

8 Demand reduction III: Clinical management, counselling, residential and homeland programs

In the final section on demand reduction, we focus on interventions which, for the most part, are aimed at people who are already engaged in VSM. We review evidence covering clinical management of VSM, counselling and family interventions, residential treatment, and homeland (outstation) rehabilitation programs. In reality, these areas cannot be so neatly compartmentalised. Residential treatment, for example, will almost certainly involve both counselling and clinical management. We also raise the issue of care for people with acquired brain injury, and discuss evidence relating to the use of homeland centres (outstations) for addressing VSM in remote communities.

8.1 Clinical management of VSM

In 1987 Joseph Westermeyer, a psychiatrist, complained that little research was available to inform the clinician treating clients who misuse volatile substances. While studies since this time have improved our understanding of the various problems and pathologies that accompany VSM, Westermeyer's observation remains apposite.

International literature gives few grounds for optimism about treatment outcomes. Beauvais and Trimble, writing in the US, state that solvent users 'defy conventional treatment and prevention efforts' (1997, p. xi). Dinwiddie (1994) reviews approaches to treatment in the US for those whose inhalant use has become long-term or chronic, and concludes that outcomes are very poor. Strategies believed to work with other drug users are often observed to be less effective among those who use inhalants (Beauvais, Jumper-Thurman, Plested, & Helm, 2002; Mackesy-Amiti & Fendrich, 1998). Others have argued that any treatment success is likely to be attributable to the fact that VSM generally declines as people age, rather than the intervention itself (Sakai, Mikulich-Gilbertson, & Crowley, 2006). Very little outcome data is available with regards to any treatment modality other than residential rehabilitation (see 8.3 below).

Many young people undergoing treatment for VSM exhibit a range of complex behaviours and are at acute risk of harm. A Canadian treatment provider reported that 'the fear of having to protect a young person who was high on solvents was hard to describe' (cited in Charles & Luca, 1999, p. 67). Over 80% of 550 respondents in a survey of Canadian drug treatment practitioners assessed their inhalant using clients' prospects of recovery as only 'poor' or 'very poor' (Beauvais, Jumper-Thurman et al., 2002). Nonetheless there are also accounts in the literature from people who have found it deeply fulfilling to be involved with young people at a critical junction in their lives. Some practitioners regard VSM intervention as an opportunity to learn to work cross-culturally, valuing both Indigenous and non-Indigenous approaches (Charles & Coleman, 1999; Charles & Luca, 1999).

In the United States, the Substance Abuse and Mental Health Services Administration has issued advice for VSM treatment. The document recommends that VSM treatment is likely to be lengthier and more expensive than treatment required in response to other forms of drug use. The authors acknowledge that their advice to clinicians is ‘based on limited experience and research, primarily with disadvantaged Native American and Hispanic populations in Southwestern and Midwestern United States’ (Substance Abuse and Mental Health Services Administration, 2003, p. 5).

The most detailed Australian VSM guidelines available concern care for people who are engaged with drug treatment or child protection services in Victoria (Department of Human Services, 2003). While the guidelines argue that a similar approach to other drug treatment should be taken, they also observe that the young age of many involved must be considered in formulating a treatment strategy. The guidelines stipulate that responses to VSM should be aimed at promoting abstinence and that services must not allow clients to use inhalants on their premises. The Office for Aboriginal and Torres Strait Islander Health in conjunction with the National Health and Medical Research Council is, at the time of writing, currently developing national clinical guidelines for the management and treatment of VSM.

A protocol outlining the respective roles of police and welfare agencies has been produced in Victoria to support the implementation of legislation providing police with powers to intervene in VSM (State Government of Victoria, 2004). In Queensland, again in conjunction with new legislation, guidelines have been produced to assist organisations in responding to VSM (Inner Urban Youth Interagency VSM Working Group, 2005). These guidelines provide advice as to how agencies might engage young people who use volatile substances: suggestions include providing easy treatment access, addressing multiple problems and networking with other agencies. Flow charts for responding to emergency situations involving VSM are provided.

In view of the complex and serious problems believed to co-occur with regular VSM, most treatment advice is that a particularly thorough client assessment is recommended (Department of Human Services, 2003; Jumper-Thurman, Plested, & Beauvais, 1995; Substance Abuse and Mental Health Services Administration, 2003). This should include assessment of family function, co-occurring poly-drug use, co-occurring mental health disorders and a thorough medical examination including screening for cognitive impairment which may impede treatment. Clinicians have recommended screening of clients receiving VSM treatment for depressive or anxiety disorders, given their high prevalence in inhalant-using populations (Evren, Barut, Saatcioglu, & Cakmak, 2006). The effect of the person’s family and social situation on their drug use should also be assessed. For chronic users an assessment of neurological impairment is advised, with follow up testing to check for improvement during treatment (Brouette & Anton, 2001; Jumper-Thurman et al., 1995).

Several assessment protocols are outlined in the literature (Central Australian Rural Practitioners, 2003; Department of Human Services, 2003; Richardson, 1989; Shaw et al., 2006). A measure for assessing adolescent inhalant use dependence severity is also described (Ogel, Askoy, Topuz, Liman, & Coskun, 2005).

