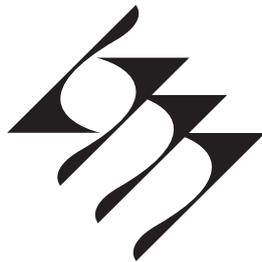


THE PLACES OF SAFETY MODEL: AN EVALUATION

RESPONDING TO VOLATILE SUBSTANCE MISUSE

SEPTEMBER 2005

CRIME AND
MISCONDUCT
COMMISSION



QUEENSLAND

CMC vision:

To be a powerful agent for protecting Queenslanders from major crime and promoting a trustworthy public sector.

CMC mission:

To combat crime and improve public sector integrity.

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Foreword

Volatile substance misuse (VSM) is an issue of significant public interest because of widespread concerns about the health and welfare of those engaging in it. VSM has also, at times, raised community concerns about risks to public safety. Police officers are often called upon as the first official response to situations involving VSM. However, they cannot always respond effectively because of certain limitations to their powers. In recognition of these limitations, in November 2003 trial legislation was introduced in five sites across Queensland, enabling police to detain young people affected by VSM for the purpose of transporting them to a place where they can safely recover.

In each of the locations in which the new police powers were trialled, a designated 'place of safety' was provided for young people who did not require emergency medical treatment or hospitalisation but could not be returned to the care of a family member or friend because no suitable family member or friend was available. Each of these designated places of safety was funded by the Queensland Department of Communities.

This report documents the CMC's evaluation of the effectiveness of the places of safety model. This evaluation was complementary to a review of the police powers supporting the place of safety trial, which the CMC was required by legislation to undertake.

The very specific focus on the places of safety component of the government's response to VSM documented in this report derives from a request to the CMC made by the Department of Communities. The Commission considered the request for a detailed evaluation of the places of safety in light of its statutory responsibilities and the requirement to review the supporting police powers. Given these responsibilities — and the CMC's crime prevention function — the Commission determined that undertaking such an evaluation was appropriate as well as of significant public benefit.

This report outlines a potential new response to VSM that builds on the strengths of the trial initiative but also addresses those aspects that proved less successful in meeting the government's broader policy objectives.

I am confident that the way forward described in this report warrants consideration by government, in the interest of enhancing its capacity to address VSM statewide in a manner that is practical, sustainable and fiscally responsible.

Robert Needham
Chairperson
Crime and Misconduct Commission

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Abbreviations

ATODS	Alcohol, Tobacco and Other Drug Services
CMC	Crime and Misconduct Commission
PPRA	<i>Police Powers and Responsibilities Act 2000</i>
QAS	Queensland Ambulance Service
QPS	Queensland Police Service
QuIVAA	Queensland Intravenous AIDS Association
VSM	volatile substance misuse (often known as 'chroming')
YETI	Youth Employment and Training Initiative

Acknowledgments

The Commission is very grateful to the many individuals and agencies from both government and non-government sectors who contributed to this evaluation. In particular, thanks are due to the place of safety coordinators; Department of Communities; Queensland Police Service; Department of the Premier and Cabinet; Queensland Ambulance Service; Queensland Health; Brisbane Youth Service; representatives from Aurukun Council; Western Cape College, Aurukun Campus; Aurukun police; and Elders and representatives from Torres Strait Island government and non-government organisations.

This report was prepared for the Commission by Julianne Webster (project manager), Dr Mark Lynch, Angela Carr and Jennifer Epps.

The evaluation of the operations of the designated places of safety, however, required the dedication and commitment of a significant number of additional researchers. The research team responsible for the evaluation included Daniel Abednego, Kim Adams, Chris Cockerill, Eva Dacre, Kate Foote, Andrea Kanaris, Derran Moss, Matt Vance, Jodie Walton, Jackie Wellen and Katrina Yettica-Bell, all of whom made critical contributions to the evaluation.

Special thanks are also due to Lisa Ballard for her assistance during the final stages in the production of this report, and to the Commission's Communications Unit staff who prepared the report for publication.

Susan Johnson
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Summary

Volatile substance misuse (VSM) is defined as ‘the deliberate inhalation of a gas or fumes released from a substance at room temperature, for the purpose of intoxication’. The acute effects of VSM result from the suppression of inhibitory responses within the central nervous system.

Involvement in VSM appears to be most common among young people between 13 and 15 years old. The majority of young people who engage in VSM do so socially or experimentally, with only a small proportion subjecting themselves to regular exposure over several years.

In 2003 the Department of Communities called for submissions from community-based, non-government organisations to apply for funding if they were interested in establishing a designated ‘place of safety’ for young people affected by VSM. The aim of these places of safety was to provide a safe, monitored environment for children and young people who were intoxicated through VSM. In addition, and critically, places of safety were intended to provide a means of connecting people engaging in VSM with a broad range of welfare services equipped to address the underlying problems behind VSM.

