Chapter 6

A holistic approach to petrol sniffing

6.1 Both previous reports by the Community Affairs committee have emphasised the importance of a holistic approach to petrol sniffing that includes a comprehensive low aromatic fuel strategy, the sustained commitment to, and funding of, a range of community-based diversionary and development programs in Indigenous communities, effective policing strategies, and complementary health care strategies.

6.2 Concerns were raised by Mr Brian Gleeson about whether the current bill is a stand-alone measure or part of a 'multi-faceted approach to addressing petrol sniffing'. Mr Gleeson stated 'that effective efforts to address substance abuse must deal with both supply and demand issues with a heavy focus on investing in preventative measures'.[1]

6.3 The committee acknowledges that Senator Siewert has said that the bill needs to be part of a suite of measures, and that her second reading speech stated that low aromatic fuel is:

> a vital element of a broader strategy — a comprehensive response which addresses the underlying causes of petrol sniffing, including a combination of supply, demand and harm minimisation measures. Such a response must include community management plans; youth services; effective and culturally sensitive policing; treatment and rehab services and information services. Many of these components already exist and are quite successful — but the missing piece of the puzzle is the power to regulate fuel.[2]

6.4 The committee notes below some of the elements of a comprehensive approach that were presented in evidence at the hearings into the bill, as well as some of the concerns that were raised about these complementary strategies.

Complementary health care strategies

Early childhood development programs

6.5 The nature of early childhood development was raised as a crucial indicator of future susceptibility to addiction in teenage children. Dr Boffa noted that several major studies have linked addiction, mental health problems and chronic disease to adverse outcomes in early childhood, particularly up to the age of three.[3]

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1 Mr Brian Gleeson, Office of the Coordinator General for Remote Indigenous Services, *Submission 3*.

2 Senator Rachel Siewert, Low Aromatic Fuel Bill 2012, Second Reading Speech, *Senate Hansard*, 1 March 2012, p. 1363.

3 Dr John Boffa, Public Health Medical Officer, Central Australian Aboriginal Congress, *Committee Hansard*, 24 July 2012, p. 27.

6.6 Dr Boffa said that good support programs for parents with young children 'can make a big difference even in quite alienating, adverse social environments', but these programs are 'not being implemented'. Yet, according to Dr Boffa, the implementation of early childhood support programs now could help prevent a generation of young people susceptible to addiction in a decade.[4]

Primary healthcare addiction services

6.7 Concerns were raised by Ms Ah Chee and Dr Boffa about the fragmentation of primary healthcare service delivery with respect to substance abuse. Dr Boffa said that the current level of funding was not necessarily the issue, but suggested instead that the problem lay with securing agreement on a service model that incorporated a permanent addiction service within each primary healthcare service:

> We think the treatment of addictions needs to be a core part of primary healthcare service delivery across the board. Every health service has to have the capacity to treat young people and adults that are addicted to any substance. And it is the same treatment approach. Irrespective of the substance, it is those three streams of care that Donna [Ah Chee] mentioned earlier. Pharmacotherapies, psychotherapy—often cognitive behaviour therapy—and social support and advocacy are what you need to do, whether the addiction is paint, petrol, alcohol or marijuana, and I do not think we are very good at that. We fund separate programs for each drug, and then, even within those separate programs, the doctor is sitting over here in the clinic, there are other staff over there dealing with petrol and there are a few other people coming in to deal with some other drug. There are multiple providers, and it is a privatised mess.
>
> The money is there to do much, much better. If we funded according to need and we agreed on a service model, there is enough money now in the Northern Territory to make sure that every primary healthcare service has a permanent addiction service, and it is one of our bugbears that it has taken so long.[5]

Drug and Alcohol programs

6.8 Ongoing funding for effective complementary healthcare programs means that experienced people and programs are already on the ground ready to respond quickly when outbreaks of petrol sniffing occur, thereby minimising the scale of the sniffing outbreak.[6] *Makin' Tracks* run by the National Indigenous Drug and Alcohol Committee (NIDAC) was a mobile drug and alcohol program that covered a large area of South, Central and Western Australia with a particular focus on rural and remote

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4 Dr John Boffa, Public Health Medical Officer, Central Australian Aboriginal Congress, *Committee Hansard*, 24 July 2012, p. 27.

5 Dr John Boffa, Public Health Medical Officer, Central Australian Aboriginal Congress, *Committee Hansard*, 24 July 2012, p. 31.