The requirement for detoxification from VSM is contested; some consider it unnecessary due to the short acting nature of VSM-induced intoxication (Department of Human Services, 2003). Others argue that adverse effects of VSM on brain function endure for weeks beyond the period of acute intoxication and that treatment should not commence until cognitive impairment has diminished (Jumper-Thurman et al., 1995).

No pharmacotherapies are available to treat inhalant dependence, although anti-depressive and anti-psychotic medications are often used to treat co-occurring mental health concerns (Dinwiddie, 1994).

Individuals who misuse volatile substances appear also to have higher rates of mental illness than would be found in the general community. Dual diagnosis services are required to provide concurrent treatment (Butt, 2004). Homelessness also frequently accompanies long-term VSM; however, many housing services will not accept people who are currently substance affected into their programs. The possibility of past sexual abuse should also be considered. Many people engaged in VSM treatment are poly-drug users and treatment attention should not focus solely on one substance (Dell, Dell, & Hopkins, 2005). Some researchers argue that as intensive VSM is a marker of 'global vulnerability' (Wu et al., 2004) or part of a 'risk behaviour syndrome' (Kurtzman et al., 2001), interventions should address the constellation of risks or associated problems, rather than focusing specifically on VSM. Due to the range of problems experienced by many users, a coordinated service response is critical (Lubman, Hides, & Yucel, 2006).

Some studies argue that developing therapeutic relationships with young people who use volatile substances is particularly important as a precursor to any useful intervention (Butt, 2004; Inner Urban Youth Interagency VSM Working Group, 2005). These kinds of relationships often take time to establish. Part of establishing supportive relationships is to approach users with respect and patience and to be clear about what the service is able to offer and the expectations made of service participants (for instance, not to use drugs in the premises). Inhalant users frequently lead rather chaotic lives and find it difficult to attend set appointment times. An outreach approach to treatment and intervention is therefore frequently appropriate (Department of Human Services, 2003).

The efficacy of group interventions is unclear. Young people who use inhalants have reported being taunted by other drug users attending treatment services (MacLean, 2004). Thus caution should be taken when introducing a young person with a history of VSM to group therapy with other drug users (Substance Abuse and Mental Health Services Administration, 2003). It is important that workers avoid further stigmatising them and ensure, as far as possible, that they are treated with respect within drug treatment services. Avoiding labelling young people as, for instance, 'chromers' is one way to do this (Butt, 2004).

It is important that treatment includes supporting people to participate in diversionary recreation activities. Some users of inhalants have poor living skills and many programs include components to assist young people with hygiene, nutrition and interpersonal skills, as well as encouraging them to attend school or training where this is feasible (Substance Abuse and Mental Health Services Administration, 2003).

Brady (2004) encourages the use of brief interventions by health care professionals in responding to disclosure of alcohol and other drug misuse by Indigenous people. Similarly, Lynskey (2003) observes that brief interventions by doctors have been effective in targeting other forms of drug abuse by adolescents, and ought therefore to be implemented where young people are discovered to be misusing volatile substances. A training package for VSM brief intervention has been developed in Queensland (see National Inhalant Abuse Taskforce, 2006, p. 42).

As indicated earlier, some volatile substance misusers require hospital treatment. One article advises on treatment of patients admitted to acute psychiatric units for inhalant-associated psychotic disorder (Hernandez-Avila, Otega-Soto, Jasso, Hasfura-Buenaga, & Kranzler, 1998).

In the past, when petrol included lead, treatment sought to remove organic lead stored in the bodies of sniffers. The main hospital treatment used was chelation therapy, which involved the use of a chemical compound (a chelating agent) which binds heavy metals. However, as leaded fuel has been phased out in Australia, chelation therapy has little role in the current care of petrol sniffers.

Much of the health care provided to petrol sniffers in remote areas occurs in community clinics. The Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual (Central Australian Rural Practitioners, 2003) includes advice for health staff on acute and ongoing care of petrol sniffers. It lists the three main acute health issues for sniffers as fits, strange or violent behaviour and, in the longer term, weakness and infections. The manual advises airway protection in the case of acutely affected sniffers and rapid evacuation to a facility where ventilation is available, and provides advice on options for sedation if required.

Recommendations for clinical management and treatment of VSM among Indigenous youth include investigating the young person's sense of cultural identity and belonging, ensuring access to culturally appropriate services, role models and opportunities to learn about and participate in cultural activities (Butt, 2004). A 'resiliency and holistic' approach to VSM treatment for Indigenous youth has been adopted by Canadian treatment centres (Dell et al., 2005). This entails the use of Indigenous and Western techniques to strengthen clients' spirit or 'inner resiliency'.

In the NT, legislation now authorises courts to sentence people to mandatory treatment (see section 10.1). Researchers have found little empirical evidence to indicate the effect of sentencing people to mandatory alcohol and other drug treatment on subsequent drug use or offending (Pritchard, Mugavin, & Swan, 2007). It is therefore important that outcomes for clients in the NT be closely monitored.

