a desirable treatment option to assist her to cease sniffing. This young woman has sniffed regularly for many years and has accessed services at YETI for much of this time. She has frequently requested assistance to access rehabilitation services. Even though gaining admission is a very complex process, the young woman has entered residential services several times. Despite repeatedly urging practitioners to assist with admission, the maximum period she stayed was limited to days of what should have been weeks or

months of treatment. On one occasion she remained at a rehabilitation service for over a week, however, stated that she left after seeing her dead father's spirit at the centre. Practitioners reported a lack of appropriate rehabilitation services for young people in North Queensland and both practitioners and young people who used inhalants, interviewed for this research, cited the availability of rehabilitation services as essential.

Family tensions and being 'kicked out' of the family home were also cited as a motivation for ceasing inhalant use. For example, one former inhalant user answered as follows when asked why she stopped sniffing.

*'Cause I was sick of getting kicked out of where I was staying and it causes too much problems, fights, family fights and that and my family won't let me go there if I've been doing it. And now that I've moved into my own place, I don't sniff, can't sniff there and that.'*

Pressure from family and partners was cited as a motivation for ceasing use. However, it appears that such pressure is not always effective and can increase stress and feelings of stigmatisation, which may contribute to a cycle of increased sniffing. Presumably any pressure from family would need to be accompanied by offers of support to reduce the risk of further alienation. Young people reiterated that coercion to cease sniffing would not help them cease, however there were those who mentioned being constantly told to stop by family members until they finally agreed. Those interviewed who stopped using inhalants attributed it to pregnancy, contact with support services and contact with statutory justice or mental health services.

*'I stopped cause I was in jail and people kept telling me to stop. I was sniffing every day but only when I felt like getting it'*

*'I stopped cause probably I used to go to a youth service, it was just when I lived on the streets more that I sniffed'*

*'I had to change my friends, all the friends I sniffed with are all under mental health now. I reckon if I didn't stop I would be under mental health now, sniffing, smoking, cracks in the head from violent partners...they're under mental health now'*

One of the regular inhalant users stated that she could give up sniffing 'at the click of my fingers' but she had no desire to, as she believed sniffing assisted her to cope with issues in her life. However, during the same discussion she said that she really wanted to give up sniffing to regain custody of her children but that she was finding it difficult.

Several young people interviewed discussed counselling as a desired way to cease inhalant use. Others said they had undertaken counselling previously and thought it was effective. One of the more unique approaches to ceasing inhalant use came from a long-term, dependent inhalant user who said that when she wanted to stop sniffing, such as when entering 'rehab', she would eat the antacid medication 'Quik-Eze'. She said that this stopped her craving inhalants.

It should be noted that, among the young people interviewed who are known to have ceased their inhalant use, most said that they replaced inhalants with another substance, generally cannabis.

*'Like some boys and girls had kids and they stopped and now they smoked dope and those that didn't have kids they're under mental health now'*

## 8.10 Perceptions of Inhalant use

This section of the report will present the findings of young people's perceptions of their inhalant use. As mentioned previously, there is often a high level of stigma associated with being known as an inhalant user, which may have impacted upon responses. Amongst interview respondents who have engaged with YETI over several years, there remained a degree of denial in relation to the level of their inhalant use. Three of the interviewees denied being current inhalant users, or at least downplayed the frequency of their use, despite evidence that these individuals were currently using. This may have been an attempt to please the interviewer or fear of stigmatisation associated with inhalant use. Others expressed an element of inevitability to their problems, suggesting that they no longer had control over whether or not they sniffed.

Stigmatisation due to sniffing is also evident in the dynamics between young people accessing youth services such as YETI. Young people who refrain from use refer to those who use as 'sniffer dogs' and attribute many problems to the fact that this group sniff.

*'Some of my friends judge me, they say like, I don't do that so why are you doing that, it's real low sniffing. I say it's not real low it's just something, something people do'*

Several respondents described attempts to conceal sniffing from non-inhalant using friends because of the 'shame' associated with sniffing. It seems that stigma is not only limited to presence or absence of sniffing but to the levels of sniffing, respondents noted a judgement hierarchy among different groups. Young people known to only occasionally use inhalants saw this use as merely being a fun activity with friends of little importance and appeared eager to point out that they were not dependent on inhalants and did not sniff alone.

Inhalant use seems to invoke strong reactions from different people with many young people admitting disdain for sniffers but acceptance of alcohol or cannabis use. The perception amongst workers is that young people do not see cannabis or excessive alcohol use as a problem because they are substances that have been normalised through use within family. Several young people supported this view. In interviews, young people said that their mothers knew that they smoked cigarettes and cannabis but did not know that they sniffed.

Several young people said that they would be very angry at their siblings if they found out they were sniffing, but thought it was fine if they drank alcohol or smoked cannabis. One interviewee said that she had no objection to younger siblings or cousins using other substances but that paint is different because it *'messes with your brain'*. They also stated that if they saw other young people experimenting with sniffing they would chastise them because they didn't want them to experience similar 'troubles'. However, when asked if they would have listened to such advice when they were young, most admitted that they would not have.

In all interviews with young people, participants were asked what they thought of young children sniffing. When the question related to strangers sniffing most said that they would not say anything and would not interfere.

*'Can't really say anything to them because they're not my family. They might go tell their big sisters you know. "She's talking to me or swearing at me. She was talking mean to me." And then I'd get into a big fight. I can just tell them it's not good for you. They'll end up with brain damage and that.'*

One former inhalant user said that she initially joined in with groups of people already sniffing, then went on to become an instigator, encouraging others to join in. Later when she was aware that she was addicted, she would go off by herself because she did not want to influence younger children in the group.

*'I don't know. It was because I was the eldest one in the group so I didn't want, like someone else in the group start following me, cause there were like 11 year olds hanging around.'*

This may also suggest a shift of thinking with regards to self-perception, and perceived perceptions of others when a young person moves from casual sniffing to addiction.

*'The other people around us used to bring the glue and hang around the group. I was the only one that never used to carry it in front of their faces. I was the oldest I didn't want other people to look at what I was doing.'*

*'We would hide it when other people came, it just doesn't look good, you just carry your bag and a bottle, I would think about myself but they would be thinking what does it do to you.'*

*'I never used to sniff indoors I always walked around and sniffed, people look at me and I think shame and I would get paranoid.'*

When asked specifically in relation to what they would do if younger siblings or family members were thinking of sniffing, answers were often quite different. Chronic inhalant users said that they would be angry and several said that they would hit their younger brother or sister if they caught them sniffing.

*'They weren't good about it. They say "you make bad name for us" and this and that. I said "I'm not part of them". "That's how you think, but you are and you're not making good name". They'd stop me, take my can. Some of my uncles hit me with my spray can. Or they'd just pop my cans and I would stand there and cry for my paint. That's how bad I was. I'd cry for my paint.'*

The stigma associated with inhalant use was further heightened for the young women interviewed who had children. Having children led to increased pressure to cease inhalant use and feelings of guilt associated with not being able to look after their children. One woman spoke of being yelled at by her mother and being accused of being a bad mother.

*'When I'm arguing with my mum I want to sniff all the time. It's just the words that come out of my family's mouth, what they say to me like, they say "You don't love your kids cause you sniff and all that." And I say, "You don't know, I love my kids. I sniff for a reason."*

There was also talk of being victimised on the streets for inhalant use. There were stories of young people being harassed by passing cars and having eggs thrown at them by strangers when they were sniffing on the street.

The majority of inhalant users YETI engage with are young people from Aboriginal or Torres Strait Island backgrounds. In the group discussion people talked about being discriminated against when they went into retailers that sold paint and glue. They said that they would be followed around the store and watched constantly, even when they just legitimately wanted to buy something. This made them angry.

*'Cause it feels like they're just being a bit racist sometimes too. You see all the white people walking in, buying things and everything, not getting followed around. Then if you see a black person walking into the store, they're following you straight away. And there has been some paint stores that have said, "We can't serve no dark people, only white people we can serve."'*

Of interest, whilst some inhalant users discussed being upset about being discriminated against because of their skin colour and associated assumptions about their sniffing, they too held similar beliefs. One of the individuals who expressed anger over the racism also admitted that she was shocked to see non-Indigenous people sniffing in Mackay as she thought this was something 'only black people' did.

## 9 Interventions to Address Inhalant use

What does an effective intervention look like when working with inhalant users? Despite the lack of empirical research, there are many lessons to be learned from those who have worked with young people who use inhalants. Even the most cursory investigation into interventions reveals that there is no single treatment that can miraculously overcome the problem of individuals engaging in inhalant use. Ultimately it seems that the most effective interventions addressing VSM are approaches that include efforts to address social and economic disadvantage and enhance opportunities, skills and confidence of young people (d'Abbs & S. J. MacLean 2008). Effective interventions must encompass a range of approaches to address the complex issues of disengagement, family dysfunction, stigmatisation, addiction and homelessness, which often accompany young people who use inhalants.

A first response for inhalant users should include efforts to address any immediate health and well-being issues followed by longer term planning which includes a coordinated multidisciplinary and multi-sectoral approach to effectively deal with immediate needs as well as any underlying factors affecting a young person's inhalant use (CCYPCG 2011).

In the following sub-sections we will explore the various interventions, which are used to prevent and treat inhalant use and our findings in relation to these interventions in action in Queensland. We also utilised this opportunity to undertake our own assessment in order to inform the development of the practice principles and framework utilised by YETI in their approach to working with young people who sniff. This will be presented in Section Nine of this report. Interventions in Section Eight are grouped into the three broad categories of supply reduction, demand reduction and harm reduction as described in the National Drug Strategy (Ministerial Council on Drug Strategy 2010). We also

include a discussion on some factors, which are relevant across these categories such as working with Aboriginal and Torres Strait Islander communities and working collaboratively. We finalise this section of the report by looking at some of the reported barriers to address inhalant use and include a specific section on working with young people who have been in residential care. This was due to the overwhelming feedback we received from practitioners in relation to this topic.

## 9.1 Demand Reduction

### 9.1.1 Awareness-based approaches

When working with young people who are known to engage in VSM, it is important to equip them with information regarding the health risks of inhalant use. Whilst education activities alone are unlikely to cause an individual to stop using inhalants, they still represent an important part of any intervention. An evaluation of the *Get Real Challenge* intervention in Brisbane (an activity based education program) found that one of the greatest challenges of educational activities for VSM was the need to create a balance between activities that are engaging and those that are educational (Butt 2004). Dropout rates in their program were highest when this balance was not found and they could not maintain the interest of participants.

*'Every worker tells me what it can do and how much it can effect me what it can do how it can kill me, I could be dead you know thinking I'm alive but I'm dead'*

Among the young people attending YETI most had some awareness of the physical impacts and health risks of inhalant use, though only a few reported that this had influenced their behaviour. YETI practitioners reported some of the most useful education tools were the 'sniffing flipcharts' (Sniffing and the Brain; When Boys and Men Sniff; and When Girls and Women Sniff) developed by the Menzies School of Health Research. These culturally appropriate resources written in plain English document the risks of sniffing and although they seem to focus mostly on petrol are extremely useful. When asked for ideas that might help young people who sniff, one young person suggested:

*'Just talk to them about their sniffing ask them if they want counselling, maybe if they watch movies that show what paint does to their bodies and brains'*

Encouragingly, several young women interviewed for the project reported curbing their inhalant use while pregnant as a result of information they had received relating to health risks. Unfortunately, some misconceptions have arisen from the health messages, which seem to have been supplemented with stories or rumours within peer groups. These related to both the effects on the individual using substances as well as to perceived impacts on unborn children. When asked why she stopped inhalant use when pregnant, one respondent replied:

*'For my son's safety. I didn't want him to have brain damage or be born with paint on his skin or anything like that'.*

It is widely agreed that VSM education as a preventative measure should be avoided in groups where sniffing is not already widespread. A review of published literature found few examples of preventative education programs to reduce the risk of inhalant use uptake. Where guidelines are provided to schools regarding VSM it is generally recommended that this be provided in a context of occupational health and safety. Examples can be seen in Victorian Education Department guidelines which recommend that young people should be taught about appropriate use of chemicals, alerted to the hazards, and equipped with strategies to prevent or reduce possible harm whilst avoiding discussing these substances as drugs except where welfare staff are aware that VSM is occurring as a social activity (Department of Education and Training 2000). Programs based on this type of education are seen as a way to 'inoculate' young people against future use. However, discussions around deliberate inhalation and drug-like effects of these substances should be avoided for fear of promoting the activity (Adams & Morgan 2007).

Guidelines provided by the Queensland Department of Education, Training and Employment are less detailed than those outlined in Victoria. State guidelines warn against introducing young people to VSM through education and recommend linking prevention messages '*to topics such as poisons,*

*product safety, first aid and fire safety*<sup>4</sup>. The VSM service at TAIHS in Townsville implement such an approach with school groups and other young people, providing information to children regarding the dangers of household chemicals, without specifically referring to the use of these substances as inhalants. None of the services in Cairns, Mount Isa or Rockhampton reported implementing universal preventative education or awareness programs.

### 9.1.2 Counselling

Counselling is an important element of a suite of interventions available to young people who are engaging in chronic inhalant use and most young people interviewed reported that counselling was a desirable approach to assist them with their issues.

*'I reckon you should do something like counselling and get us to talk about what it does to you what could happen down the track how you would end up'*

*'It would make me stop if I stopped hanging round with the people doing it or if I had a counsellor who could talk to me all the time about not sniffing and keeping my mind off the not sniffing yeah...like if there was like workers saying "that's a bad thing" or maybe if they mention "you should be thinking about your kids". I'm trying my hardest but...'*

*'Drug and alcohol course would help it helped my sister in law she was sniffing and smoking and she went to counselling and she got a house and everything'*

Despite the expressed views of young people, some practitioners who offered counselling services suggested these services were generally under-utilised by young people who sniffed. Service providers in some cities reported that inhalant users rarely expressed a desire to stop their inhalant use. Research also reports that stigma associated with inhalant use may prevent young people from admitting to their use or seeking treatment (S. J. MacLean 2003; NHMRC 2011b).

Some practitioners expressed frustration at the fact that young people presenting did not see their inhalant use as a problem, however recognised it as a symptom of other life issues, which were addressed as a priority. Other practitioners reported that young people who used inhalants frequently expressed a desire to talk through their issues and some young people 'didn't stop talking about wanting to go to counselling and rehabilitation services' but struggled to commit to process.