Six service providers were ultimately selected to operate designated places of safety on behalf of the Department of Communities.

During the nine-month period of the evaluation, a total of 1848 contacts were made at the places of safety. However, a substantial number of individuals returned to the place of safety repeatedly, with only 316 separate individuals responsible for generating the much larger number of contacts. The characteristics of the place of safety clients were as follows:

- There were almost as many females as males.
- The majority (64%) identified as Aboriginal.
- The most prevalent age was 15 years.
- Police referrals constituted only 7 per cent of all referrals throughout the evaluation period.
- The majority of stays were overnight (1142).

In the final three months of the evaluation period the estimated average costs were:

- \$487.21 per contact
- \$2354.45 per client.

The major challenge to the trial response to VSM proved to be the requirement for non-government organisations to fulfil two roles simultaneously. The places of safety were required to offer a sort of ‘sobering up’ facility, as well as providing a means of connecting people engaging in VSM with welfare services that might help them desist from the practice.

Connecting the client group with welfare services depends in large part on providing them with a congenial environment that inclines them to enter into a more stable relationship with the organisation, which then allows for the offering

and acceptance of access to the necessary welfare services. The obvious difficulty here is that if a facility is made attractive to those engaging in VSM (because, for example, it offers food, clean clothes and overnight accommodation), it risks offering little real disincentive to VSM. More troublingly, it may actually offer an incentive to VSM as a way of obtaining access to the desired facilities.

The recognition of this difficulty at the heart of the current response to VSM leads the Commission to believe that there needs to be a clear separation between a medically oriented **intoxication-recovery service** and the more general welfare-oriented **client assistance services** that are typical of non-government organisations working on behalf of the government.

The necessity to separate these services does not, however, preclude assigning responsibility for providing both to a single non-government organisation.

The Commission also believes that certain limitations to the police powers underpinning the government's new response to VSM hindered the police, and that these powers will require some modification if the general intent of the government's welfare-oriented policy response is to be preserved. These suggested modifications relate to some relatively minor administrative aspects of the trial police powers, together with three matters that are of considerable significance:

- requiring police to alert the Department of Child Safety when they apprehend a person on a VSM-related matter
- providing police with the authority to require people to provide their name and address
- providing police with the authority to hold a person affected by volatile substances until such time as either the level of intoxication subsides or an appropriate place of safety is available.

In terms of a broader multi-agency response to VSM (supported by changes to police powers), the Commission has identified nine principles that it believes should guide any enhanced response by government to VSM.

- 1 Responding to the immediate consequences of inhalant intoxication is a first-order priority. Responding to more general welfare needs that underpin VSM is a longer-term, second-order priority that needs to be clearly separated from any intoxication-recovery service.
- 2 It is critical to recognise that any attempt to somehow isolate VSM from the use of other drugs is normally only possible in an abstract rather than practical sense.
- 3 New efforts to address VSM should take into account the strengths and limitations of any existing or previous case management initiatives.
- 4 Successful responses to VSM depend on the recognition that, despite some significant uniformities in the nature of the factors underpinning VSM, the local circumstances in which it occurs have a strong determining influence on the type of response that is likely to prove effective. Failure to recognise this could prove highly detrimental to any response strategy deployed.
- 5 The characteristics of the entity responsible for delivering a service response to VSM are just as important as the VSM response strategy itself. Great care needs to be taken with finding the most appropriate service deliverer. The need for careful assessment of an organisation's service delivery capacity is particularly great when that body is a non-government, community-based organisation.

- 6 Where the government makes a non-government organisation responsible for giving effect to some aspect of its policy response to VSM, there is an attendant obligation to ensure that the designated non-government organisation already has the requisite resources (both human and material), or to support the organisation in the acquisition of those resources.
- 7 When entering into contracted arrangements with a non-government service provider, the government must clearly, precisely and exhaustively specify the services it is purchasing (funding); it must also — equally clearly and precisely — monitor compliance with the terms of the negotiated agreement.
- 8 When entering into contractual arrangements with government, non-government organisations must accept the necessity for clearly, precisely and exhaustively documenting the manner in which they give effect to the terms of negotiated agreements. This must be undertaken in such a way that it is possible for an independent external entity to audit the services provided.
- 9 No single agency can be made responsible for responding to VSM. It is just one of many possible manifestations of broader welfare needs, and individual agencies can only ever provide specific contributions towards a larger strategy. The wider strategy must draw on a range of organisations, both within and outside government, with the collective aim of rectifying the community deficits that cause the emergence of VSM as a significant social problem.