One aspect of rehabilitation which appears to have been neglected in the literature is the need for intensive physiotherapy for chronic volatile substance misusers, to enable them to restore wasted muscles, regain coordination, and overcome symptoms of neuropathy. Peggy Brown, of the successful Mount Theo Petrol Sniffer Program, advised a meeting of families working with sniffers to 'work them hard: walking up the river bed a lot, wearing rucksacks on their backs with stones in' (Winbarrku Outstation, 1994).

8.2 Counselling, family interventions and after-care

Counselling is the form of drug treatment most commonly provided in response to VSM by Australian drug and alcohol treatment services (National Inhalant Abuse Taskforce, 2006), although there is little research literature on which to build an evidence-base for VSM counselling interventions. US treatment protocols, cognisant of possible effects of long-term VSM on the user's brain, advise that counselling sessions be short and 'a slow rate of recovery' anticipated (Beauvais, 1997; Beauvais, Jumper-Thurman et al., 2002; Substance Abuse and Mental Health Services Administration, 2003). However, many young people using inhalants have not consumed these substances for long enough to acquire serious brain injury; indeed one study which tested both volatile substance users and other drug users for neuropsychological impairment on admission to residential treatment found no cognitive difference between these groups (Sakai et al., 2006).

Early psychological and psychiatric approaches to VSM treatment are outlined in Morton (1987). A 'biopsychosocial' approach to VSM therapy is advocated by McCartney (1999). This entails attention to transference and counter-transference in the therapeutic relationship, behavioural and cognitive approaches to increasing self-awareness and self-control, and negotiating the inside–outside boundary.

Victorian VSM management guidelines recommend a range of counselling and support approaches. The guidelines advise that clients should be clearly advised of the harms to which they are exposing themselves. Motivational interviewing (to enhance the client's enthusiasm to change their behaviour), self-monitoring strategies (assisting them to achieve greater insight) and relapse prevention (recognising and managing their response to triggers for use) should form part of any long-term individual counselling strategy. Recommended therapeutic techniques include goal setting, developing contracts with clients in relation to consequences of inhalant use, and skill development in managing emotions, decision making and communication. Family-based interventions are also advised, as are assertive outreach and follow-up, and provision of diversionary activities and other means to ameliorate social isolation. Clients should be referred to other drug or mental health services as needed and co-occurring poly drug use should also be addressed (Department of Human Services, 2003, pp. 21–27 & 35–37).

Some research considers how counselling might be provided for Indigenous clients in remote settings. San Roque et al. note that one of the primary needs of petrol sniffers is for 'psychological or personal attention, i.e. the chance to be listened to and "tell their story"' (1999, p. 20). Researchers found that among a sample of ex-petrol sniffers in a remote community in northern Australia, the most commonly identified reason for giving up petrol sniffing was advice or encouragement from family members (Burns, Currie et al., 1995). The authors conclude that interventions addressing petrol sniffing might support the role of Aboriginal families.

Franks (1989), a member of the Healthy Aboriginal Life Team (HALT), has provided a useful account of the application of counselling techniques in two Central Australian communities. Central to the HALT approach was the combination of individual and family counselling

with community development techniques. The twin goals were to promote the community's capacity to control petrol sniffing at the community level, and to help kin networks to regain their capacity to care for and control their members. The particular role of counselling in this context was to 're-include the sniffers within the extended family group from which they had become alienated' (Franks, 1989, p. 17). Another important aspect of the HALT approach was the presence in the team of a respected Aboriginal member, who worked in close cooperation with the counsellor.

Franks describes two types of individual counselling, as well as family counselling. *Simple support counselling* was used where the family was strong and could mobilise support; the counsellor's role was one of helping persons to reach decisions and giving encouragement. Where family functioning had become distorted, *in-depth counselling* was appropriate. Counselling involved 'validating feelings; clarifying the problems; setting and prioritising goals; and actively moving towards the achievement of these goals by agreeing to undertake specific tasks' (Franks, 1989, p. 19). Individual counselling was used in conjunction with *family counselling*, in which the Aboriginal member of the team played a major role, identifying family and community supports which could be mobilised.

Other evidence supports the importance of including families in counselling interventions with Indigenous volatile substance users. Mosey (2000) adapted HALT's technique of 'family mapping', and drew also on work by Orford and his colleagues on 'family coping' (Orford et al., 1998). Mosey's intervention aimed to reduce the shame families felt about petrol sniffing. She concluded that when families functioned better overall, the drug-using member would also become more able to alter his or her own behaviour. In an evaluation of a petrol sniffing program in Kaltjiti, family counselling was viewed as a successful means of making families more responsive to the needs of petrol sniffers (Shaw, 2002).

Outside the Indigenous context, family therapy has been recommended (McCartney, 1999). In 1982 a psychiatrist argued that families of children misusing volatile substances shared certain pathological dynamics. Therapeutic interventions with 41 families resulted in 26 young people ceasing VSM (assessed at six months post-treatment) (Framrose, 1982). Another study reported by Morton (1987) found that individual treatment combined with provision of diversionary activities and family intervention was more effective than individual treatment alone.