*'I need to go to ATODS I keep telling them I'm going to go but I don't I just never do it my worker says just let me know but I never do it...when I see her next I will tell her maybe when I see her again maybe I would go by myself but I would like a worker to go with me'*

Young people are most likely to come into contact with agencies such as YETI when seeking case management support or practical assistance such as getting food, washing clothes or having a shower. As one counsellor put it, she believes that it is important to always address the 'now' that is being experienced by clients before encouraging them to address the past or future through counselling or other therapeutic approaches. It is also vital that a young person commencing treatment or support for their substance use is properly assessed for intellectual impairment and/or behavioural problems, as well as past traumas or possible stress inducing issues to inform future case management (CCYPCG 2011). YETI staff utilise a series of practice tools to ensure effective assessment occurs for case management. A holistic approach to assessment ensures that a broad range of pre-identified risk factors and strengths are utilised in any plan for intervention and work collaboratively with counsellors when appropriate referrals are required.

Within counselling practice, practitioners noted the importance of the 'stages of change' approach to ensure the most appropriate match for motivation and change. Others discussed Motivational Interviewing frameworks, Narrative Therapy and Acceptance and Commitment Therapies. Some successes were also attributed to Cognitive Behaviour Therapy and Dialectical Behaviour Therapy (Bruun & Mitchell 2011).

---

<sup>4</sup><http://education.qld.gov.au/health-safety/promotion/drug-education/docs/guidevsmdraft3.doc> [accessed 29/07/2013].

### 9.1.3 Activity-Based Approaches

Activity-based or diversion activities play a critical role in any broad strategy to address inhalant use. Such activities provide alleviation from boredom, which can contribute to young people experimenting with various drugs including inhalants. Activity-based programs should have an emphasis on developing skills and building confidence among participants. The majority of inhalant users do not use forever, with sniffing sometimes a phase during adolescence. Not all users require treatment and therefore diversionary activities based on recreational or skills development activities may be of use (NIAT 2006). It should be noted however, that older, chronic sniffers sometimes do not wish to, or are not capable of participating in diversion activities.

*'I smashed a police car and then I went to juvy but when i got out we moved to a small town and then I started again because it's a small place and there's nothing to do there nobody sniffed there but I sniffed paint'*

*'Services should be doing activities a lot more activities...like fishing or going out for a barbecue...going to the lookout...stuff'*

Whilst, diversion activities can be useful for working with younger occasional sniffers, sometimes young people simply make a choice to use inhalants despite being offered alternative forms of entertainment. Diversion can be effective in keeping young people safe for the duration of activities however practitioners reported that it is best undertaken in conjunction with concurrent alcohol and drug treatment interventions (e.g., case management to address underlying issues, counselling etc.). Unless recreational activities are accompanied by other interventions to address underlying issues that have led to, or exacerbated VSM, they are unlikely to be successful in the longer term (CCYP 2002). Furthermore, if young people are not supported to develop their broader skills and confidence levels, recreational activities are only likely to be successful for the duration of the activities with little or no ongoing impact.

Practitioners described a sense of isolation amongst young people who are homeless and involved in sniffing, emphasising the importance of supporting young people to find a sense of belonging or community. This may be in the form of involvement in sporting teams, cultural groups, churches or school to encourage the young person to form an alternative identity away from sniffing. Involvement in mainstream groups may produce a sense of community, which can in turn bring feelings of responsibility to that community. Connection and belonging may be a necessary step to assist a young person to move away from dependence on crisis services and a reduction in their substance use.

*'I think that they should change their lives and go to church. Church has helped me a lot...it 's like the effect of sniffing comes to you, like you're mental really low in the brain, you feel really dopey and you start getting paranoid, your mind starts speaking to you in your head and some of the people I was living near they go to church and next door they always sing downstairs and I would always find an excuse to go downstairs and listen to them, so I would grab the rubbish bin and take it downstairs and listen to them and then one of the youth there asked me if I wanted to sit with them and then I sat with them and then my life just changed'*

Various project reports have emphasised the importance of avoiding creating activities for young people for which participation is contingent on inhalant use (Cheverton et al. 2003; Butt 2004; d'Abbs & S. J. MacLean 2008). This is based on concerns that it further isolates young people who sniff, normalises inhalant use and risks creating the perception that sniffing is being rewarded. By including young people who sniff in activities with young people who do not sniff the risk of bridging between groups can occur (Cahill et al. 2005). It should be noted that YETI practitioners highlighted this as sometimes a complex practice whereby all caution needs to be undertaken to ensure that young people who do not use inhalants are not exposed to 'ringleader' or charismatic inhalant users.

There was general concern amongst practitioners about the lack of early intervention services and support available to young people. The perception was that young people are only able to access services if they are already involved in the justice or crisis services. Activity-based programs in Brisbane have shown promising outcomes. An independent evaluation of the Get Real Challenge intervention in Brisbane found that individuals who had the greatest levels of participation in activities

also demonstrated greatest reductions in VSM and increased engagement in education. The most active individuals also demonstrated decreased suicidal ideation and general improvements in social, physical and emotional wellbeing (Butt 2004). Cause and affect are once again difficult to determine here, as it is unclear whether participation is directly leading to improved outcomes or individuals who are motivated to participate are also more predisposed to making other changes in their lives. That said diversionary activities are identified by young people, practitioners and research as having a positive impact on the lives of vulnerable young people.

#### 9.1.4 Family Support

Throughout this project the need for improved family support has repeatedly been cited as an essential part of any intervention to address inhalant use. Families may play a positive role by providing emotional and practical support to young people, but equally, problems within a family may be key factors contributing to inhalant use. When investigating underlying causes for inhalant use, the role and impact (both positive and negative) of family and community must be considered. Whilst there has been little methodical research into the effectiveness of family interventions in reducing substance use, evidence strongly suggests that involving families represents an important part of a holistic approach (Velleman et al. 2005).

Support from family can make a dramatic difference in individual efforts to cease inhalant use. A former YETI client returned to her home in a remote community when she became pregnant and subsequently ceased to sniff. She was given strong support from her family and has not returned to sniffing. The same prior mentioned evaluation of the activity-based project with young people from Aboriginal and Torres Strait Island backgrounds in Brisbane also found that most participants rated family as an important part of their life, but felt that they were not getting the necessary feelings of support and closeness from their family (Butt 2004). Velleman (2005) concluded that the family have a central role in interventions and are also able to prevent substance use amongst young people and increase protective factors.

Parents or carers who are experiencing domestic violence, unemployment, poverty and/or intergenerational disadvantage may have difficulty meeting all the emotional and practical needs of their children and adolescents. However, several practitioners suggested that no matter how dysfunctional a family would appear, young people generally express a longing to stay connected and in general, the greater the disconnection from family the more likely a young person was to engage in sniffing.

Throughout this research, practitioners identified the need for better mechanisms for supporting families of inhalant using young people. The types of interventions suggested generally fitted within three categories as described by Copello et al. (2005), that is:

- (1) *working with family members to promote the entry and engagement of substance misusers into treatment;*
- (2) *joint involvement of family members and substance misusing relatives in the treatment of the latter; and*
- (3) *interventions responding to the needs of the family members in their own right.*

The need to work with families of people going into residential rehabilitation was raised by several practitioners. It was suggested that, where possible, agencies should work with the families of clients both before and during their time in rehabilitation so that they are in a better position to provide support. Former inhalant users also highlighted the importance of practitioners speaking to families to help them better understand a family member's inhalant use problems.

Amongst clientele accessing services such as YETI, there is often more than one family member that sniffs making it even more difficult for an individual to cease their inhalant use if they alone are the target of interventions. Separating young people from their inhalant using peers is clearly important for assisting someone to change their sniffing habits. However, it is particularly difficult to encourage someone to stay away from such peers when they are family members. Some of the young people interviewed were also aware of this problem as a former inhalant user describing the difficulties of one member of a family attending residential rehabilitation services and not being supported by her family upon her release.

*'It's not good that one gets help and then tries to tell them. People are different you know. They're like, "Ah, you think you're good just because you come back from rehab." Yeah, you know, "I give you a week, two weeks, you'll be on the bottle again." You know, that's how they talk.'*

Some practitioners suggested that there is a need for therapeutic rehabilitation services equipped to accommodate entire families. All members of the family would have access to support, while ensuring that individuals each had their own dedicated worker. This model may be suitable for only a small number of families as it assumes that all are willing or motivated to participate.

#### 9.1.5 Case Management

When practitioners were asked about preferred interventions assuming unlimited resources, most suggested a need for increased levels of case management. This was generally based on a premise that effective interventions need to be flexible so that programs can be individually tailored for each young person and provide one-on-one case managers sufficient time to support young people comprehensively. A review of psychosocial interventions by MacLean et al (2012) identified several programs whereby a case management or family case management approach was utilised and the agency subsequently reported successful outcomes in reducing substance misuse.

*'I reckon the problem starts from home there's something wrong at home that's why people sniff, try and get the family to understand where we're coming from, why we do it...I prefer my case worker spoke to my family, not a different worker who doesn't know the family otherwise you have to start from the start and explain it all again'*

Given the reluctance of young people to seek treatment for substance use, case management also represents an opportunity to engage young people who are likely more concerned about practical difficulties they are facing than addressing their substance use. It is via the need for case management that many young people are likely to engage, build relationships with services such as YETI and then seek a more structured alcohol and drug counselling intervention.

Specific case management assistance required includes but is not limited to increased support for:

- Accessing and maintaining tenancies – addressing homelessness through access to social or private housing, completing housing applications, supporting young people to develop independent living skills, moving furniture, tenancy training, financial counselling, brokerage support, tenancy termination support.
- Attending to legal issues – reducing criminal offending risk factors and increasing protective factors by: providing court support, submitting letters of support, referrals for legal aid information and advice, liaison with youth justice or detention centres, discussions regarding cause and impact of offending, legal rights education, contact point when incarcerated, exit planning from detention, probation and parole support.
- Supporting contact with children in state care – practical assistance to achieve requirements of case plans, promote and prepare for reunification, assistance to help young people preserve family cultural connections, practical assistance for scheduled child contact visits.
- Supporting family or kinship contact to maintain cultural links – provision of telephone cards or access to telephones and computers to enable family connections, organising family contacts, providing brokerage for travel costs, assistance with transport, assistance to attend funerals, supporting connections with elders or positive family role models, returning to country and/or community.
- Providing school support – liaising with schools, practical assistance with brokerage for school supplies, addressing risks of disengagement, re-enrolling students.
- Supporting young people's access to rehabilitation or detoxification services – organising GP reviews, addressing barriers to participation, exit planning.
- Developing alternatives to incarceration – support with treatment plans, support with court diversion programs and community service obligations.

There was concern over the lack of positive role models in the lives of some young people from families whereby violence and substance misuse were normalised. Several practitioners identified a need for mentors or role models to provide one-on-one support to young people. These were described as 'big brother or sisters' who could provide out-of-hours case management support. That

said, other practitioners felt that mentoring support needed to be undertaken by professional practitioners rather than volunteers. They explained that culturally appropriate committed volunteers were difficult to find and the complexity of the role required experience and qualifications.

Disengagement from education is often cited as a common characteristic of young people who use inhalants. Assisting young people to reconnect with education was identified as vital to disrupting long-term cycles of inter-generational educational disadvantage. Flexible Learning Centres in several of the major regional cities of Queensland were highlighted as an important avenue for allowing young people who have experienced disruptions to their education the opportunity to reengage.

Where case management involves multiple agencies, it is important for one agency or person to become the main contact person to coordinate care and share information (NHMRC 2011a). This is essential for maximising effectiveness of case management efforts and reducing gaps and duplication of services. Such a principle is the basis behind an initiative such as the Coordinated Care for Vulnerable Young People Panel in Cairns, as described in Section 6.1.3.

#### 9.1.6 Residential Rehabilitation

Practitioners working with young people in all four locations frequently suggested some form of residential rehabilitation service as an important component of treating inhalant misuse. Whilst some thought there was a need for rehabilitation services dedicated to specifically treating VSM in Queensland, in general, most were more concerned about the lack of any culturally appropriate residential rehabilitation services available to young people aged 17 years and under. Where rehabilitation services were available, access for clients was seen as difficult because services generally prioritised other substance use problems over VSM. Most practitioners interviewed believed it was important for those working in rehabilitation facilities to be trained in dealing with both VSM and cultural safety. It was identified that when staff in residential rehabilitation facilities have higher levels of awareness in the identification and treatment of VSM, they more effectively engage with young people and youth services to ensure effective coordinated responses. This is important considering that VSM has been identified as easily concealed from untrained staff or misunderstood through stigma. Users often have complex health and psychosocial issues and require specialised assistance, which may be, integrated into existing rehabilitation centres through increased education and training.

*'Some love their sniffing, others sniff cause they don't have drugs or alcohol, the ones that just like sniffing they need help, they need to change the people they hang around with, even when they go to rehab they come out and other people are sniffing, maybe they could go away together to rehab...they all need help, it's not good one just gets help, the others just say you think you're good just cause you came back from rehab'*

Rates of continued abstinence after attending residential rehabilitation services are generally very low, largely because these facilities will generally only accept patients with highly challenging chronic VSM issues (NHMRC 2011b). If continued abstinence is the only measure of success of rehabilitation services, then they would not be considered successful. However, practitioners felt there was still benefit in giving people the option of some respite from their use, even if this did not lead to permanent abstinence. Such a view was reiterated by one of the young people interviewed who has entered residential facilities on several occasions.

*'I want to go to rehab, when I'm too into it, with me and my sniffing, the first time I went to rehab it kind of woke me out of it. I don't know where to get any pain there. I don't know who to ask. I don't ask people, I don't even ask the workers. I'm eating in rehab and I get all strength around my bones and I can lift stuff'*

This would provide the opportunity for them to have a break from the stress associated with their substance use, family issues and homelessness. As one practitioner described, many of these young people are surrounded by anger for much of their lives and a residential facility can provide some respite from this.

Other suggested services included having a town-based residential service where inhalant users could go for short periods as a form of respite. Even if use recommenced upon leaving the service, at least young people would have the option of a place to go for a break without the pressure of expectations

that they will come out 'fixed'. This is pertinent, when other respite options are both more expensive and deleterious (e.g., prison, mental health hospitals etc.). Staff from services working with young people in Townsville told of clients who admitted to deliberately offending so that they could be sent to juvenile detention where they were able to temporarily cease their inhalant use and access various education and training programs.

Practitioners discussed various residential options for working with inhalant users. Some advocated for remote 'bush' or outstation facilities where young people could be isolated from drugs and alcohol and their peers. Outstations appear very effective models for high-risk young people using inhalants, if they are well managed and sufficiently resourced. In Australia, there are currently two funded outstation residential rehabilitation services for young Aboriginal people that sniff, both in the Northern Territory (Gillian Shaw et al. 2011)<sup>5</sup>. These services have a strong focus on reconnecting people with Aboriginal culture and are located in remote, isolated places (NHMRC 2011b). National guidelines recommend outstation rehabilitation for anyone who sniffs (even if only occasionally) as long as it is culturally appropriate and the young person, or their family when they are underage, agrees (NHMRC 2011b).