These nine principles are central to the way forward for responding to VSM described in the final section of this report, 'An enhanced response to VSM' (p. 16). In evaluating the places of safety strategy trialled, the CMC considered six variations on an innovative service delivery model. It would always have been unrealistic to expect all six models to operate equally effectively, given the complexity of the problem and the absence of any generally applicable proven responses to VSM. It is therefore not surprising that certain elements of the trial response were ultimately not assessed as sustainable. However, the important point that needs to be recognised is that, in trialling and evaluating a number of different approaches, the Department of Communities has made it possible to develop a service delivery model that shows real promise in terms of offering the effectiveness and flexibility to adapt to the local context anywhere in Queensland.

The way forward described in this report takes as its starting point an approach developed in one of the trial sites. This is based on a 'faxback' system between police who respond to VSM and a community-based agency that is able to focus on the broader long-term needs of young people engaging in the practice. In building on this initiative, the CMC has sought to outline a model that is genuinely multi-agency in character and does not impose the burden of responding to VSM on any particular agency. Any such approach would be destined to failure from the outset.

The Queensland Government is to be commended for sponsoring an innovative approach to the problem of VSM, and subjecting itself to an independent external evaluation of this new approach, despite the very real possibility that the trial would not prove as successful in all aspects as hoped.

The Commission accepts that there are no easy answers to the problem of VSM. In outlining an option for a new service delivery model, the Commission has sought to find a way forward that builds on the strengths of the approach trialled by government.

In the event that the government is not ultimately convinced of the appropriateness of the service delivery model suggested in this report, the Commission believes it essential that any amendments made to the current model are consistent with the intent of the nine guiding principles described earlier.

Introduction

What is volatile substance misuse (VSM)?

Volatile substance misuse (VSM) is ‘the deliberate inhalation of a gas or fumes released from a substance at room temperature, for the purpose of intoxication’.¹ In Australia, approximately 250 products have been identified as containing potentially intoxicating inhalable substances. These are commonly divided into four main classes:²

- **solvents:** e.g. glues, paint thinners and removers, dry-cleaning fluids, petrol, contact adhesives, correction fluids, felt pens
- **aerosols:** e.g. spray paints, insect spray, hair spray, deodorant spray, air fresheners, cooking oil spray, fabric protector spray; Ventolin
- **gases:** e.g. household gases (butane, bottled domestic gas, cylinder propane gas), medical anaesthetics (ether, chloroform, halothane, nitrous oxide), refrigerant gases
- **nitrites:** e.g. amyl nitrate, butyl nitrate.

Many of these are commonly used household products, so they are both legal and easy to obtain. The relative toxicity of the volatile substances depends on the specific nature of the chemical compounds they contain, and the substances vary in their pharmacological effects. However, all volatile substances have in common the short-term effect of depressing the central nervous system.³

The acute effects of VSM result from the suppression of inhibitory responses within the central nervous system.⁴ Users feel euphoric, exhilarated, relaxed, and high or intoxicated, in much the same way as they would if they had consumed alcohol. As with alcohol, these initial effects tend to be followed by sensations of dizziness, nausea, numbness, fatigue, confusion, perceptual distortions, impaired coordination and headaches.⁵ In some instances, prolonged use of volatile substances has been reported to result in hallucinations of significant duration and intensity. The Drugs and Crime Prevention Committee estimates that the short-term effects of VSM last about 5–45 minutes after inhalation.⁶

Involvement in VSM appears most common among young people aged between 13 and 15 years.⁷ The majority of young people who engage in VSM do so socially

1 Drugs & Crime Prevention Committee 2002a, p. 7.

2 Drugs & Crime Prevention Committee 2002b, pp. 16–17.

3 Chick & Cantwell 1994; Drugs & Crime Prevention Committee 2002a.

4 Chick & Cantwell 1994; Cleland & Kingsbury 1977; Drugs & Crime Prevention Committee 2002a, p. 54).

5 Benignus 1981; Bingham, Cohnsen & Powell 2001; Ellenhorn et al. 1997; Reynolds & Prasad 1982; Stollery & Flindt 1988; Zenz 1988; Zenz, Dickerson & Horvath 1994.