Working with users of volatile substances poses particular challenges, sometimes leading to despondency on the part of workers. A youth worker contributing to the Victorian Inquiry into Inhalation of Volatile Substances argued that few options were available to him in encouraging and assisting clients to modify their inhalant use:

A twelve, thirteen, fourteen year old person possibly doesn't even have the cognitive development to undergo insight-based therapy. That's how a lot of our services are funded. We really don't have anything else to offer these people. (Quoted in Youth Affairs Council of Victoria Inc., 2001, p. 12)

Volatile substance users are likely to require intensive after-care and monitoring for relapse (Butt, 2004; Jumper-Thurman et al., 1995). In one Canadian residential treatment centre an after-care plan is devised before clients are admitted and community members are required to pledge support to the young person concerned (Dell et al., 2005). Efforts should be made to assist young people to cope with peers who continue to use volatile substances.

After-care is often provided through an outreach model, focusing on monitoring and reinforcing skills learned in treatment. Shaw et al. suggest that after-care services for people in remote communities should include:

- personal support for individuals;
- working with families to reintegrate the client into community life; and
- making changes to communities so that there are alternative activities available, and fewer people sniffing. (Shaw et al., 2006, p. 45)

8.3 Residential treatment and rehabilitation

The 1985 Senate inquiry into VSM in Australia opposed the establishment of residential rehabilitation programs, claiming that most Indigenous people did not want sniffers removed from their communities to urban residential facilities. Other commentators have argued that residential services are required in light of the frequently chaotic family situations of inhalant users, and peer reinforcement of drug use (Jumper-Thurman et al., 1995). Successive coronial inquests into deaths associated with petrol sniffing in South Australia, Western Australia and the Northern Territory have also exposed and condemned the dearth of residential facilities. Partly in response, governments in Victoria, SA and the NT have recently moved to establish residential treatment facilities for Indigenous clients, although only the NT facilities will focus exclusively on inhalant users (National Inhalant Abuse Taskforce, 2006).

8.3.1 Residential programs in North America

By far the most developed residential models of VSM treatment are to be found in Canada, where nine centres target First Nation young people who use inhalants⁵. All the programs are run by Native Americans and young people receiving treatment are aged between 12 and 26, with 112 treatment beds available across the country. A detailed discussion of assessment procedures, detoxification programs, counselling, rehabilitation, case management and treatment settings in North American treatment centres is provided in a report issued by the Centre for Remote Health (Shaw et al., 2006).

Treatment at Canadian Centres consists of a blend of Native American and Western treatment strategies aiming to increase young people's resilience. The philosophy guiding two centres is outlined in an article by Dell, Dell and Hopkins (Dell et al., 2005). The centres seek to improve both individual young people's capacities to cope with adversity and at the same time to bolster supports within local communities. Other centres appear to follow a similar approach, although

⁵ Transcripts of interviews with young people, a family member, an elder and treatment staff involved in a residential program in Calgary, Canada, are available in Charles & Coleman (1999).

the structure of programs varies. Some separate males and females, while others do not; some have set intake times, others admit young people whenever a vacancy arises. In the past, people generally stayed at treatment centres for six months but a new four month program has been introduced after staff felt that young people were becoming bored (Dell & Graves, 2005).

The Canadian treatment centres are linked by membership of the Youth Solvent Addiction Committee (YSAC), a body which provides training and support as well as collating information about best practice in solvent abuse treatment (Youth Solvent Addiction Committee, 2003).

In 2006 a delegation from Central Australia visited Canadian centres in order to consider their suitability to the Australian context (Kavanagh, 2006). The group concluded that factors leading to the success of Canadian VSM treatment centres included:

- Funding—centres are funded at approximately \$123,000 per bed per annum with additional grants available on meeting occupancy requirement. This allows a staff/client ratio of 3:1. A centre providing psychiatric and solvent abuse treatment has 14 beds and 45 staff.
- Indigenous ownership and management—most centres have educated and committed Indigenous directors and boards of management. The role of Indigenous culture in healing is highly valued within the centres.
- Program structure—programs are well-structured providing a holistic approach to VSM including attention and love as well as boundary setting for youth. All programs are accredited and incorporate both Western techniques and Indigenous approaches. Young people acquire life skills while in treatment. YSAC supports collaboration between the centres.
- Staff—centres are staffed by a diverse range of professionals who receive regular and ongoing training.
- Emphasis on importance of formal education—most are funded to employ a full-time teacher and 70% of participants return to school after treatment (Kavanagh, 2006).

Kavanagh then identifies a number of barriers in the way of implementing similar service models in Australia, noting, firstly, that at present few well educated Australian Aboriginal staff would be available to take up positions of responsibility within funded centres; secondly, that it would be difficult to find locations for centres where youth could not easily leave the program, yet where a skilled workforce was available. Remote area Australian Indigenous youth, she adds, may be reluctant to attend centres located a long way from their communities, while low literacy levels may make it difficult for some Australian young people to participate in activities. Finally, after-care arrangements would have to be made available in young people's home communities (Kavanagh, 2006).