Given that the majority of young people who come to the attention of services due to their inhalant use are from Aboriginal and Torres Strait Island backgrounds, rehabilitation services need to be culturally safe. In particular, practitioners noted the need for: local communities being involved; building trust with residents; and ensuring practitioners from Aboriginal and Torres Strait Island backgrounds undertook key roles in the service development.

Among those that advocated for rehabilitation facilities, most stressed that these would need to be structured environments where people were given goals and had daily schedules of activities to maintain participants' interest and motivation for change.

Some practitioners were concerned about the effectiveness of voluntary residential therapeutic models, advocating instead for secure statutory care models, such as those in Victoria<sup>6</sup>, where clients are not able to leave for at least a minimum amount of time in which they can be supported to reduce their high-risk behaviours. This resulted from concerns that young people frequently absconded from residential rehabilitation within the first few days when they were experiencing the negative physical effects of ceasing sniffing.

The immediate period after young people were released from rehabilitation and detention facilities was of great concern to practitioners in all locations. Many were apprehensive about the lack of collaboration between residential facilities and local agencies that were able to provide support to the young person and their family upon their release. Agencies indicated the need for improved exit planning for young people leaving rehabilitation or detention facilities believing that this would reduce the risk of relapse for individuals returning to the community. Practitioners also advised that support should also be available to families of young people whilst they were in rehabilitation as it may be counterproductive for young people to return home if the family environment remained chaotic.

## 9.2 Supply Reduction

Supply reduction is an important element in the battle against inhalant use and is recognised as such within the Australian Government's National Drug Strategy (Ministerial Council on Drug Strategy 2010). Strategies for supply reduction are divided into two general categories *product modification* and *restriction of access* to inhalants. Product modification refers to deliberating changing the chemical composition of substances to remove or reduce the ability to produce intoxicating effects or make products less desirable as inhalants due to unappealing smells or tastes. *Restriction of access* to substances refers to strategies such as locking up substances or refusing sale of products where it is suspected that they will be used as inhalants.

<sup>5</sup> <http://mttheo.org/home/mt-theo/>

<sup>6</sup> See the Victorian Department of Human Services website: <http://www.dhs.vic.gov.au/cpmanual/out-of-home-care/secure-welfare-placements>

The vast majority of the literature evaluating effectiveness of supply reduction strategies in Australia has focused on petrol sniffing in remote communities, where there have been very significant successes. This is perhaps most evident in the case of the National Petrol Sniffing Strategy as described in Section 6.2.3. via initiatives such as replacement of petrol with low-aromatic products (i.e. Opal and ULPLA), subsequent rates of inhalant use dropped dramatically in some locations (URBIS 2008; d'Abbs & S. J. MacLean 2008; d'Abbs & Gillian Shaw 2008).

Restricting supply of substances such as petrol in remote communities is different to VSM supply reduction activities in urban settings. In remote communities, access points for inhalable substances are far fewer and therefore more controllable. In more populous cities and towns, supply is difficult to control as there are many different kinds of volatile substances for purchase and these are available from many outlets.

According to Queensland's *Summary Offences Act 2005*, it is illegal for a retailer or salesperson to knowingly sell a 'potentially harmful thing' to someone who the seller reasonably believes will inhale or ingest it or who intends to sell it to another person for inhalation or ingestion. However, it may be difficult for retailers to enact their right to refuse sale of inhalable substances because they can be prosecuted if they are judged to have refused to sell a volatile substance on unreasonable grounds (e.g. the reason for refusal is based solely on a person's age). In this situation, the retailer may be in breach of discrimination legislation. Race must not be the reason (or part of the reason) for refusing to sell<sup>7</sup>.

*'When you walk in the shops to see if there's any glue in the shop and often there's not because I think the shop owners know now. I think the shop owners should stop selling glue and Rexona. Rexona is the main one because they don't have the glue. Some of the girls they can sniff twelve cans a day...I've been around them and I've like seen how they react and they see things and it's not good things they see, from my thinking it's bad things but they think it's good'*

VSM services in Cairns, Townsville and Mount Isa were all engaged in some form of education strategy to ensure that retailers were aware of their right to refuse sale of substances to people when there is a reasonable suspicion that the substance will be used as an inhalant. As inhalants are legal substances, supply cannot be stopped and a balance needs to be found between access for legitimate purposes and regulation of supply to those who seek to misuse these products (Ministerial Council on Drug Strategy 2010).

*'We know the certain times when they stack the glue like when they don't stock the shelves in (large supermarket chain) we don't go looking for it'*

*'It's a stressful thing when you want to buy it and they're not going to sell it to you, lots of these mob up here do it, I just never been back near those stores'*

It is partly due to the ease of access and difficulties in controlling supply that inhalant use is an attractive form of substance use for intoxication. Young people often report using inhalants as a substitute for other substances such as cannabis, as they are cheaper and easier to obtain (CCYP 2002). Young people described stealing products from supermarkets, including going into stores in groups so that some could distract store staff while others stole products.

*'I was getting paint from shops stealing it we used to rip the cages open with bolt cutters'*

*'I would just steal tins, four in the front one under the arms and one between the legs and then I just walked out. When I think about it that was my crazy days'*

Strategies to reduce access to inhalants often involve working with retailers to ensure that volatile substances are not easily accessible. This may include: displaying substances in visible locations within stores so that they cannot be easily stolen; storing inhalants in locked cupboards or cages; and having empty display items on shelves with genuine products behind the counter. Whilst VSM services involved in supply reduction activities reported generally positive support from retailers, managers of

<sup>7</sup> Department of Communities, Child Safety and Disability Services website <http://www.communities.qld.gov.au/communityservices/community-support/volatile-substances/about-volatile-substance-misuse>

large retail chains were not always able to make the necessary changes to the layout of their stores due to company policies. Practitioners reported that the placement and prominence of certain products may be determined by contracts with suppliers at a national or state level and sometimes cannot be changed at the individual store level.

When working with retailers regarding supply reduction, it was reported as essential to have a strategic and systematic program in place. VSM workers in Mount Isa said that they had observed marked reductions in inhalant use as a result of supply reduction efforts, particularly working with retailers to restrict the ease of access to deodorants. However, without a dedicated supply reduction worker it was noted that there could be issues maintaining this progress. Practitioners noted that staff turnover in the retail sector is generally high so stores need to be visited regularly to ensure knowledge and support for efforts continue.

Efforts to restrict access to certain products were reported to lead young people to choose alternative volatile substances. For example, one young person said that she did not often sniff paint because proof of age was required to purchase the product and she didn't have any. She thus became reliant on other people purchasing paint for her or she would steal it. She stated in interviews that she was generally more likely to inhale glue rather than paint. Other young people also said that if retailers locked away paint, young people would just change to something else such as glue.

### 9.3 Harm Reduction

Inhalant use is inarguably a harmful activity and even those who only occasionally inhale volatile substances risk severe health problems. Many practitioners acknowledged that some of the young people who are engaging in this behaviour express no real desire to cease their inhalant use and persist despite the efforts of those around them encouraging them to cease. The National Inhalant Abuse Taskforce also recognised the necessity of working to minimise the potential risk of immediate harm to young people, whilst concurrently undertaking longer term planning to support reduction and abstinence (NIAT 2006).

Harm reduction strategies reported by practitioners included: providing information about not sniffing alone; supporting young people to develop safety plans to avoid high-risk behaviours whilst intoxicated; providing young people with information regarding the product they are using; and providing young people with safe places to rest and recover when intoxicated. There is some reported debate about whether inhalant users should be given information about the different danger levels of particular substances because it is feared that this may be introducing them to substances that they had not previously considered as inhalants (d'Abbs & S. J. MacLean 2008; CCYP 2002).

When working with chronic inhalant users, case managers reported discussing strategies with young people to restrict their inhalant use to certain times of the day as a way of reducing overall quantity and frequency of inhalant use. Practitioners interviewed raised concerns about the dangers that young people put themselves in when intoxicated, with several reports of people being hit, or almost hit, by cars when staggering onto a road. Young people were encouraged to look out for each other if they were sniffing and to stay away from traffic and other dangers. In the hottest months of the year, frequently reminding inhalant users to stay hydrated and avoid sniffing in sunny areas was also seen as an important aspect of harm reduction.

*'all the paints got different tastes but I like blue because it don't get me more high like matte black and chrome cause I got lifted by a couple of cars when I was sniffing chrome...I was lifted by a big ute'*

In seeking assistance for young people who are currently intoxicated, staff from various agencies suggested the need for a dedicated quiet space for drug-affected people waiting in the Emergency Department of the hospital. This would be a medically supervised space designed to increase the likelihood of intoxicated people receiving the required medical attention without the need to wait in a loud, brightly lit public waiting area.

#### 9.3.1 Rest and Recovery Services

The Queensland Department of Communities, Child Safety and Disabilities Services funds places of safety to recover from the effects of volatile substance intoxication in inner-Brisbane, Logan, Mt Isa,

Townsville, Cairns, Caboolture and Rockhampton. These places are provided for young people who do not require emergency medical attention, but cannot be returned to the care of a family member or friend due to the lack of an appropriate option. The target age range for these services is 12 to 17 years of age.

Places of safety in the form of rest and recovery services were generally seen as a necessary alternative to incarceration for young people who were inhalant affected and unable to return to a suitable home. However, concerns were raised by several practitioners across locations about providing additional services or benefits to young people where being intoxicated was a criteria for inclusion. By providing food, a cool place to stay in hot weather, activities and non-targeted transport<sup>8</sup> services to young people, some practitioners expressed concerns that this risks normalising sniffing and may make it advantageous to sniff to access intensive services. Such concerns were raised by workers within dedicated VSM services and by other agencies.

The format and approaches of these places of safety varied across locations in North Queensland. In Cairns, the Youth Substance Misuse Service (YSMS) provides rest and recovery services for young people intoxicated due to inhalant use. Young people can self-refer to this service during office hours only, with out of hours access restricted to police referrals. When new clients attend the service, they are offered rest and recovery facilities, assessed to determine their existing knowledge of the dangers of inhalant use and given information about harm minimisation strategies relating to staying safe while sniffing. Young people are able to access some case management support through this service.

In Mount Isa, Young People Ahead (YPA) provides rest and recovery services, which are available 24 hours a day, seven days a week. Young people are able to self-refer at any time and workers are available for support 24 hours a day. As part of a larger youth service, the VSM service is able to provide significant case management for inhalant users. YPA also provides a drop-in service, which is open in the morning and afternoon, outside of school hours. This was developed as an entry point for engaging young people without the need for them to be inhalant affected. Townsville Aboriginal and Islander Health Services Ltd. (TAIHS) operate a VSM service, including a 24-hour rest and recovery service that can be accessed through self-referral or referral from another agency. At the time of this report, the service was exploring options for separating the rest and recovery service from other support and diversionary activities. Staff at the centre aimed to keep these services separate to dispel the perception that intoxication was a necessary pathway to accessing diversionary activities. The VSM service at TAIHS was also exploring options for broadening their target age range to capture a greater portion of young people who are using inhalants.

The following section will examine additional practice components, which were discussed by practitioners and may be positioned within and across Demand, Supply and Harm Reduction strategies.

#### 9.4 Local Action – Interagency cooperation

Practitioners interviewed throughout the process of this research emphasised the need for improved collaboration between government and non-government agencies. It was reported that treatment for inhalant use should be a 'multidimensional' process and unlikely to be adequately provided by a single organisation.

Cooperation and goodwill were generally described as being good to very good in all locations visited, but there were instances where practitioners identified the need to increase the frequency and opportunities for communication and cooperation. This included the development of formalised agreements such as Local Partnership Agreements and Memorandum of Understandings between agencies. There were some concerns raised, that much of the cooperation was based on the working relationships of individuals and there were few formalised working agreements in place.

Local Action Plans to address inhalant use were developed in both Cairns and Mount Isa during 2012. These plans were developed via local forums involving multiple agencies and provided the opportunity

---

<sup>8</sup> Non targeted transport refers to transport provided that does not clearly address a case management related goal.

to increase stakeholders' collective understanding of each other's roles and responsibilities in relation to inhalant use. Actions to emerge from these planning forums included those that targeted at-risk young people; families and carers of inhalant using young people; inhalant supply outlets; and the broader community.

One of the actions identified within the Cairns planning process was the development of a local referral pathway for agencies that may encounter young people using inhalants. This has been completed and can be found in Appendix 1.

## 9.5 Specific Strategies/Frameworks for working with Aboriginal and Torres Strait Islander Young People

When reviewing specific strategies or frameworks for working with Aboriginal and Torres Strait Islander young people, substance use, they must always be viewed within the wider psychosocial cultural context. That is, young people's inhalant use is set against a backdrop of colonisation, racism and marginalisation.

The majority of social indicators for: health; education; employment; housing; literacy and income consistently paint a negative picture for Aboriginal and Torres Strait Islander peoples. Significant levels of: vulnerability; grief; trauma and disadvantage are the ongoing consequences of invasion, dispossession, and racism. All these factors contribute to high prevalence of substance misuse and are entrenched in a history of social problems, which cannot be fixed by a single simple intervention (Spooner and Hetherington, 2005; Crane, P., Francis, C., and Buckley, J. 2013).

The Western Australian Solvents Abuse Working Party reported that an individual is not isolated from the impacts of community level stress. (Rose J, 2001). Rose (2001) cites two general risk factors, social disadvantage and family dysfunction, as predictive of substance misuse. Rose states that additionally VSM in Aboriginal and Torres Strait Islander communities is influenced by circumstances including: degree of community cohesion; cultural identification; numbers engaged in use; local patterns of use; access to resources and supports; and other local influences.

A range of best practice approaches have been developed to respond to this context. Some of the most recognised strategies are efforts to reconnect young people with aspects of traditional culture. A program in Brisbane found that young people who rated their connection to culture as high and participated more frequently in cultural activities were less likely to engage in VSM (Butt 2004).

Referring young people to outstations or homelands has also been utilised as a means of breaking the cycle of substance misuse among young Aboriginal people and supporting young people to reconnect with country. Outstations such as the program provided at Mt Theo in the Northern Territory were highly regarded by practitioners who were interviewed. That said, research reports that some outstations may not always be equipped to treat the complex medical and psychological needs of chronic users and there may be a lack of employment, skills development and social interaction opportunities available in remote outstations (d'Abbs & S. J. MacLean 2008).