6 Mr Scott Wilson, Co-deputy Chair, National Indigenous Drug and Alcohol Committee, *Committee Hansard*, 16 August 2012, p. 2.

communities. *Makin' Tracks* ran from 1999 until 30 June 2012 and employed two 'highly skilled Aboriginal drug and alcohol workers' that both had a masters in Indigenous health. However, NIDAC had to terminate both workers because they did not succeed in the latest funding round.[7]

Mental health funding

6.9 Dr Brett Cowling noted several challenges relating to primary health care in the Ngaanyatjarra lands including the geographical size of the area and its remoteness, the absence of tri-state agreements to deal with large patient flows from WA to the NT, and the paucity of funding for mental health support and suicide prevention.[8]

6.10 Dr Cowling confirmed the evidence received from other groups such as NPY Women's Council that the majority of mental health clients in the Ngaanyatjarra lands would have had contact with some form of volatile substance.[9]

Case management

6.11 Dedicated resources for youth case management and family engagement that target the core issues underlying petrol sniffing are an important complement to the low aromatic fuel strategy. Ms Williamson expressed the view that intensive work with an identified core group is an ideal addition to youth diversionary activities.[10] However, funding provision varies and case management is funded in the NT and SA, but not in WA.[11]

Youth programs

6.12 Youth diversionary programs based on sport and recreation and arts programs are available in the NT, SA and WA. Funding for the programs in the different states and territories comes from different bodies including DoHA, the AGD, and FaHCSIA.[12]

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7 Mr Scott Wilson, Co-deputy Chair, National Indigenous Drug and Alcohol Committee, *Committee Hansard*, 16 August 2012, p. 3.

8 Dr Brett Cowling, CEO, Ngaanyatjarra Health Service, *Committee Hansard*, 25 July 2012, p. 23.

9 Dr Brett Cowling, CEO, Ngaanyatjarra Health Service, *Committee Hansard*, 25 July 2012, p. 24.

10 Ms Christine Williamson, Manager, Youth program, NPY Women's Council, *Committee Hansard*, 25 July, pp. 2–3.

11 Ms Christine Williamson, Manager, Youth program, NPY Women's Council, *Committee Hansard*, 25 July, p. 2; Dr Brett Cowling, CEO, Ngaanyatjarra Health Service, *Committee Hansard*, 25 July 2012, p. 24.

12 Ms Christine Williamson, Manager, Youth program, NPY Women's Council, *Committee Hansard*, 25 July, p. 2.

6.13 Outbreaks of petrol sniffing were said to be more likely to occur in communities with low levels of youth support and services.[13] Short-term funding from the AGD currently allows CAYLUS to coordinate the provision of a youth worker as an emergency response to a petrol sniffing outbreak.[14]

6.14 Having a team of local Indigenous youth workers in each community is a good long term goal. This has occurred at Mount Theo over a long period of time, while at Titjikala Ms Lisa Sharman has recently become a youth team leader after five years as a youth worker. There are distinct advantages to having a team, particularly one that includes some members from outside the community, because a team can operate more effectively across a number of families and across various cultural protocols.[15]

6.15 The Youth in Communities funding provided by FaHCSIA does not cover a number of regions in the Central Desert and Barkly Shires. Mr McFarland noted that there seems to be a disconnect between the 'commitment to youth service provision and the petrol sniffing strategies zone', and that perhaps the zoning concept needed revisiting if it imposed limits on which Shires could gain access to youth services.[16]

Partnerships between stakeholders

6.16 Mr Scott Wilson noted the importance of cooperation between the Commonwealth and states because of the differences in responsibilities. He pointed out, however, that the states have responsibility for the delivery of many programs and services, and emphasised the importance of developing good stakeholder partnerships on the ground and that NIDAC would 'encourage working partnerships between community based patrols, law enforcement, and drug and alcohol treatment services' across all jurisdictions.[17]

Senator Claire Moore

Chair

13 Mr Blair McFarland, CAYLUS, *Committee Hansard*, 24 July 2012, p. 45; Mr Scott Wilson, Co-deputy Chair, National Indigenous Drug and Alcohol Committee, *Committee Hansard*, 16 August 2012, p. 4.

14 Mr Blair McFarland, CAYLUS, *Committee Hansard*, 24 July 2012, p. 45.

15 Mr Blair McFarland, CAYLUS, *Committee Hansard*, 24 July 2012, p. 46.

16 Mr Blair McFarland, CAYLUS, *Committee Hansard*, 24 July 2012, p. 47.

17 Mr Scott Wilson, Co-deputy Chair, National Indigenous Drug and Alcohol Committee, *Committee Hansard*, 16 August 2012, p. 5.