Some studies of North American residential VSM treatment outcomes are not encouraging. Coleman et al. (2001) report that 56 of 78 young Indigenous Canadians relapsed after discharge

from residential treatment for inhalant use (the article does not detail how long after discharge this assessment was made). Dinwiddie (1994) reviews disappointing studies of residential treatment for inhalant users. Shaw et al. cite a study (Health Canada, 2005) indicating that poor client outcomes were due in part to a lack of follow-up and after-care for clients (Health Canada 2005, cited in Shaw et al., 2006, p. 48).

A few other studies report higher success rates. The Nimkee NupiGawan Healing Centre collects client follow-up data indicating that six months after treatment 82% of clients in 2000 and 95% of clients completing the program in 2001 reported abstinence from VSM (Dell et al., 2005). Treatment completion would appear, however, to be low, ranging from 11% to 62% of clients across the Canadian centres (Health Canada 2005, cited in Shaw et al., 2006, p. 48). Dell et al. (2005) make the interesting point that some young people require more than one stay within a residential program before they are able to desist from VSM. Treatment re-entry, they suggest, should be viewed as part of a process, rather than as 'recidivism'. They argue also that increasing family involvement in treatment (through recognition of family members in funding formulas) has improved Canadian treatment centres' client completion rates (Dell et al., 2005).

Another recent study (Sakai et al., 2006) followed 34 male sniffers admitted to residential treatment centres in the US two years after treatment. On introduction to the program, 14 met DSM criteria for inhalant abuse or dependence; at follow up only one did so. The study found, however, that people admitted for VSM treatment were more likely than those admitted for other drug use to have developed subsequent conduct disorders. Other researchers have found that individuals who used inhalants directly before treatment, are hospitalised during treatment or are generally unmotivated in treatment, have the poorest treatment outcomes (Coleman et al., 2001).

8.3.2 Australian residential programs

In Darwin, the Council for Aboriginal Alcohol Program Services (CAAPS) conducted a residential program between 1985 and 1990, under which male petrol sniffers were admitted alongside clients admitted for alcohol misuse. An independent evaluation found no evidence of program effectiveness with respect to petrol sniffers (d'Abbs, 1990, pp. 47–9). CAAPS subsequently stopped admitting petrol sniffers because of inadequate funding (Northern Territory of Australia Coroner's Court, 1998).

More recently, CAAPS has again received funding to provide residential treatment services for volatile substance users, this time through an eight week program that includes literacy and numeracy, recreation activities such as rock climbing and sport, health and hygiene education and cultural information (Central Australian Aboriginal Alcohol Program Services, 2007).

In Alice Springs the Drug and Alcohol Services Association (DASA) has provided a detoxification program for inhalant users for two years. Of 20 young people attending the program (one stayed for a month), nine were regarded as having 'very positive outcomes' (Drug and Alcohol Services Association, 2006). DASA has now been given additional government funding to run an

eight-week residential program for users of volatile substances. This program provides treatment involving negotiated case-management, and structured after-care for people aged 17 years and over. Clients receive a medical examination within 48 hours of admittance and a series of counselling sessions based around a program developed by DASA. Group activities and outings include nutrition information, relaxation and exercise. DASA plans to assist young people to access numeracy and literacy education (Drug and Alcohol Services Association, 2006). A family member is allowed to accompany each client. Some clients also attend Bush Mob camps or outings (see section 7.3.2). Clients can be mandated by courts to attend the program but may also attend on a voluntary basis (Central Australian Youth Link-Up Service, 2006a).

One remote treatment centre that has achieved impressive results is the Mt Theo Petrol Sniffing Program in Central Australia, described below under ‘Homeland centres (outstations)’.

8.4 Care for people with acquired brain injury (ABI)

Few options are available for long-term care of young people who have become severely disabled as a result of petrol sniffing or other forms of VSM, and their care generally falls to family members (Shaw et al., 2006). It is likely to be inappropriate to accommodate these people within short-stay residential treatment programs.

Shaw et al. (2006) propose that as the nature of VSM-associated disability varies considerably according to the severity of brain injury and the range of chemicals involved, care needs of individuals will vary widely. Care for people who continue to use volatile substances is particularly difficult. Community-based models for care of disabled young people include accommodation within aged care facilities (often considered a poor option), training local rehabilitation staff, and disability respite facilities (Shaw et al., 2006). A representative of the NPY Women’s Council told the Senate Select Committee that her organisation had no option but to house one young person, disabled as a result of petrol sniffing, in a motel room in Alice Springs, paying \$400 per day for a carer to look after him (Vicki Gillick cited in Senate Community Affairs Reference Committee, 2006). Shaw et al. argue that additional local services are urgently needed in communities with chronic petrol sniffers.

In urban areas it is more likely that people may be referred to services dealing specifically with ABI for assessment. Nonetheless, this group have poorer treatment outcomes than others with a history of VSM and many are likely to require long-term supported accommodation or residential care.

8.5 Homeland centres (outstations)

Homeland centres, or outstations as they are also known, have been seen as offering a means to combating petrol sniffing in Indigenous communities in two ways: first, as a primary preventative measure, in that families who move to homeland centres are less likely to be plagued by substance misuse; and second, as a remedial centre to which petrol sniffers can be sent for a time in the hope that they will mend their ways.