Best practice principles for working with young people from Aboriginal and Torres Strait Island backgrounds (and also non-Indigenous young people) were reported as focussing on: holistic wellbeing, collaboration and partnerships, cultural safety, accessibility, and client driven processes. Good models included the provision of trauma informed services and those that focussed on building strengths and resilience through greater self-determination. Research also reported that the most effective treatment strategies for dealing with marginalised Aboriginal and Torres Strait Islander young people may be those that focus on changing the mix of economic, cultural and spiritual content of people's lives rather than focusing on a particular substance (d'Abbs & S. J. MacLean 2008). Characteristics of successful education and recreation programs to address VSM in Indigenous communities have

*'included measures to avoid stigmatising users; strengthened cultural connections; involved the community; provided alternative education opportunities; focused on the development of work skills; included a range of activities; provided opportunities for challenge and risk-*

*taking; and have been offered on a flexible basis to suit local circumstances' (Midford et al. 2010).*

### 9.5.1 Return to Country and Culture

Over the past three years, YETI has prioritised opportunities to return young people from Aboriginal and Torres Strait Island backgrounds in Cairns to their community of origin. This intervention serves two key functions: separating young people from peers with whom they may be engaging in high-risk behaviours; and encouraging reconnection with family and culture.

The approach, whilst proven successful is only feasible where there is demonstrated interest by the young person and support networks in the destination location such as the possibility of connection with family as described in the follow case study.

#### **John and Rachel** (please note names and places have been changed)

John and Rachel were siblings who moved to Cairns from Mt Isa aged 10 and 12 years of age respectively. Both resided in kinship care for most of their lives and moved to Cairns to reunite with their mother when she started a new relationship. When their mother separated from this violent man, they all moved in with another family but the mother left when she started a new relationship, leaving John and Rachel by themselves.

YETI staff first became aware of John and Rachel when police evicted them from an unoccupied house they had been squatting in with other young people. By the time these two young people started attending YETI, both were homeless and sleeping rough with a group of other young people. Both were involved in the juvenile justice system, mostly for charges relating to stealing food. Rachel openly identified herself as a sniffer at that stage and it is believed that she had already started sniffing before coming to Cairns. John was also known to be sniffing.

YETI advocated for John to be able to be placed in care due to his age and obvious risk factors. Both John and Rachel were sniffing glue daily. Other young people voiced their concerns regarding John's level of sniffing and he was regularly found early in the morning, sitting on the front doorstep of YETI covered in glue. John was put into a residential care unit but had no daily support worker and hence continued his inhalant use when he was dropped off in the city during the day. The siblings were separated at various stages but were eventually given a placement together. John regularly got in trouble for his involvement in car thefts amongst other crimes and was sent to a Youth Detention Centre. All of this was occurring during a period of particularly high levels of sniffing amongst many young people in Cairns. YETI advocated for both siblings to return home but there were no real options for sending Rachel and John back to Mt Isa as their previous kinship carers were identified to have significant substance use issues.

The siblings were eventually offered residential care placements in Mt Isa close to family. Although John and Rachel frequently absconded from their care facilities in Mt Isa, it was decided that at least they had more options for seeking support from other family members.

Inhalant use largely stopped while they were in Mt Isa and it seemed that closer family connections were beneficial for them.

YETI practitioners reported that the most effective intervention for supporting inhalant users was separating individuals from others who are using. This may involve separating them from peer networks and based upon individual assessment where a strong desire may be identified by a young person to reconnect with culture, as identified in the following case study:

#### **Nicole** (Please note names and places have been changed)

Nicole had been attending services at YETI for several years when her behaviour became increasingly concerning to staff. At around 16 years of age Nicole was involved in regular, heavy paint sniffing and was sleeping rough. Her home situation was unstable as she was living in the overcrowded house of her aunt but frequently required crisis accommodation. Nicole was never in the care of Child Safety,

but she and her family had contact with the Department throughout her childhood and early adolescence.

As a teenager, Nicole began to identify as a lesbian and became involved in opportunistic sex in exchange for glue. During her 'coming out' process, Nicole showed increased interest in reconnecting with her Aboriginal culture, which she expressed through traditional singing and seeking information and media relating to her family's home community in Cape York.

As Nicole's inhalant use and wellbeing worsened, YETI raised the possibility of her leaving Cairns to stay with family in Cape York. She was very receptive to these suggestions so YETI staff made contact with aunts in the community to discuss the possibilities. Suitable family members were found and YETI funded Nicole's return to country.

Nicole maintained contact with YETI upon her return with regular phone calls to the service. On several occasions she said that she was bored in the community and asked to return to Cairns. YETI staff consistently encouraged her to stay in community longer. Whilst living in the Cape York community, Nicole has reportedly been doing very well, engaging in cultural activities such as learning traditional dance and cultural practices from community elders and most importantly not engaging in VSM.

At one stage Nicole, returned to Cairns for a period of around a month. During that time she reconnected with many of her old friends, many of who were still heavily involved in inhalant use. Nicole frequently visited YETI in a highly intoxicated state during this period and staff once again became very concerned for her wellbeing. All were relieved when Nicole asked to return to Cape York where she remains.

Nicole voluntarily moved to her family's community with the support of YETI because she had become increasingly interested in reconnecting with her traditional culture. Staff at YETI continue to have contact with Nicole and believe this has been an important part of encouraging her to stay in community when she has had doubts. It has also been helpful that she has been able to receive news about her peers in Cairns without the need to return.

As was the case for Nicole, many of the young people who use inhalants in Cairns do not have access to stable accommodation, may be competently homeless or couch surfing' at the houses of family or friends. Whilst Nicole's return to country was entirely voluntary, there are also individuals who were ordered to leave Cairns as an aspect of court sentencing conditions, as was the case for Mark:

**Mark** (Please note names and places have been changed)

Mark is a young man who originates from a Torres Strait Island. Mark first started attending YETI when he was 15 years old. At the time he was living with an aunt in Cairns but was frequently rough sleeping with a group of homeless young people. There was a history of family violence and Mark's younger brother had been removed from the family and placed into the care of Child Safety.

Mark was frequently sniffing glue and paint and regularly attended YETI for case management support. He was known to be in violent relationships with younger women and was repeatedly getting into trouble with police, with a range of public nuisance and assault charges against him. As a result of his offending, Queensland's Murri Court ordered nineteen-year old Mark to leave Cairns and return to his community in the Torres Strait for a minimum of twelve months as an alternative to incarceration.

Before leaving Cairns, YETI staff made arrangements to continue to provide support for Mark while he was away and provided phone cards to ensure he was able to contact YETI. Whilst in the Torres Strait, Mark has engaged in on-going phone counselling every two to three weeks with the service's well-being counsellor and together they have developed well-being plans to assist Mark to look after himself and avoid returning to his high-risk behaviours.

Since leaving Cairns, Mark has not been offending, has found work and is believed to have totally stopped sniffing.

A support plan and follow up ensured greater success for Marks return. Efforts to return young people to home communities have higher rates of success when individually planned to ensure communication pathways between key stakeholders are established and appropriate supports are available. Returning to country was not reported to guarantee instant success in improving a young person's behaviour and it often took some time, or several attempts, for an individual to re-integrate successfully. Where support mechanisms were not extremely structured, there was greater risk that returning to community would not work out as planned.

**Fiona** (Please note names and places have been changed)

Fiona is a young woman from Central Queensland and was 10 years old when she first presented at YETI with some older cousins. Fiona was known to be sniffing glue at this time and was not living at home. When she came into the service she was frequently intoxicated. YETI staff notified statutory child protection agencies and referred Fiona to the Coordinated Care for Vulnerable Young People panel (refer 3.6.4).

By the time Fiona was 11 years old, she was more frequently in trouble for shoplifting and breaking into houses. Fiona had significant involvement with the youth justice system. During this time YETI was in regular contact with Fiona's mother and stepfather.

YETI negotiated with Fiona's mother to send her to stay with her grandmother in Central Queensland. This grandmother had culturally adopted Fiona as a young child and Fiona had lived with her for most of her childhood. Various agencies were involved in planning to return Fiona and committed to provide support to the grandmother in community.

Fiona was sent to Central Queensland and did not commit any further offences. However, after several months Fiona came back to Cairns and, after some time, presented at YETI. She was sniffing heavily again. It transpired that Fiona's grandmother had not received any financial or other support to help her look after Fiona and the placement therefore fell through. Miscommunication between agencies also meant that no formal referrals were in place for Fiona to access community support services.

After returning to Cairns, Fiona got into a lot of trouble and emergency inter-agency meetings between government and non-government agencies were held to discuss the situation. During this period, Fiona's offending and inhalant use escalated further. Fiona was eventually returned to other family in Central Queensland. This kinship arrangement unfortunately was unsuccessful and she is currently in youth detention.

Fiona's story provides a good example of the need for improved coordination and support for family members in destination communities. Whilst, it is unlikely that there was a single reason for why the attempt to return Fiona to her community of origin failed, there were some identifiable systemic failures that prevented an optimal outcome. Fiona's return to country was organised hastily in response to an emergency situation and concern for the young person's well-being. Sufficient local support mechanisms for Fiona while she was in Central Queensland were not determined prior to her departure and no single agency was designated to coordinate support.

Practitioners interviewed recommended that a team of workers in the destination community could have provided some support for Fiona to make sure that she was settling in to the community, attending school and that both her and her grandmother were receiving the assistance they needed.

The case study of Joe provides an example of where multiple agencies worked much more successfully to improve outcomes for a young person returning to a remote community.

**Joe** (Please note names and places have been changed)

When he was 10 years old, Joe was living in a Torres Strait Island community and it came to the attention of authorities that he was sniffing. As a result of substantiated neglect he was removed from family into statutory care in Cairns. Joe started attending YETI when he was around 12 years old and whilst officially in the care of the state he was self-placing with his father.

Joe began to get into trouble and ended up in detention for some minor offences. While in detention, his father died. Upon release, his inhalant use increased to very high levels and he was frequently absconding from his care placements to inhale glue. On one occasion Joe was arrested and passed out while in detention due to inhalant intoxication.

During this period, Joe became quite violent and was relocated to a placement out of the city in an attempt to reduce his access to inhalants. Joe ran away from his placement almost daily and spent time associating with family members in town camps around Cairns. Joe was hospitalised several times for his inhalant and alcohol use and there were serious concerns for his safety.

Joe's sniffing and offending escalated, following several assault charges the Department of Child Safety decided to work towards Joe returning to his home community in Cape York.

As part of their overall strategy for his return home, Child Safety approached YETI to support Joe on community. By this stage, Joe was keen to leave Cairns. He returned to the community to stay with an uncle and processes were put in place to support him locally. YETI employed a local man to act as a support and mentor to Joe, to help him integrate into the community and to act as a contact point for other agencies working with Joe. The Team Leader from YETI supported the local worker through phone supervision and visits to the community.

YETI staff continued to visit Joe in Cape York for approximately nine months after leaving Cairns, which helped to provide some continuity in his support.

At the time of writing – more than a year after his return to Cape York, Joe was no longer sniffing and was very reflective on his past issues. He also expressed concern about his former peers in Cairns and the fact that they may still be using inhalants. He seemed to clearly associate his offending behaviour with his inhalant use.

One indication of how things had improved for Joe was the fact that after several months of being in Cape York he was required to attend court in Cairns. There was concern about his returning and the risk that he may abscond and get involved in his old lifestyle. Joe did abscond to seek out various family members around Cairns, but much to the relief of everyone concerned, he got himself to the airport on time and returned to Cape York. Joe has now been in Cape York for the past two years.

YETI recognises the significance of opportunities for cultural healing through the mobilisation of networks and relationships of care. Interventions, which are able to harness the strengths and resources that exist within a community provide the best outcomes for young people, families and communities. Helping young people to build or restore caring relationships is also evidenced in research as an effective approach to redirect young people away from risk or damaging practices such as VSM (McCoy, 2006).

That said, one practitioner noted that great care is required with family reconnection efforts and it is flawed to assume that 'connecting to country' will help everyone. 'If traumas have arisen on country you cannot always reconnect them successfully'. This highlights the significance of keeping young people's voices and needs in the centre of practice and ensuring that planning, support, collaboration and cultural safety are key themes of the reunification framework. YETI's approach is discussed in more detail below in the section discussing Practice Principles.

#### 9.5.2 Services and Interventions in Remote Communities

Over the past 20 years several multi-faceted, community based approaches to preventing and managing VSM have been implemented, not only in urban/regional centres, but also importantly in remote communities (d'Abbs & Maclean 2008). Those remote communities impacted by petrol sniffing have been the targets of many of these service responses.

The most significant and successful intervention has been the Petrol Sniffing Strategy and in particular the roll out of low aromatic fuels. This initiative, a product modification whereby harmful psychoactive components in petrol have been replaced with low aromatics, has been widely implemented in remote communities, in the Northern Territory. Other supply reduction strategies trialed in remote locations have also included: securing petrol supplies with locks and statutory and

voluntary restrictions on sales of VSM products. Targeting retailers with information in relation to VSM has also been reported as effective; in particular the Central Australian Youth Link-Up Service (CAYLUS) supply reduction work in Alice Springs and nearby communities was identified as valuable. Whilst supply reduction related initiatives are critical in remote communities these approaches have been identified as most effective when supported via community based demand reduction strategies. These include: educational and recreational interventions, counseling and family support and treatment and rehabilitation programs.

An analysis of the factors, which improve VSM interventions in remote communities, concluded that there is benefit derived from support, education, advocacy and information about VSM. These programs may be provided locally or based in regional centres. It was further noted that drug and alcohol practitioners based in remote communities require support from specialists with specific skill sets in working in VSM. Finally it was identified that in order for community based interventions to be effective, they require the support of government agencies (e.g., police, health clinics and schools), community controlled services and other local stakeholders (d'Abbs & Maclean 2008; 56).

## 9.6 Barriers to Addressing Inhalant use

When service providers were asked about the types of interventions that may assist a young person to cease their inhalant use, some had difficulty defining what a successful treatment would look like. This is probably because there is no single solution. In general, people were far better at defining the types of interventions that do not work. All workers universally agreed that telling young people they had a problem with sniffing and lecturing them about ceasing generally acted as deterrents to change. Other barriers included: workers who have no relationship with young people trying to talk to them about their sniffing; trying to deter inhalant use by restricting services available to sniffers; coercing, rather than encouraging young people into changing their behaviour; and attempting to educate or scare young people into stopping sniffing.

There are numerous barriers that make treating inhalant use a very challenging task. In particular, the young age of most inhalant users means that they may not be suitable (or eligible) for some alcohol and drug treatment options. Very young people also may not yet be contemplating ceasing their substance misuse and reluctant to engage in treatment programs.

Other identified barriers to addressing inhalant use included the lack of diagnostic and treatment models, professional training and skills in working with inhalant users, and low awareness of the seriousness of inhalant use (Beauvais et al. 2002). In regional centres, there was noted to be a lack of funded services for young people, limited staff skilled in the area of youth drug and alcohol practice and issues accessing detoxification and rehabilitation services. The competency of particular agencies and individuals was not assessed as part of this project, but workers acknowledged that the complex, and often stressful, nature of working with inhalant users can lead to high staff burn-out rates and vicarious trauma.

Further treatment barriers identified included issues regarding adequate assessment of suspected neurological damage amongst users (i.e., undiagnosed Acquired Brain Injuries) and some perceptions that permanent neurological damage may discourage substance treatment services from prioritising inhalant users, with preference given to users of other substances who are perceived as having better recovery prospects (Beauvais et al. 2002).

Practitioners reported that treatment for inhalant users appears to take longer than for users of other substances and that success rates may be lower. This lack of success is partly explained by the fact that most inhalant users present comorbid drug and alcohol and other mental health issues. Where rehabilitation services are available, there is also concern that the limited amount of time users are admitted to such services may be insufficient for effective treatment. Beauvais et al. (2002) noted that in some cases time limited interventions missed opportunities and discontinued services when participants were in the most active stages of change. This perception was echoed by practitioners concerned about short, voluntary stays in residential rehabilitation services and the risk that young people would leave before they had had a real opportunity to recover from the withdrawal that accompanies some young people's experience.

In reality, it is not easy for service providers to determine longitudinal success rates for VSM interventions. Young people who engage with agencies when they are sniffing may stop accessing services once they have ceased inhalant use. Similarly, agencies that only work with young people to the age of 17 years may not have contact with young people as they enter into adulthood. Responses to various interventions may not be instantly determinable so results might not be attributable to a particular agency or treatment modality.

For aforementioned reasons, homelessness is common amongst inhalant users and often addressed via case management approaches. Practitioners highlighted difficulties in housing only one member of a group of inhalant users. If one person is housed while their peers remain homeless, the chances of them maintaining a tenancy are fairly low due to groups of young people gathering in the household and tending to engage in antisocial behaviours (e.g., fighting, yelling etc.) Young people may have considerable kinship responsibilities, and peer obligations that impact on their capacity to maintain their tenancies. In Cairns there have been repeated situations where one member of a group is housed and several friends and family congregate in their accommodation, causing various problems, eventually leading to eviction. To avoid this situation it may be useful to ensure that: several members of a peer group are housed at once; supported accommodation models are available; and/or young people enter housing programs following efforts at rehabilitation.

Practitioners working with inhalant using young people described many difficulties working with this cohort compared to users of other substances. Residential care workers noted that young people who used inhalants were far more likely to abscond from their placement making it difficult to build relationships and trust and hence address the underlying issues. Young people who were using inhalants were also reportedly more aggressive and unpredictable when compared to users of other substances.

Perhaps not unique to users of inhalants, there were stories of young people trying to cease their use, only to be encouraged by friends to keep using, further highlighting the importance of separating peer groups.

*'I think she just wanted me to sniff she didn't want to do it alone she didn't want to let me sit there and do nothing she wanted me to sniff with her so I grabbed that bag and I kept on looking at it and I thought should I do it or not? But inside of me was thinking should I do it or not? Do I want to do it? Should I do it or not? but I don't want to do it, but my mind was paranoid things talking in my head and then I had three sniffs of it and my mind totally went'*

Practitioners reported high levels of: suicidal ideation, disassociation and disillusionment amongst young people using inhalants. This group were generally considered to be the most disengaged and vulnerable of all the young people accessing youth services. Whilst young people's ability to deal with stress fluctuates greatly, practitioners observed that chronic sniffers seem to have a critical lack of ability to regulate their emotions. Some may demonstrate resilience in times of major family crisis, but then display excessive anger over apparently minor issues relating to dealing with Centrelink or other government offices. That said, the causal relationship between inhalant use and emotional regulation is unclear. It is difficult to determine to what extent young people with pre-existing emotional regulation difficulties (associated with trauma and disrupted attachment) are attracted to inhalant use and what comes about as a result of this use.

#### 9.6.1 Isolating VSM Services

Concerns were raised by services in Cairns, Mount Isa and Townsville about the risk of providing young people with services specific to VSM. Practitioners from dedicated VSM services, as well as other agencies, reported anecdotal evidence of young people using inhalants specifically to get benefits such as: rest and recovery services; takeaway food; and non targeted transport assistance. Practitioners raised concerns that this could be seen as rewarding young people for inhalant use. Naturally, individual motivations for sniffing are difficult to verify but nonetheless this perception gives cause for concern.

Ogwang et al (2006) suggested that support provided by welfare organisations to young people using inhalants in public spaces can potentially contribute to the problem. That is, sniffing may seem more attractive because, whilst young people are sniffing, there are organisations that want to assist them.

VSM services in some locations outlined concerted efforts they had made to avoid this situation and were well aware of the risks of being seen to 'encourage' young people to use inhalants as a means of getting benefits not offered to them if they were not sniffing. A program aimed at reducing VSM, the Get Real Challenge for Indigenous young people in Brisbane deliberately included young people who did not use inhalants to avoid providing fun activities as an incentive to use inhalants and to reduce the risk of the group as a whole being labelled as sniffers (Butt 2004).

### 9.6.2 Release from detention or residential rehabilitation

Prevalence of inhalant use within a community frequently spikes when prominent inhalant users return to a community after time away in detention or rehabilitation services. Practitioners across all regions identified this as a key problem and recommended greater communication between detention facilities and support agencies to reduce this risk. Whilst most young people cease sniffing in detention, they were reported to frequently start again upon release. Agencies working with inhalant users all emphasised the importance of ensuring clear exit and relapse prevention strategies are developed prior to release. This requires inter-agency cooperation and the development of clear protocols.

### 9.6.3 'Captains'

Further complicating supply reduction efforts in regional cities is the issue of 'captains' (an expression used by practitioners and some young people). The term relates to older non-Indigenous men who supply young women from Aboriginal and Torres Strait Island backgrounds with drugs (including inhalants) in exchange for sexual favours. This is known to occur in Cairns and anecdotally reported in both Rockhampton and Mount Isa. Several of the young women who access YETI services have told of older men who supply them with inhalants in exchange for 'friendship'. YETI practitioners have met a number of these men.

These so called 'captains' are usually older (over 50 years of age), non-Indigenous men who are known to spend a lot of time around young Aboriginal and Torres Strait Islander women, particularly those that are vulnerable (i.e., homeless and/or inhalant using). The situation as described by these young women is that these men 'help' by providing somewhere to stay; transport around town and sometimes intercity transport; money; a place to gather with friends; and access to substances such as paint for sniffing, alcohol or cannabis. Many of these young people are homeless and living in poverty, so access to resources such as accommodation, food and transport are likely to be highly valued.

The young women who attend YETI never refer to these men as 'boyfriends', but have admitted to having sex with them when intoxicated, and others tell of their peers having sex with these men. Many of the young women admit this reluctantly and more frequently refer to these men as just friends. In some cases, these men have previously had similar relationships with the mothers of some of the young women who attend YETI. These men recruit the young women through other girls that they know. Young people at YETI reported that the men drive around town with paint in their car, offering it to young people they meet in the street. YETI make reports about 'captains' to the Child Protection Investigation Unit, however as the young women are not willing to provide statements in relation to the activity we understand it remains difficult to prevent.

## 9.7 Inhalant use and residential care

Many practitioners referred to a close correlation between inhalant use and young people's exposure to abuse and neglect in family homes. For this reason we have chosen to include this in a separate section in this report. This abuse and neglect sometimes led to young people entering the child protection system. Practitioners in all four cities reported the statutory care experiences of young people were a key issue in inhalant misuse. As such, a number of residential care practitioners in services known to work with inhalant users were interviewed for this research. These practitioners were all conscious of the high incidences of inhalant use amongst young people in their care.

Residential care staff requested increased training and support to better respond to young people misusing inhalants. In particular, residential staff identified a need for greater access to up-to-date information regarding substances being inhaled and the relevant support services available. Some said that it would be useful to have staff training 'packages' that could be provided to new residential

carers during their workplace induction. Lengthy training sessions were deemed less useful than brief sessions that could provide staff with basic strategies for: understanding signs of suspected inhalant misuse; supporting intoxicated young people; and developing safety plans with young people. Practitioners noted that this might include a local relevant agency attending staff meetings to brief staff regarding relevant services and intervention strategies.

Residential care workers made it clear that rest and recovery services could be provided within residential facilities. That said, practitioners noted, that some care workers still required improved confidence and skills to support inhalant-affected young people on-site and clear frameworks to determine when medical assistance was required. Residential care workers were concerned about the co-tenancy of inhalant using young people in care environments with other young people who may be influenced by them and potentially introduced to sniffing.

There was a reported need for increased access to flexible counselling services amongst inhalant-using young people, which could be provided either in the residential setting or externally, depending on the needs and preferences of the young person. Counsellors were encouraged to take the time to develop a relationship with residential care workers in order that they could: share information regarding the young person; describe some of the day to day issues impacting on the young person; and discuss what has worked well (and not so well) historically.

Staff from various agencies described some difficulties in establishing trusting relationships with young people due to rotating staff rosters and different 'care' styles. Several practitioners said they would like to see more effort put into genuine therapeutic models of residential care, as opposed to the youth work dominated models that seem most prevalent.

Another theme that emerged during interviews with practitioners was a desire for increased support for young people in the care of the state as they approach the age of 18 years and no longer qualify for child protection services. This included an increased focus on young people's future housing needs and 'life skills' as they transition to independent living.

# Practice Principles

## 10 YETI's approach – The development of practice principles

During the research process, YETI undertook informal action learning processes in an effort to identify some good practices for working with inhalant users. YETI practitioners were interviewed and the results of these interviews were used to inform ongoing reflective team discussions regarding effective ways of working. This process of critical reflection and review shaped the following observations and series of practice principles.

The following section will give an overview of key aspects of YETI's practice framework and discuss in further detail the underlying principles used by YETI when working with young people who misuse inhalants. YETI recognises that there is a lack of evidence based approaches for structuring inhalant use interventions (excepting d'Abbs and Maclean's critical 2008 research, *Volatile Substance Misuse: A review of interventions*) and has instead tried to rely on evidence informed frameworks for its interventions. This has largely entailed consideration of: harm minimisation frameworks; motivational interviewing practices; consultation with young people and practitioners regarding 'what works and what doesn't' and a focus on cultural safety.

YETI's practice with inhalant users is strongly focussed on the provision of 'soft entry points' (i.e., a drop in centre or outreach activities) to engage and build rapport with young people. These 'soft entry' points provide access to a range of programs including: case management; primary health services; creative and educational activities and therapeutic counselling or healing. This suite of approaches aims to meet young people 'where they are at'. Young people generally make their way from participating in activities towards more intensive and personalised support processes. This pathway approach with 'step up' and 'step down' opportunities could be represented visually as a stairwell to change, where risk assessment, and harm minimisation occurs throughout. This stairwell approach is framed by a series of principles for working with young people who use inhalants; these guide service delivery and underpin the individual steps that mark pathways to change and different futures. These principles have been identified as Hope, Home, Diversion and Dignity.

### 10.1 The Interplay of Principles

Principles, whilst useful to frame interventions are not always discrete and easy. Principles can intersect and overlap, yet in the end join together to construct meaningful practice and steps to change. In the case of YETI's work, the four principles of Hope, Home, Diversion and Dignity need to work in harmony. At a day-to-day level, diverting young people from using inhalants (by providing activities, or removing bottles of paint and distracting young people via expressed care for their immediate wellbeing) and reminding them of the need to be kind to themselves and others indicates our respect for individual dignity. YETI believes that hope itself arises from reclaimed dignity and that this is inherently linked with connection to country, family and activities, which create meaning and purpose. Meaning and purpose frequently leads young people to a yearning to connect with community and home and so each principle entangles with each other to underpin change. One principle is not more important than the other and all must be present to ensure different futures for vulnerable young people who are sniffing.

### 10.2 Hope

The Senate Committee into Petrol Sniffing identified and reinforced the causal factors of sniffing as largely socioeconomic. That is, *hunger, poverty, illness, low education levels, almost total unemployment, boredom and general feelings of hopelessness*. These are viewed significant in the environment in which self-destructive behaviour can occur. YETI works with young people who have come from such backgrounds and have also histories of abuse and trauma. The Senate Committee found that it was *the habitual feelings of hopelessness, boredom and lack of opportunity*, not the substance itself, which made the addiction chronic. This absence of 'hope' was regarded as significant in developing YETI's practice framework.

Tom Calma, former Aboriginal and Torres Strait Islander Social Justice Commissioner, Race Discrimination Commissioner and Australian Human Rights Commissioner stated in his 2009 Mabo Oration '*from self-respect comes dignity and from dignity comes hope*'. YETI recognises that the

principle of hope cannot be viewed in isolation and that all efforts to support dignity improve hopefulness and pathways to improved wellbeing.

Research with social workers indicates that a sense of clinical optimism can affect the outcomes of the professional relationship (Byrne et al 2006). Optimism can be transferred onto others and may predict persistence in service provision. That said, hope is a slightly more nebulous concept to describe than optimism and the therapeutic transference of hope can be somewhat intangible. YETI practitioners made some efforts to describe what hope looked like and how it may be implemented by:

- Being welcoming and genuine in early interactions;
- Developing and fostering rapport and relationship;
- Having personal 'one on one' discussions about individual strengths, abilities and opportunities;
- Clearly understanding and being able to articulate these strengths;
- Identifying and reinforcing strengths, opportunities for changes and future possibilities;
- Remaining overtly positive about these opportunities despite individual setbacks (even if these setbacks occur daily); and
- Being consistently positive and caring for a long-term period.

Building trusting and therapeutic relationships was viewed as an extremely vital component of the principle of hope, and it was recognised that these relationships took time to establish especially with young people who have been exposed to cycles of abuse. At YETI, practitioners believed that the very formation of a positive relationship within itself could give rise to a sense of hope and possibility about self. These relationships are encouraged to develop and build to a level of 'intimacy'. Evidence-informed case management practice as identified by Gronda (2009) distinguishes two dimensions of this 'intimacy'; the first is a genuine expression of the connection that creates a relationship, the second being the intimate nature of most case management activities (e.g., shopping, attending health appointments, providing transport etc.).

YETI identified that case management practice with young people who use inhalants was particularly emotionally demanding and staff required high levels of support. They regarded hope transference as requiring a sophisticated skill set, one that entails considerable personal fortitude and professional experience to manage safely. They recommended access to regular high quality professional supervision to assist practitioners to manage boundaries, the professional relationship and power imbalances. Practitioners also identified mechanisms such as good induction processes, strong clinical governance procedures, regular internal supervision and the employment of experienced practitioners (most ideally from culturally appropriate backgrounds) as important aspects of supporting young people.