The 1985 Senate inquiry into VSM pinned great hopes on the homelands movement, describing it as ‘the only apparent solution to petrol sniffing in the long term’ (Commonwealth of Australia Senate Select Committee on Volatile Substance Fumes, 1985, p. 200). It did point out, though, that the homelands movement entailed problems of its own, notably with regard to provision of primary health care and educational facilities. Today, while some Indigenous families continue to prefer living in homeland centres to larger settlements, the suggestion that these centres constitute a potential solution to VSM in Indigenous communities is no longer being seriously promoted, except in those centres that house designated treatment or rehabilitation facilities, such as Mt Theo (see 8.5.4 below).

Use of homeland centres for petrol sniffer rehabilitation received strong support from the Petrol Link-up team (Shaw et al., 1994), which argued that outstations gave young people a chance to ‘get away from petrol and to become involved in more constructive activities’, and at the same time allowed communities a break from petrol sniffers. Removal of sniffers to outstations was also seen by the Petrol Link-up team as performing a symbolic role as a ‘statement by the community that petrol sniffing is not acceptable’. Sending young people to outstations reasserted the power of adults over young people. As one Pitjantjatjara man put it: ‘They are not big men—I am a big man and I tell them what to do’ (cited in Shaw et al., 1994, p. 15).

Outstations are important to Indigenous communities for cultural reasons. Travelling or moving to significant locations is often seen by Aboriginal people as a solution to substance misuse problems as ‘the land itself is understood to nurture and heal those who live upon it and partake of its resources’ (Brady 1995, p. 1494). Outstations have also often been the preferred strategy of communities (Divakaran-Brown & Minutjukur, 1993; Mosey, 1997).

Intjartnama outstation is one example of a cultural model for intervention into substance misuse. Elva Cook, together with her late husband, started caring for alcohol-affected people at Intjartnama outside the community of Hermannsburg around 1988 and took in petrol sniffers some time later. The program operated as an ‘Aboriginal family group’, utilising a bi-cultural approach combining Aboriginal cultural values and the family kinship system, with European therapeutic communities:

Recovery is achieved though helping the person to think about five aspects of healing: care for family, care for self, care for land, place and travelling, care for *Tjukurpa* (dreaming) and care of spirit ... (Cook, Cook, & San Roque, 1994, p. 42)

Another outstation was described by Bryce et al. (1991) as operating on a ‘work model’. The model involved rounding sniffers up and gaining parental permission for their care at an outstation or other location with a bore, where they were nurtured and put to work so ‘their lungs and noses will forget petrol’ (1991, p. 60). These programs were usually run by a husband and wife team, who sometimes received funding for wages, fuel, vehicle costs and food. Girls and boys were usually segregated. The programs were popular because they gave communities respite from sniffers, safe in the knowledge that sniffers were in the care of kin. Bryce et al.

interviewed people running these programs, who reported great satisfaction in teaching young people hunting skills. Bryce et al. did not comment on the success rate of these programs, although they did report that only a few months after one husband and wife team at Pipalyatjara failed to secure funding to keep 15 boys at their outstation, all the boys involved were in jail at Port Augusta.

Other positive accounts of the effects of spending time at an outstation may be found in the literature. Evaluation of a ‘dry out camp’ at Yalata and Oak Valley where sniffers spent 3–12 months showed that after attending the camps many young people became involved in positive community activities, helping the night patrol and attending school instead of sniffing (Sputore et al., 1997). Another project at Yalata involved ex-sniffers working with current petrol sniffers—a process that reportedly enhanced the ex-sniffers’ self-esteem. A program in Far North Queensland where young people were taught skills for working with horses is described in the Senate Community Affairs Reference Committee’s report on petrol sniffing (2006, p. 88).

Despite their popularity and apparent successes, providing services in remote locations for young people with acute needs can be problematic. The literature suggests that three issues must be addressed in the provision of homeland VSM programs: firstly, funding, infrastructure and associated resources must be provided; secondly, a sustainable model is required to balance the sometimes conflicting needs of funding bodies and communities; and, thirdly, community support and involvement are needed, both in the outstation program itself and in developing follow-up and after-care programs for those returning from outstations.

8.5.1 Infrastructure and resources

Shaw et al. (1994) suggest that where outstation programs fail, they do so often because of lack of secure funding or through disputes over access to resources such as vehicles. A meeting of outstation managers at Winbarrku, organised by Petrol Link-up in 1994 (Petrol Link-up Project, 1994), concluded that outstations taking petrol sniffers needed support in relation to liaising with court and welfare bodies over referral and placement of young people, seeking funds, establishing income for young people in their care, and for facilitating information exchange. The meeting recommended that a permanent service be established to support outstations, a function now undertaken in Central Australia by Central Australian Youth Link-Up Service (CAYLUS).

The experience of Ilpurla illustrates some of the difficulties outstations have experienced in caring for young people exhibiting risky behaviours with minimal resources. Ilpurla is a cattle station where as part of a petrol sniffing program young people are taught skills such as breaking in horses and maintaining vehicles and stock equipment (Central Australian Youth Link-Up Service, 2006a).