As they build a relationship with a young person, YETI staff assess causal triggers to inhalant use (e.g., trauma; neglect; boredom; unfulfilled ambitions; unemployment; and dislocation from family and country). The assessment process with young people is a conversation structured by an intake form (Attachment Six). The form is simple and was developed via consultation with YETI practitioners and young people attending the service. The intake conversation includes: investigating a sense of cultural identity and belonging; exploring role models and opportunities for learning and participation; and an acknowledgement of issues currently impacting on young people's wellbeing. The process prioritises encouragement of optimism and increasing the confidence of young people via warm conversations about hope and the future.

Whilst young people are supported with immediate practical interventions when they enter the service (e.g., access to food, telephones, showers, first aid etc.) the intake and assessment approach ensures young people have some individual time to identify goals, which encourage: family contact; regular meaningful activities; physical security; and opportunities for self-expression. Practitioners believed that conversations whereby young people received positive reinforcement for their strengths might activate a sense of self-respect, dignity and hope. YETI practitioners also identified that heavy inhalant use in adolescence may hinder the development of resilience, emotional regulation and problem solving skills. A lack of these skills was considered to ultimately impact on young people's

abilities to form the types of healthy relationships that are key to coping and instilling a sense of hope.

YETI practitioners articulated that when not actively encouraged to participate in the formulation and creation of future goals and hopes young people risk having no sense of future and may be left to spiral in crisis. This 'crisis journey' may perpetuate inhalant misuse and entail increasing contact with the justice system.

### 10.3 Dignity

The principle of dignity was identified as central to YETI's practice with young people who engage in VSM. YETI's senior practitioners defined dignity as the: ability for a person to have an innate right to self-worth, respect, human value and ethical treatment in all regards. Respect for the inherent dignity, worth and autonomy of young people who engage with services was considered key to the success of therapeutic relationships, particularly where prior trauma may have had a significant impact on a young person's sense of self-worth and value. Practitioners agreed with the Human Rights Commissioner that without reclaimed dignity young people might lose the connection between self-respect and hope.

In particular, YETI practitioners reported that the stigma associated with sniffing might impact strongly on young people's efforts to reclaim their dignity. Stigma associated with inhalant use frequently results in ostracism from non-sniffing peers, kin, family and other key community supports (e.g., church, recreation and sporting clubs etc.). These experiences of stigma may reduce the young person's chances of: successful school completion, accessing employment and training opportunities and further increase the impacts of social isolation. Young people may experience deep feelings of shame, which can impact on many dimensions of their social and emotional wellbeing. In Aboriginal and Torres Strait Island communities shame is a word that can have many meanings but more often than not, it is linked with things that are considered embarrassing or have associated stigma or negative connotations. Shame is widely recognised as a barrier that prevents young people from seeking supports and ongoing feelings of shame can impact on an individual's social and emotional wellbeing.

YETI practitioners believed that supporting young people to not be overwhelmed by 'shame' and promoting the dignity of individuals were both key to service delivery. In practice this means that each person who enters a service is treated respectfully, personal information is kept confidential and young people are recognised as individuals with: different backgrounds, immediate needs and uniquely determined futures. YETI practitioners are trained to ensure that warm and personalised screening and assessment occurs to determine appropriate service delivery based on a young person's wishes and there is ample time and scope to consider culturally safe support requirements. Options are made available to a young person to ensure an informed 'choice' of service. Individually determined goal setting in case management is viewed as promoting increased control over the choices a young person is able to make in their lives. That said, YETI recognises that prolonged use of substances may create addictive or compulsive behaviour and a sense of some 'confusion' that can hinder decision-making. Young people are provided with simple choices and options to help them: firstly, consider moving from a crisis state; secondly, set short term goals; and finally, consider future ambitions and undertake longer term goal setting. Harm minimisation techniques are introduced to young people and approaches suggested to help decrease risky inhalant use.

YETI practitioners believe that the concept of dignity is inherently linked to both young people's self-identity and cultural identity. As such, they reported: respect for young peoples' cultural and spiritual views; the value of family and kinship bonds; and a desire to improve cultural safety as key to practice approaches. Culturally safe approaches encourage practitioners to analyse power imbalances, institutional discrimination, and colonisation through reflective practice. Cultural safety is a concept based on work undertaken by nurses in New Zealand who identified the outcome of culturally nuanced practice as being key to interventions (Papps, & Ramsden, 1996). Simply put, individuals need to feel safe in a service and assured an equal experience irrelevant of their cultural background.

*‘Cultural security is about ensuring that the delivery of health services is such that no one person is afforded a less favourable outcome simply because she or he holds a different cultural outlook’ (WANADA, 2012).*

In a youth service cultural safety relies heavily on: young people’s participation; the development of trust; and developing mutually accordant goals and aspirations. Dignity is embodied via routes of culturally safe service delivery and is seen as a critical component in enhancing empowerment and promoting self-determination for young people. YETI recognises that having a lack or absence of cultural safety within the service can create power imbalances and access for young people. The creation of a culturally safe environment is enacted through the therapeutic relationship to which establishing and maintaining trust is essential. Culturally safe practice at YETI incorporates trauma informed practice and recognises the importance of micro skills in relationship building.

YETI practitioners are continually aware of the power imbalances that can occur in professional relationships and whilst maintaining appropriate boundaries the practice framework recognises that building trust occurs through meaningful use of self. This use of self as a tool to cultural safety places importance upon:

- Courtesy and respect through being approachable and warm;
- Sharing appropriate information about our own histories;
- Ensuring that all interactions are focused on building trust and being curious;
- Being human and laughing at ourselves;
- Not promising too much;
- Making time to chat and yarn;
- Ensuring that every service visit is worthwhile for young people by ensuring quality time with practitioners, the provision of small emergency relief support or ensuring contact with other useful service providers such as doctors or Centrelink;
- Recognising that all respectful relationships take time to occur and that appropriate interventions are more likely to succeed given time to build mutual respect; and
- Being prepared to take new tacts or provide support from different ‘types’ of workers (i.e., cultural background, gender, age etc.) if it’s not working out.

Intrinsic within this framework is a young person’s participation as an individual, considering their choices, hopes and future aspirations.

## 10.4 Home

The National Drug Strategy 2010 - 2015 identifies drug and alcohol interventions linked to family and community as key to helping people reduce their substance use (Ministerial Council on Drug Strategy, 2011). YETI believes the importance of the connection to family and country for vulnerable young people, particularly those from Aboriginal and Torres Strait Island backgrounds cannot be understated. In particular, YETI practitioners recognise the relationship between trauma-informed practice models (Atkinson 2013) and the protective attributes of kinship, tradition and country as key to working with Aboriginal and Torres Strait Island young people.

During the research, staff at YETI shared understandings of concepts of both ‘Home’ and ‘Country’ and there was a general agreement that for most young people ‘Country’ incorporated a sense of connection with land, spirituality, Elders, tradition and respect. ‘Home’ was a more complex term, one that engendered a sense of family, safety and emotional refuge. Practitioners recognised that both home and country can be confusing places for some disenfranchised young people and places where traumatic events and experiences may have unfolded. That said, for most young people YETI has worked with, home communities are also the source of healing, connection and belonging. Identifying and exploring young people’s connection with their home country or area; and family or extended family was recommended as key to good outcomes when working with young people who use inhalants.

YETI has demonstrated very successful outcomes, supporting young people to return to country and family. Many young people who are supported to return home to country and family are ceasing their substance use and becoming safer in their use of alcohol. As discussed in Section 8.5.1, the processes

of supporting young people to return home rely upon: careful assessment; and 'joined up' planning with a young person, family members and local support agencies.

YETI practitioners saw the principle of 'Home' as providing a place-based framework for their practice. For young people who are still in the process of forming identity or in healing from past trauma, a connection to 'place' was identified as vital. A sense of place and/or historic connection to place was regarded as supporting young people to: be more engaged in community life; foster greater networks; build good relationships; and hold a stronger sense of self and of identity. Connection to country and to community was regarded as vital to recovery processes and was supported by literature (Atkinson, 2013), which discussed how individuals have significantly higher chances of healing from trauma if they are able to remain connected to place and develop a sense of belonging. Prolonged impacts of displacement from country were seen to further fracture and isolate young people. YETI practitioners articulated that the greater the sense of a young person's connection to community and belonging, the greater the support networks and problem-solving skills they were able to develop. This self-sufficiency minimised young people's dependence on services and encouraged independence and empowerment.

## 10.5 Diversion

YETI practitioners identified that diversion is a multi-faceted term; 'divert' itself was originally derived from the Latin *diverstere*, which means to turn in separate ways (Joudo, J 2008). The concept of diversionary practice at YETI refers to changing the direction or course of a person away from substance misuse and antisocial behaviours towards more healthy activities. In relation to inhalant misuse YETI focuses on two key aspects of diversion. Firstly, a crisis intervention that diverts young people from immediately engaging in inhalant use. Secondly, activities and programming that plays a more preventative role in reducing interest in taking up inhalant use in the near future. The principle of diversion aims to encapsulate both these activities.

Prior to the development of practice frameworks at YETI practitioners shared an understanding that young people who were actively sniffing near or adjacent to the service required an immediate intervention based on the principle of diversion. Simply put, this meant distracting young people enough to obtain the volatile solvent and removing it and providing young people with a place to rest and recover. That said, whilst some young people who are sniffing easily hand over the source of their intoxication (e.g., paint bottle, glue bag, tins of paint etc.) this is not always the case. Distracting young people, talking them through alternatives and being flexible around interventions was identified to work, although sometimes it took some time. Ultimately, providing young people with other more attractive options (e.g., a glass of water, a safe place, a kind word, a non-threatening space etc.) tended to be more preferable than walking the streets intoxicated. This is diversion in its most simple form, albeit more highly nuanced in practice. YETI relies on the frameworks provided in the National Health Council's Clinical Guidelines to underpin these interventions. The use of emergency callouts (i.e., police and ambulance interventions) whilst useful in some circumstances (e.g., high risk situations with problematic inhalant use) can often confound efforts at diversion and may have problematic side effects. If emergency services are used unnecessarily, services risk rupturing their relationships with heavy users and if used too infrequently an individual's health may be compromised. The National Clinical Guidelines have proved useful in guiding decision-making and ensure the health of individuals is given priority over young people's individual wishes whilst intoxicated. YETI identified that following all episodes of acute intoxication when emergency services were called, young people continued to engage with the service and there was no long-term impact on rapport and relationships.

Aside from the crisis related diversionary approaches YETI uses when young people are actively engaged in inhalant use, diversion is a good foundation for preventing young people from commencing their inhalant use and/or decreasing the likelihood that they continue to engage in inhalant use. Demand reduction research demonstrates that:

*'diversionary activities need to be developed in conjunction with community members and affected groups; offer a range of programs designed to re-engage young people with education; and provide creative programs that deliver key messages on harm minimisation*

*(where appropriate) and healthy lifestyle messages in a subtle and non-lecturing way'*  
(FACSHIA, 2010 p. 37).

Structured preventative and early intervention diversionary activities at YETI focus on engaging two key cohorts of young people: those currently involved in inhalant use; and young people in the community at risk of involvement in inhalant use. Diversionary activities are undertaken in the centre and in outreach settings. Centre based activities include art projects, cooking, educational projects, reading and watching movies. These activities ensure that young people have something meaningful to do with their time and distract them from getting bored. Outreach programming can include circus, sports, swimming, fishing and walking together. YETI also coordinates a local diversionary activity program for young people 'Young People in Space'. The project aims to provide early intervention and prevention activities based programming in public spaces adjacent or nearby to social housing communities. The program targets 'hotspot' locations and is held after school when young people are more likely to engage in substance misuse. The Young People in Space program can work alongside family members and is clearly linked to case management and therapeutic counselling opportunities. YETI considers the following factors (Cheverton et al., 2003) when designing diversionary activities for young people who misuse inhalants:

- Avoid stigmatising participants by advertising activities as targeting drug users;
- Include drug users and non-drug users;
- Involve young people at all stages of project development;
- Focus on skill and capacity development, rather than deficits;
- Offer various activities and levels of participation;
- Provide support services;
- Include risky and exciting activities;
- Support young people in developing friendship networks;
- Offer a goal for people to work towards; and
- Ensure ongoing support.

Diversion as a practice principle, not only encapsulates crisis diversionary interventions and activities programming. The most significant and important diversionary scheme for young people who use inhalants is school. All YETI practitioners ensure wherever possible that young people are supported to: attend and remain at school; re-engage with school; continue to work on their numeracy and literacy skills; and consider longer term goals setting around further training or education.

In conclusion, these practice principles act to underpin and inform the framework for service delivery at YETI. They frame practice and provide a basis for evidence based learning and practice reflection and development. Working with highly marginalised young people who use inhalants presents ongoing daily challenges. Working with the historic legacy of the past as well as the current complex mix of systemic social and political factors within the context of regional cities means working on the cutting edge. The importance of documenting this journey and the journey of the young people they walk beside enables the sharing and lessons of their ongoing learning and contributes to broader developmental discourse within the field. In this way young people and practitioners become instruments of positive change and together co-create pathways to different futures.

# Conclusion and Recommendations

## 11 Conclusion

As we have indicated, there is unlikely to be any single approach that can effectively address inhalant misuse in our communities, although the best solutions will likely require a combination of approaches including: supply, demand and harm reduction strategies. This project was relatively small, with a limited scope and may produce more questions than it answers. That said, throughout this process we have identified practice interventions which are producing positive outcomes and several areas that warrant further investigation.

The National Inhalant Abuse Taskforce (NIAT 2006) recommend a coordinated and sustained national response between government, non-government and private agencies working in the fields of health, education, justice, police, youth, sport and recreation to address VSM. This is consistent with recommendations from practitioners who participated in this study and also with Peter d'Abbs and Sarah MacLean's review of interventions which summarised that the most successful VSM interventions were likely to include a combination of activities that address the underlying causes for inhalant use such as social disadvantage and marginalisation whilst also enhancing opportunities for skills development, employment opportunities and confidence building among young people (d'Abbs & S. J. MacLean 2008).

This research and other published literature suggests that approaches addressing VSM are unlikely to be successful if they do not address underlying issues that fuel inhalant misuse (CCYP 2002). All service providers interviewed were of the opinion that inhalant use is predominantly a symptom of other issues being experienced by young people. Practitioners reported that it was necessary to address issues such as family dysfunction, child abuse and neglect, violence against women and children, homelessness and legal problems faced by inhalant users before significant progress could be made to address substance misuse.

The complex needs of inhalant users and, indeed vulnerable young people more generally, necessitates cooperation between many agencies. The collaboration between agencies within each of the four cities was generally quite extensive and based on goodwill and common goals. There is however a danger that this cooperation is frequently dependent on the working relationships of individual practitioners and may disappear or diminish as key individuals leave. Therefore, it is important to entrench collaborative processes into formal/semi-formal agreements between agencies and enshrine these systems in organisational memories.

It is far more difficult to treat chronic sniffers than those who experiment or use infrequently, therefore very different interventions need to be developed for these groups (S. J. MacLean & d'Abbs 2002). Likewise, evaluations should consider interventions for chronic inhalant users separately to those targeting occasional or recreational users. There remain some important questions that need to be answered in order to more effectively address inhalant use in our communities. Whilst much of the literature says that young people often 'grow out of' inhalant use, there is a distinct cohort that clearly does not cease their inhalant use as they approach adulthood. The reasons for choosing this path is not always clear, though from the experiences seen at YETI, it appears young people from some of the most marginalised and dysfunctional family settings are less likely to see inhalant use fade out with the end of their adolescence. Young people whose families have lost connection with country and traditional culture and spirituality seem particularly vulnerable to ongoing inhalant misuse. For some individuals, inhalant use continues beyond the time when they are eligible for assistance through government and non-government youth services. Final recommendations from an inquiry into the inhalation of volatile substances in Victoria included the need for a review of service provision for those young people who having turned 18 years of age and can no longer receive assistance or participate in programs designed to assist them with their volatile substance misuse (Drugs and Crime Prevention Committee 2002b).

Practitioners in Mount Isa, Townsville and Rockhampton described a need for increased access to early intervention programs for young people using inhalants. There were concerns that often young people were only able to access services when they came to the attention of authorities through either the health or justice systems. Across all the regional centres there were generally activity-based programs available for young people through organisations such as the PCYC, after school

programs and local council youth programs. However, practitioners reported that young people most at risk of inhalant use are unlikely to get involved in these kinds of activities. More attention is required to ensure that all community programs address barriers to participation and consider ways to increase participation for vulnerable young people.

Practitioners identified the need to find a 'circuit breaker' to get young people out of the cycle of sniffing. Time in residential rehabilitation facilities was considered a useful strategy. That said, some residential services were perceived as being difficult to access and often unsuitable for young people. Unfortunately the most accessible opportunities for respite from sniffing are currently youth detention centres or prisons, both which present young people with exposure to a range of problematic issues.

Interviews with young people and practitioners who work with inhalant users, suggested that it might not be sufficient to treat individual inhalant users, if they then return to their hometown and again associate with sniffing peers. In some circumstances it was advised as useful to treat 'communities' of sniffers. This would be particularly important where the group consists of several members of one family.

Another key issue facing young people who use inhalants is the social stigma that is associated with the activity. Sniffing is frowned upon by most of the community including families and peers of young people involved. This stigmatisation no doubt contributes to further alienation of young people, who may already be disengaged from mainstream education, employment, recreation and pro-social activities. Young people engaged in VSM are more likely to respond to interventions that are socially inclusive rather than those that demonise or alienate them, an approach that is endorsed by the Commission of Young People and Child Guardian (CCYP 2002).

Whilst education and awareness raising alone is unlikely to prevent inhalant use, it still forms an important part of any suite of interventions to address the issue. Examples of how health education regarding the risks associated with inhalant use can benefit even the most chronic users was evident in the numbers of young women who reported ceasing their inhalant use when they were pregnant for fear of the negative effects on their unborn children. Few agencies were engaged in any form of preventative education activities with non-inhalant users for fear of introducing the uninitiated into inhalant use. Those services that engaged in preventative education campaigns were careful to present information in relation to the general dangers of handling hazardous substances.

There was a perception amongst some service providers that government expectations for working with young people were not always appropriate. This was particularly of concern in regard to concepts of 'mutual obligation' when dealing with the most vulnerable of young people. For vulnerable young people who may be homeless and have little family support, it was not always easy for them to attend pre-arranged appointments and undertake job seeking whilst they struggled with their inhalant use. Some young people experienced multiple payment suspensions that in turn increased their vulnerability to opportunistic prostitution and exploitation by others.

This research project also identified the need for improvements in our understanding of the rates and nature of inhalant use over time and across different jurisdictions. There is currently no other data collected locally to assist in triangulating these findings. Furthermore there is a further research gap was the paucity of understanding of current inhalant interventions funded across Australia. The National Inhalant use Taskforce recommended that governments include evaluation and monitoring activities in all grant treatment program funding (NIAT 2006).

Finally, as stated earlier, this research constituted just one part of the Cairns VSM-CAP Project. The research aimed to identify, explore and report some of the issues and interventions associated with inhalant use in regional centres of North and Far North Queensland. The report has endeavoured to give a voice to people at the 'coal face' of sniffing in regional Queensland both those young people who sniff and the practitioners who dedicate their time to work with them. The report has also enabled the articulation of the practice framework employed by YETI and hopes that this contributes to future discussions of what works and what doesn't, in the context of supporting young people who misuse inhalants.

## 12 Recommendations

The issues associated with inhalant use in our communities are extremely complex and it is unlikely that a single agency or approach will adequately address all needs. The following recommendations provide a summary of the suite of services and collaborative processes that we believe are needed to more effectively address inhalant use within a community.

1. Systematic Interagency Collaboration
  - There needs to be formalised agreements about ways of working between government and non-government organisations in relation to addressing inhalant use within the community.
  - Community action planning should consider the local/regional context, including the relationships between regional cities and remote communities, to which they provide services.
2. Coordinated Case Management
  - Interagency cooperation on the case management of individual clients is essential. No single agency will ever be able to address all the case management needs of young people who use inhalants.
  - Systems should be developed to allow shared case plans which can be produced in a timely fashion to allow rapid responses.
  - Clear referral pathways should be developed between and within government and non-government agencies.
  - Clear processes and protocols for information sharing between relevant agencies require development.
3. Case Management Support
  - Agencies should each identify a key caseworker to take on overall responsibility for a particular client. However, this should also be accompanied by team support to reduce the risk of disruption if for any reason the key worker is no longer able to continue.
  - Case management should not be limited to only addressing substance misuse. Effective work will need to also address practical needs (e.g., legal issues, housing, re-engaging with education and employment etc.).
4. Family Support
  - Agencies working with young people need to strengthen working relationships with family support agencies. This is particularly important where the person involved is a minor.
5. Separation from Peers
  - Agencies working with young people should be cognisant of dynamics between young people using their services and minimise opportunities for younger clients to associate with older inhalant using clients.
  - Wherever possible, child protection authorities should avoid placing inhalant using young people into residential care facilities where they may influence others.
6. Return to Country
  - Return to Country strategies represent a very specific and successful approach to separating young people from peers with whom they may have a history of using inhalants.
  - Efforts to return young people to remote communities need to be done systematically and strategically using clearly defined processes.
  - A single key agency should be identified to coordinate support for the young person prior to their departure and whilst they are in the community.
  - Agencies need greater access to brokerage funding to assist returning young people to remote communities.
  - Systems should be put into place with agencies and/or individuals in the community to provide on-going support to the young person.
  - Practitioners in remote and isolated locations should be provided with training and capacity-building opportunities.

## 7. Diversion Activities

- Any suite of programs for young people who use inhalants should also provide access to a range of creative and recreational diversion activities. These are particularly important as early interventions.
- Diversion activities should provide potential engagement points for other interventions such as case management or therapeutic counselling.
- Activities should not restrict participation to young people who use inhalants. Effort should be made to avoid the stigmatisation of developing activities that are seen as only being for 'sniffers'.
- Activity-based programs should be well-structured and provide strategic recreational or skills development opportunities.

## 8. Residential Rehabilitation

- Residential rehabilitation services should be available for young people who have an inhalant use problem. Characteristics should include:
  - Flexibility of access;
  - Cultural safety;
  - Youth friendly;
  - Communication with case workers/counsellors who have already built relationships with the client in preparation for commencement at rehabilitation, during rehabilitation and in preparation for exit; and
  - Improved relapse prevention for young people being released from rehabilitation facilities.
- Increased access to well supported remote outstation rehabilitation services. These should provide meaningful activities and responsibilities to occupy young people and teach new skills as well as access to counselling services.

## 9. Therapeutic services

- Counselling should be made available for young people to address underlying issues of trauma and grief that may contribute to inhalant use.
- Counselling services should also be made available to family members where appropriate to assist them to better understand the young person's behaviour.
- Counselling services need to collaborate with agencies providing other interventions to young people such as case management and activity-based programs.

## 10. Supply Reduction

- A strategic plan needs to be developed to ensure a regional approach to supply reduction.
- Development of appropriate supply reduction materials.
- Longitudinal monitoring of inhalant use trends/purchases/theft of products.
- Training in relation to supply reduction for key stakeholders in the community (e.g. retailers, industry, government and non-government practitioners etc.).
- Capacity building for youth workers in remote communities to address supply reduction activities.

## 13 Bibliography

- Adams, S. & Morgan, M.L., 2007. *Inhalant Abuse Prevention: Staff Education and Student Curriculum*, Richmond, Virginia.
- ADCA, 2010. *Policy Position: Inhalants*, Alcohol and other Drugs Council of Australia.
- Atkinson J 2013. Trauma-informed services and trauma-specific care for Indigenous Australian children. Resource sheet no. 21. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.
- Australian Institute of Health and Welfare, 2011. *2010 National Drug Strategy Household Survey Report*, Canberra.
- Beauvais, F. et al., 2002. A Survey of Attitudes Among Drug User Treatment Providers Toward the Treatment of Inhalant Users. *Substance Use & Misuse*, 37(11), pp.1391–1410.
- Butt, J., 2004. *Independent Evaluation of the Get Real Challenge: Issues facing Indigenous youth who misuse volatile substances, and outcomes of a program targeting these issues*.
- Byrne, M. K., Sullivan, N. L. & Elsom, S. J. (2006). Clinician optimism: Development and psychometric analysis of a scale for mental health clinicians. *Australian Journal of Rehabilitation Counselling*, 12 (1), 11-20.
- Cahill, H., Murphy, B. & Hughes, A., 2005. *A toolkit of interventions to assist young people to negotiate transitional pathways*.
- Cairney, S. & Dingwall, K., 2010. The mysterious practice of petrol sniffing in isolated indigenous groups. *Journal of paediatrics and child health*, 46(9), pp.510–5.
- CCYP, 2002. *Volatile Substance Misuse in Queensland*, Brisbane: Commission for Children and Young People.
- CCYPCG, 2011. *The Chroming Report*, The State of Queensland (Commission for Children and Young People and Child Guardian).
- Cheverton, J., Schrader, T. & Scrogings, Z., 2003. *Sniffing Around the Valley*, Brisbane.
- Cleary, S., 2001. Inhalant Abuse by Young People. In Paper presented at the Character, Impact and Prevention of Crime in Regional Australia Conference convened by the Australian Institute of Criminology and held in Townsville, 2-3 August 2011, p. 12.
- Copello, A.G., Velleman, R.D.B. & Templeton, L.J., 2005. Family interventions in the treatment of alcohol and drug problems. *Drug and alcohol review*, 24(4), pp.369–85.
- d'Abbs, P.H.N. & MacLean, S.J., 2008. *Volatile Substance Misuse: A review of interventions*, Canberra: Australian Government Department of Health and Ageing.
- d'Abbs, P.H.N. & Shaw, Gillian, 2008. *Executive Summary of the " Evaluation of the Impact of Opal Fuel"*.

- Denov, M. & Campbell, K., 2002. Casualties of Aboriginal Displacement in Canada : Children at Risk among the Innu of Labrador. *Refuge*, 20(2), pp.21–33.
- Department of Education and Training, 2000. *Volatile Solvents: A resource for schools*, Melbourne: Department of Education and Training.
- Dinwiddie, S.H., 1994. Abuse of inhalants: a review. *Addiction*, 89(8), pp.925–939.
- Drugs and Crime Prevention Committee, 2002a. *Inquiry into the Inhalation of Volatile Substances: Discussion Paper*, Melbourne.
- Drugs and Crime Prevention Committee, 2002b. *Inquiry into the Inhalation of Volatile Substances: Final Report*, Melbourne.
- FAHCSIA (2010) Research to Inform the Development of The Youth Diversion Communication Strategy in the East Kimberly and Central Desert Region (CDR). Final Report. Cultural and Indigenous Research Centre Australia. Department of Families, Housing, Community Services and Indigenous Affairs, Canberra.
- Gray, D. et al., 2006. *Policing, volatile substance misuse, and Indigenous Australians*.
- Gronda, H. 2009. What makes case management work for people experiencing homelessness? Evidence for Practice. AHURI final report No. 127. Melbourne Australian Housing and Urban Research Institute.
- Hancock, S., 2004. *The Brunswick Buzz: Findings from the participatory research project about young people and chroming in Brisbane's inner city*, Brisbane.
- Henry-Edwards, S., 2003. Inhalant policy: What can we learn from the National Drug Strategy? In *inhalant Use and Disorder Conference convened by the Australian Institute of Criminology. 7-8 July 2003*. Townsville, p. 9.
- James, M., 2004. Petrol Sniffing On Cape York Peninsula An Intervention Strategy. , pp.1–18.
- Joudo J 2008. *Responding to substance abuse and offending in Indigenous communities: review of diversion programs*. Research and public policy series no. 88. Canberra: Australian Institute of Criminology.
- Konghom, S. et al., 2010. Treatment for inhalant dependence and abuse (Review). *Cochrane Database of Systematic Reviews*, (12), p.18.
- Lubman, D.I., Hides, L. & Yücel, M., 2006. Inhalant misuse in youth: time for a coordinated response. *The Medical Journal of Australia*, 185(6), pp.327–330.
- Mackesy-Amiti, M.E. & Fendrich, M., 1999. Inhalant use and delinquent behavior among adolescents: a comparison of inhalant users and other drug users. *Addiction (Abingdon, England)*, 94(4), pp.555–64.
- McCoy, Brian. (2006, 5–8 November 2006). *Petrol sniffing: social pathways and desert practice*. Paper presented at the Australian Professional Society on Alcohol and Other Drugs (APSAD), Cairns.
- MacLean, S. et al., 2012. Psychosocial therapeutic interventions for volatile substance use: a systematic review. *Addiction*, 107(2), pp.278–88.
- MacLean, S.J., 2012. *Developing an Inhalant Misuse Community*.