In 1998, Northern Territory Coroner Warren Donald held an inquest in Alice Springs into the death four years earlier of a 14 year old boy at Ilpurla. The boy, a chronic petrol sniffer, had died from loss of blood after punching a window while intoxicated from sniffing. Earlier on the same

day, while still intoxicated, he had been placed at the outstation by a relative. Donald concluded that the boy had been accepted into the care of the outstation without any medical assessment of his condition, and placed under the supervision of people who lacked the necessary skills or training to identify or respond to his needs. Further, when the medical emergency occasioned by the boy lacerating his arm took place, the outstation did not have adequate communication facilities for obtaining prompt medical advice. (The outstation had no telephone, despite having been trying to obtain one for six years.)

The coroner found that the absence of trained medical personnel to conduct assessments prior to sending young people to outstations, along with inadequate communication technology at the outstation, contributed to his death (Donald 1998, p. 28). He concluded that, although outstations such as Ipurla provided temporary respite, both for sniffers themselves and for their communities, they were not adequately resourced to meet the often complex psychological and medical needs of chronic sniffers.

Despite the difficulties inherent in providing services at remote locations it is apparent that homeland centres used in responding to VSM must be not be located close to main roads or communities. They must be isolated to prevent people escaping and petrol or other drugs coming in (Mosey, 1997).

In Cape York, James has argued that there are significant problems associated with sending petrol sniffers to outstations, which, he contends, do not have facilities to give young people educational and life skills training they require (James, 2004, p. 9). Furthermore, he argues, as people cannot be self-sufficient on outstations, the model perpetuates passive welfare dependency. James proposes that young people who are asked to leave their communities as a result of petrol sniffing and associated behaviours be sent to appropriately paid and supervised host families in places where educational, training and work opportunities are available.

8.5.2 Sustainability

Homeland centre or outstation program models cannot simply be transported from one community to another. Programs must be developed in accordance with the resources, energy and commitment levels of local communities (Senate Community Affairs Reference Committee, 2006). The support of elders is a critical element in all programs. Programs at outstations or homeland centres depend for ongoing viability on Indigenous people with appropriate relationships to the area being prepared to spend long periods of time away from their communities caring for young people.

Family members must also support the process. Walalkara, a homeland fifty kilometres from the community of Kaltkiti, was established in 1999 as a rehabilitation/respite centre for sniffers. The model used here was that families would accompany young people and spend two weeks with them at the outstation (Shaw, 2002). Family members were, however, reluctant to use the outstation, largely because they did not want to leave the community for an extended period. Similarly, an outstation for girls at Marla Bore failed due to lack of support from parents,

who ‘felt sorry’ for their daughters and brought them home (and sometimes other girls also) (Stojanovski, 1994).

Homeland centre or outstation programs tend to operate episodically, when needed. They may close for periods of time and this makes funding them difficult for bureaucracies. Some outstations or homeland centres previously providing care for petrol sniffers have closed in recent years. Reasons for these closures are not always clear and in many instances government-funded evaluations of programs are not made publicly available.

8.5.3 Availability of support and after-care in communities

It is critical that after-care and a program of activities be available for people returning from outstations. The community at Mornington Island organised to send young people to camps on school holidays as a strategy to prevent petrol sniffing. The success of this program in reducing VSM among participants was undone when young people returned to the community where petrol was readily available (Senate Community Affairs Reference Committee, 2006, p. 20).

8.5.4 Mount Theo Outstation: a success story

The program at Mt Theo is widely recognised as a unique success story in preventing petrol sniffing at its associated community of Yuendumu. Mt Theo has been taking petrol sniffers since 1994, under the care of Peggy Brown and her late husband. Yuendumu had 70 petrol sniffers at the time of program commencement but is now generally free of VSM. The program at Mount Theo has been documented by staff with long-term involvement (Preuss & Napanangka Brown, 2006; Stojanovski, 1999; Stojanovski, 1994).

Mount Theo is a sacred healing place with strong *Jukurrpa* (dreaming) (Campbell & Stojanovski, 2001). It is a considerable distance from the community and any main road, making it almost impossible for young people to leave without adult assistance. Sniffers and other young people at risk are taken there and looked after by tribal elders until they have recovered from the effects of sniffing. Activities at Yuendumu include gardening, Community Development Employment Program (CDEP), traditional activities and courses. After a month young people are allowed to return to their community of origin, but if they recommence sniffing they are immediately taken back to Mt Theo. While the program caters for all Walpiri young people, it has been particularly successful with children whose families were traditional owners for the area, because of their links to this country and their care during that time by family members (Stojanovski, 1994). As petrol sniffing has become far less prevalent the program has adapted. Mt Theo is now used as an alternative sentencing option for young people who would otherwise be charged with crimes and for people found misusing substances other than petrol. In 2007, 43% of clients were Walpiri young people not from Yuendumu and 74% were referred by courts or police as alternatives to incarceration or being charged (Mt Theo-Yuendumu Substance Misuse Aboriginal Corporation, 2007).