- MacLean, S.J., 2005. "It might be a scummy-arsed drug but it's a sick buzz" chroming and pleasure. *Contemporary Drug Problems*, 32(Summer), pp.295–318.
- MacLean, S.J., 2003. "Just a Dirty Kind of Drug": Young People's Perceptions of Chroming. In Paper presented at the Inhalant Use and Disorder Conference convened by the Australian Institute of Criminology and held in Townsville, 7-8 July 2003, pp. 7–8.
- MacLean, S.J. & d'Abbs, P.H.N., 2011. Five challenges for volatile substance misuse policy and intervention in Australia. *Drug and alcohol review*, 30(2), pp.223–7.
- MacLean, S.J. & d'Abbs, P.H.N., 2002. Petrol sniffing in Aboriginal communities: a review of interventions. *Drug and alcohol review*, 21(1), pp.65–72.
- Midford, R. et al., 2010. Reviews of volatile substance use among Indigenous people. *Australian Indigenous Health InfoNet*.
- Ministerial Council on Drug Strategy, 2010. *National Drug Strategy: 2010-2015*,
- Ministerial Council on Drug Strategy, 2006. *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*.
- NHMRC, 2011a. *Caring for people who sniff petrol or other volatile substances: A quick reference guide for health workers*.
- NHMRC, 2011b. *Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia*, Melbourne: National Health and Medical Research Council.
- NHMRC, 2011c. *Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia: Appendices*, Melbourne: National Health and Medical Research Council.
- NIAT, 2006. *National Directions on Inhalant Abuse*.
- Ogwang, T., Cox, L. & Saldanha, J., 2006. Paint on their lips: Paint-sniffers, good citizens and public space in Brisbane. *Journal of Sociology*, 42(4), pp.412–428.
- Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*, 8(5), 491-497.
- Palmer, T., 2003. Chroming and Harm Minimisation. In *Inhalant Use and Disorder Conference convened by the Australian Institute of Criminology*. Townsville, pp. 7–8.
- Queensland Health, 2011. *Queensland Drug Strategy 2006–2010: End point implementation report (June 2011)*, Queensland Government (Queensland Health).
- Ridenour, T.A., 2005. Inhalants: not to be taken lightly anymore. *Current opinion in psychiatry*, 18(3), pp.243–7.
- Ridenour, T.A., Bray, B.C. & Cottler, L.B., 2007. Reliability of use, abuse, and dependence of four types of inhalants in adolescents and young adults. *Drug and Alcohol Dependence*, 91(1), pp.40–49.
- Rose J, Western Australian Solvents Abuse Working Party (2001) *Volatile substance abuse: background paper*. Perth, WA: Department of Health & Drug Alcohol Office.

- Shaw, Gillian, Ray, T. & McFarland, B., 2011. The outstation model of rehabilitation as practiced in Central Australia: the case for its recognition and acceptance. *Substance use & misuse*, 46(s1), pp.114–118.
- Skellington Orr, K. & Shewan, D., 2006. *Review of Evidence Relating to Volatile Substance Abuse in Scotland*, Edinburgh.
- Takagi, M.J., Yücel, M. & Lubman, D.I., 2010. The dark side of sniffing: paint colour affects intoxication experiences among adolescent inhalant users. *Drug and alcohol review*, 29(4), pp.452–5.
- Toumbourou, J.W., Dimsey, L. & Rowland, M.B., 2004. *Prevention of harms associated with volatile substance abuse*, Melbourne.
- URBIS, 2008. *Review of the First Phase of the Petrol Sniffing Strategy*, Canberra.
- Usher, K., Jackson, D. & O'Brien, L., 2005. Adolescent drug abuse: helping families survive. *International Journal of Mental Health Nursing*, 14(3), pp.209–214.
- Velleman, R.D.B., Templeton, L.J. & Copello, A.G., 2005. The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. *Drug and alcohol review*, 24(2), pp.93–109.
- White, V., 2006. Australian secondary school students ' use of over-the-counter and illicit substances in 2005 Report., (June).
- White, V. & Bariola, E., 2012. *Australian secondary school students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2011*.
- White, V. & Smith, G., 2009. *Australian secondary school students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2008*.
- Wilkes, E. et al., 2010. Substance Misuse and Mental Health among Aboriginal Australians. In *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. pp. 117–134.
- Wu, L.-T., Pilowsky, D.J. & Schlenger, W.E., 2004. Inhalant Abuse and Dependence Among Adolescents in the United States. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(10), pp.1206–1214.

# APPENDICES

## Appendix 1 - Cairns Service Chart for Inhalant use

Appendix one describes the Cairns Services Chart for Inhalant Use. The Chart is a diagram that describes a clinical decision making pathway for providing both critical and non-critical care for intoxicated inhalant users. The diagram describes the need to call ambulance and emergency services when there are identified Immediate Health Risks. The chart refers those concerned about someone's suspected inhalant use to a range of government and non-government services in the Cairns region.

If someone is involved in an activity that is presenting an immediate danger to self or others you should call emergency services on 000.

Critical Care (for intoxicated users) where there is an immediate health risk call ambulance or emergency triple 000 services and administer basic first aid. Where there is no immediate health risk and the person is equipped and confident to provide basic care; maintain safety, remove substances if safe to do so; rest in quiet, safe place; offer food and water when awake and alert; and watch closely and monitor until fully recovered. Where a person is not equipped or confident to deal with intoxicated inhalant users and the incident occurs between office hours and the person is between 12 and 17 call YSMS (07) 4080 5800) or the person is between 10 and 25 years call YETI (07) 4051 4927)

Ambulance and emergency services should be called where the person is gurgling or there is evidence of a blockage; has noisy, laboured or shallow breathing; cold skin, sweaty skin, pallor, blue lips; or, poor concentration, becoming more agitated, losing consciousness, unresponsive to pain, seizures. (From the NHMRC Consensus-based clinical practice guideline for the management of volatile substance use in Australia)

### Non- Critical Care

For those concerned about someone's suspected inhalant use, though not necessarily currently intoxicated and the child is under 12 years, call YETI (07) 4051 4927; a young person between 12 and 17 years, call YETI (07) 4051 4927, YSMS (07) 4080 5800 or Wuchopperen (07) 4080 1000; or, where the person is aged over 18 years call ATODS (07) 4050 3900, QDAC (07) 4046 8080, Wuchopperen (07) 4080 1000 or YETI (07) 4051 4927.

## SERVICES AVAILABLE FOR INFORMATION AND SUPPORT

### 24 Hour Support

Queensland Ambulance Service  
For emergencies – Call 000

Queensland Police Service  
For emergencies – Call 000  
For non-emergencies – Call Police Link 131 444

### ATODS

24 hour advice and support for everyone currently experiencing problems due to their own or others use of alcohol and other drugs. Alcohol and Drug Information Service on 1800 177 833. Service can provide comprehensive assessments for substance use, brief intervention, treatment planning, case management, counselling, residential treatment and referral if required.

YSMS (Youth Substance Misuse Service)  
Out of hours by police referral only. See below for further details of services provided.

## Office Hour's Support

YSMS – (07) 4080 5800

YSMS provides a responsive intervention service that targets young people aged between 12 to 17 who have been affected by inhalant use as a preliminary step into longer term treatment and support. This includes a rest and recovery service and support to young people and their families. YSMA also support retailers to understand their legal rights in regard to the sale/control of volatile substances.

YETI (Youth Empowered Towards Independence) (07) 4051 4927

YETI provides services through a range of programs focussing on the needs of vulnerable young people (aged 10-25 years) including those using inhalants, such as a drop-in program, case management, therapeutic counselling and outreach/diversionary activities. Referral can be made by any agency or individual.

Wuchopperen Health Service (Substance Misuse Program) (07) 4080 1036

WHS offers primary health care services (including social & emotional wellbeing) to Aboriginal & Torres Strait Islander individuals and families. The substance misuse program (SMP) provides counselling support, case management and community outreach services to individuals and families experiencing alcohol and other substance related difficulties. The SMP also offers assessment, support, counselling and referral to individuals at risk and/or experiencing difficulties with volatile substances. The SMP service has the capacity to provide home visiting and community outreach services.

Queensland Drug and Alcohol Council (QDAC) (07) 4046 8080

QDAC has a referral shopfront in Cairns and a residential therapeutic community in Mareeba providing residential treatment services for Aboriginal & Torres Strait Islander people aged 18 years and over from Cairns and the surrounding regions. Clients can be referred from health, welfare and community organisations, or they may self-refer.

### **For further information about issues associated with volatile substance misuse:**

National Health and Medical Research Council, Caring for people who sniff petrol or other volatile substances: A Quick Reference Guide for Health Workers

<http://www.nhmrc.gov.au/guidelines>

National Inhalants Information Service

<http://www.inhalantsinfo.org.au/>

Dovetail – information, resources, tools and examples of good practice in youth alcohol and other drug work

[www.dovetail.org.au](http://www.dovetail.org.au)

## Appendix 2 – Interviewees

Staff from the following agencies were interviewed for this report.

<b>Agency</b>	<b>Date</b>
<b>CAIRNS</b>	
YETI (Youth Empowered Towards Independence)	July – September 2012
St Luke's Residential Care Service, Anglicare	September 2012
Wuchopperen Health Service - Counselling & Support Services	March 2013
Youth Substance Misuse Service, Anglicare	September 2012
<b>MOUNT ISA</b>	
Young People Ahead	October 2012
Reconnect, Centacare	October 2012
Alcohol, Tobacco and Other Drugs (ATODS) Youth Service	October 2012
<b>ROCKHAMPTON</b>	
Darumbal Community Youth Service	December 2012
IFYS (Integrated Family and Youth Service) Residential Care Program	December 2012
Roseberry Community Services	December 2012
Department of Education, Training and Employment, Regional Youth Support Coordinator	December 2012
<b>TOWNSVILLE</b>	
Volatile Substance Misuse Services, Townsville Aboriginal and Islanders Health Service	March 2013
Department of Education, Training and Employment, Regional Youth Support Coordinator	March 2013
Alcohol, Tobacco and Other Drugs (ATODS) Youth Service	March 2013

## Appendix 3 - Agency Interview Questions

### YETI Volatile Substance Misuse – Community and Practice

1. Do you work directly with young people engaging in VSM?
2. What kind of services do you provide for inhalant users?

#### Inhalant User Characteristics

1. In your opinion, are there common traits of young people who sniff?
  - a. Any typical characteristics (e.g. gender, age, background)
2. Are there different identifiable patterns of sniffing? e.g. regular users, occasional users
3. What substances are young people sniffing and how are they doing it?
4. Are there patterns of when sniffing is more or less prevalent?
5. Why do you believe young people get involved in sniffing?
6. Do you think this is different to the reasons people start using other drugs?
7. Are there patterns around when individuals sniff?
  - a. Why do they stop for periods?
  - b. Why do they start again (triggers)?
8. Do you find the behaviour of sniffers differ from users of other drugs?

83

#### Interventions

1. Do your activities directly address inhalant use?
2. What do you do when someone who has been sniffing comes into the service (i.e. currently intoxicated)?
3. What kinds of interventions are you using? What interventions have you tried/done with sniffers?
  - a. Are these aimed at stopping someone sniffing? Harm minimisation?
4. What do you think has been most successful?
5. What do you think works? (whether or not this is something your agency does)
6. What do you think is the greatest barrier to effective inhalant user treatment?
7. Is there anything that you have tried that you think really doesn't work?
8. Do you think interventions suitable for inhalant users are different than those for users of other drugs?
9. In an ideal world what interventions would you like to see available for sniffers (assuming unlimited resources)?

## Appendix 4 - Guiding Questions for Interviews with Young People

Age:

Gender:

Aboriginal/Torres Strait Islander/neither

### Questions for Young People

1. Have you ever sniffed (paint/glue/aerosols)?
2. How old were you the first time you sniffed?
3. What was the first substance you sniffed?
4. Do you go to school?
  - a. If not, how old were you when you stopped?
5. Who were you with the first time you sniffed?

84

### Current Sniffers

1. Do you sniff regularly?
2. If yes, roughly how often?
3. In the past year, what is the longest time you have gone without sniffing?
4. Where do you sniff?
5. Do you sniff with others or alone? Why?
6. Why do you sniff? What do you feel when you sniff?
  - a. Hallucinations?
7. What do you prefer to sniff?
  - b. Why?
8. How do you usually get stuff to sniff?
9. Do you want to stop sniffing?
10. Has anyone spoken to you about the dangers/health risks of sniffing?
11. Do your family and friends know you sniff?
12. Do you drink alcohol? If yes, how much/often?
13. Do you smoke cannabis?
14. If you can get other drugs, would you sniff?
15. Do you think you will be sniffing one year from now?

### Former Sniffers

16. What did you sniff?
17. Did you sniff with others or alone? Why?
18. How/where did you get substances to sniff?
19. How long ago did you stop sniffing?
20. Why did you stop?
  
21. What would you tell someone if they were going to sniff for the first time?
22. What do you think when you see groups of young kids sniffing on the street?

## Appendix 5 - Coordinated Care for Vulnerable Young People Model

Appendix 5 describes the Coordinated Care for Vulnerable Young People Model. The diagram describes the referral flow for young people. The model describes the role of the Partner Agencies, Panel Convenor, The Panel, Care Team Meetings, Reference Group, Homelessness Project Taskforce and the Regional Managers Coordination Network.

In the model the entry point for a client is when a Partner Agency makes a referral to the Panel Convenor. The Panel Convenor will manage referrals and progress them to the Panel which is led by a Chairperson. The Panel Chair leads a focussed discussion on assessment of referrals and agencies are identified to respond and specialist advice may be sought. Care Team Meetings feed into The Panel, their role is to lead the stakeholder meetings, writing up and coordinating with identified agencies a Care Coordination Plan, reporting any progress and outcomes to the Panel Chair.

A Coordinated Care for Vulnerable Young People Reference Group oversees the activities of the Panel, monitoring and reviewing the model and progresses unresolved systemic issues to the Homelessness Project Group. The Reference Group reports to the Homelessness Project Group Taskforce, which in turn reports to the Regional Managers Coordination Network where they work to resolve systemic issues which remain unresolved through earlier processes.

## Appendix 6 - Intake Form

Appendix 6 is the Circles Intake Form.

The Circles Intake Form is the screening process that YETI intake and assessment practitioners use when they first begin working with a young person. The form has a circular diagram with the young person in the centre and a range of issues around the person. The young person is asked to place a tick in the circle if they need help in that area and becomes the basis for initial focus of assistance.

The areas covered include:

- I want to stop using drugs;
- I want to find a job;
- I need to find a place to live;
- I want to do some training;
- I have problems with my partner;
- I have to go to Court;
- I have no one to help and support me;
- I need to see a doctor;
- I am experiencing family conflict;
- I want to cut down my drinking;
- I want to stop chroming;
- I feel stressed most of the time;
- I feel sad most of the time;
- I feel angry most of the time;
- I have no one to talk to or help me;
- I need to see a counsellor; and
- I want a place to visit and feel safe