Although Mount Theo has received funding for some years, the program has always been very much owned and supported by Aboriginal people from the Yuendumu community (Saggers &

Stearne, 2007). Senior Aboriginal people run the programs and the relations they forge with young people are critical to the program's success. In the words of a program founder, Peggy Nampajimpa Brown:

I bin love the young people and make healthy. I bin care about. I bin ask all the church leaders to pray for young people and teenagers. I give them bushtucker, bush sultana, bush yam, goanna, kangaroo and wild turkey to make young people strong and healthy again (quoted in Campbell & Stojanovski, 2001, p. 9)

The success of Mt Theo should not be attributed to the outstation alone, but also to a range of complementary measures that have been implemented. These include working concurrently with all four Walpiri communities and Alice Springs agencies, the Jaru Pirrjirdi program (described earlier in this review), a seven day a week program of diversionary activities for young people in Yuendumu itself, and an 'education and outreach program' disseminating information about Mt Theo (Preuss & Napanangka Brown, 2006).

Staff have also stressed the importance of cooperative relationships between Aboriginal and non-Aboriginal people in running the program. Stojanovski provides this advice about sustainability for those wishing to establish a similar program:

While people like getting paid wages, wages do not carry the same weight and meaning as personal relationships. Wages will not keep my co-workers working through the difficult times. Emotional support and relationships of mutual obligation do ... This is what I really believe sustains our program. It is the love and the relationships that we hold for each other as co-workers and for our clients—the petrol sniffers. This is a difficult thing for governments to grasp. A structure like our program is easy to model and reproduce but the motivation care and love that holds it together is difficult to duplicate. My advice to people trying to set up similar projects is to sit down in a community for a long time, to build relationships, to never stop trying (Stojanovski, 1999, p. 26).

8.6 Summary

Clinical management of VSM

- There is limited literature to guide clinical management of VSM, and much of what is available warns of poor outcomes compared with other substance misuse.
- Thorough client assessment is recommended, to include assessment of family function, co-occurring poly-drug use, co-occurring mental health disorders and a thorough medical examination including screening for cognitive impairment which may impede treatment. The effect of the person's family and social situation on their drug use should also be assessed. For chronic users an assessment of neurological impairment is advised, with follow-up testing to check for improvement during treatment.

- Some researchers argue that as intensive VSM is a marker of ‘global vulnerability’ or part of a ‘risk behaviour syndrome’, interventions should address the constellation of risks or associated problems, rather than focusing specifically on VSM. Many people engaged in VSM treatment are poly-drug users and treatment attention should not focus solely on one substance.
- The requirement for detoxification from VSM is contested. No pharmacotherapies are available to treat inhalant dependence, although anti-depressive and anti-psychotic medications are often used to treat co-occurring mental health concerns.
- Some studies argue that developing therapeutic relationships with young people who use volatile substances is particularly important as a precursor to any useful intervention. These kinds of relationships often take time to establish.
- Recommendations for clinical management and treatment of VSM focusing on Indigenous youth include investigating the young person’s sense of cultural identity and belonging, ensuring access to culturally appropriate services, role models, and opportunities to learn about and participate in cultural activities.
- The Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual includes advice for health staff on acute and ongoing care of petrol sniffers.

Counselling, family interventions and after-care

- Counselling is the most common form of intervention in response to VSM by Australian alcohol and other drug agencies, although there is little evidence to guide intervention approaches. Inclusion of users’ families in counselling interventions is recommended in both Indigenous and non-Indigenous contexts, as is the need for outreach and provision of diversionary activities.
- Published guidelines for working with inhalant users stress the need to use counselling techniques such as motivational interviewing, self-monitoring strategies, relapse prevention and goal setting, and skill development in areas such as managing emotions, decision-making and communication.
- Difficulties in working with VSM users, particularly in employing cognitive therapies with very young users, and assisting clients to change their behaviour, can lead to despondency among workers.
- Volatile substance users are likely to require intensive after-care and monitoring for relapse. After-care is often provided through an outreach model, focusing on monitoring and reinforcing skills learned in treatment.

Residential treatment and rehabilitation

- Several Australian states and territories have recently established residential facilities for VSM.

- The most developed residential treatment models for VSM are found in Canada, where treatment consists of a blend of Native American and Western treatment strategies aiming to increase young people's resilience. Most Canadian facilities are well funded, operate under Indigenous control, have structured programs, and emphasise formal education as a means of returning clients to active participation in society.
- Outcome studies of Canadian programs point to mixed results. No recent evaluations of Australian residential programs have been published.

Care for people with acquired brain injury (ABI)

- Few options are available for long-term care of young people who have become severely disabled as a result of petrol sniffing or other forms of VSM, and their care generally falls to family members.

Homeland centres (outstations)

- The strategy of sending sniffers to homeland centres, or outstations, has been used by some Aboriginal communities as a means of culturally appropriate banishment, inculcating behaviour change, and providing relief for communities themselves.
- To be successful, such programs require adequate resources, a sustainable model of intervention, and community involvement both in the outstation programs themselves, and in providing after-care programs in the communities.
- Homeland centres are not equipped to meet the complex medical and psychological needs of some VSM users.
- The use of homeland centres for VSM intervention has also been criticised on the grounds that they do not provide clients with skills necessary to engage with the wider society, such as education and training.