6 Drugs & Crime Prevention Committee 2002b; MacLean 2003.

7 Beauvais 1992; Beauvais & Oetting 1987, cited in Toumbourou, Dimsey & Rowland 2004; Indian & Inuit Health Committee, Canadian Paediatric Society 1998; Johnston, O’Malley & Bachman 2002; Liang 1997; Liu 2003; National Centre of Social Research/National Foundation of Educational Research 2004; Stanton et al. 2000; White 2001; World Health Organisation 1999).

or experimentally, with only a small proportion subjecting themselves to regular exposure over several years.⁸ Volatile substances are seldom an individual's drug of choice; typically they are seen as a cheap and easily accessible alternative when other drugs are not available.⁹ As regular users age and gain access to increased social and economic resources, VSM tends to decline, while use of other substances such as alcohol and marijuana increases.¹⁰ Indeed, chronic VSM during youth is associated with polydrug use and, in turn, with substance abuse problems in later life.¹¹ It is also associated with school failure and drop-out, family dysfunction and abuse, crime and delinquency, mental health problems and cultural disintegration.¹² Rather than being the cause or result of any one of these issues, however, VSM is widely viewed as just one of a number of psychosocial problems associated with vulnerable or socioeconomically disadvantaged populations.¹³ Given that Indigenous peoples are often disproportionately represented as members of these populations, it is not surprising that they are also disproportionately represented as users of volatile substances.¹⁴

A range of interventions have been initiated to address VSM, both in Australia and internationally. However, few of these initiatives have been critically evaluated, and little is known about their effectiveness.¹⁵ In cases where evaluation data are available, the results tend to be mixed. For instance, although legislative restrictions on the sale of volatile substances have been shown to lead to reductions in the use of specific compounds, they have also been associated with increased use of other, sometimes more dangerous substances.¹⁶ Similarly, media campaigns targeting the parents and caregivers of young people have been found to be associated with a reduction in the number of VSM-related fatalities recorded in the United Kingdom,¹⁷ but campaigns targeting children have been criticised for promoting the practice.¹⁸

Researchers generally agree that, in order to effectively address VSM and associated issues, a range of intervention strategies need to be employed. Specifically, d'Abbs and MacLean suggest that VSM is a product of:

- the pharmacological properties of the volatile substance involved
- the needs and attributes of the users
- the social environment in which use occurs (including both peer and family interactions).¹⁹

8 Carroll, Houghton & Odgers 1998; Flanagan & Ives 1994; Langa 1993; Rose 2001; Western Australia Drug Strategy Office 1998, cited in Drugs & Crime Prevention Committee 2002b.

9 Drugs & Crime Prevention Committee 2002b; MacLean 2003.

10 Department of Human Services 1996; Makkai 1994.

11 Drugs & Crime Prevention Committee 2002b; Loxley, Toumbourou & Stockwell 2004.

12 Bellhouse, Johnston & Fuller 2001; Brady 1992; Burns, d'Abbs & Currie 1995; Coleman, Charles & Collins 2001; Creson 1992; d'Abbs & MacLean 2000; Dinwiddie 1994, cited in Drugs & Crime Prevention Committee 2002b; Drugs & Crime Prevention Committee 2002b; Fendrich et al. 1997; Howard et al. 1999, cited in Drugs & Crime Prevention Committee 2002b; Kikuchi & Wada 2003; Korman 1977, cited in Garriott 1992; Ljubotina, Galic & Jukic 2004; McGarvey, Canterbury & Waite 1996; Oetting & Webb 1992; Ramirez et al. 2004; Rose 2001; Zur & Yule 1990, cited in Garriott 1992.

13 Loxley, Toumbourou & Stockwell 2004.

14 Casswell 1992, Gfellner 1994, both cited in World Health Organisation 1999; Health Canada 1999.

15 d'Abbs & Brady 2003; d'Abbs & MacLean 2000.

16 Taylor et al. 1997.

17 Bland et al. 1997; Field-Smith et al. 2002.

18 Mundy 1995, Rodd & Leber 1997, Rose et al. 1992, all cited in Drugs & Crime Prevention Committee 2002b.

19 d'Abbs & MacLean 2000.

Strategies that systematically respond to issues associated with each of these three sets of factors are seen as offering the greatest promise in terms of reducing the prevalence and impact of VSM.

The Queensland Government's new response to VSM

In November 2003, section 371A of the Queensland *Police Powers and Responsibilities Act 2000* (PPRA) was amended to provide police officers with the power to search for, seize and dispose of 'potentially harmful things'. This amendment was specifically intended to respond to the misuse of volatile substances for the purpose of intoxication. It aimed to reduce harm associated with, and public anxiety regarding, the inhalation and ingestion of these substances.²⁰

In addition to the amendment to section 371A of the PPRA, the Queensland Government proposed the introduction of legislation providing police officers with the powers to detain a person 'affected by the inhalation or ingestion' of a potentially harmful substance and transport them to a place where they 'can receive the treatment or care necessary' to safely recover from the effects of the substance.²¹ This new legislation is currently being trialled in five locations across the state under subsections 371B–D of the PPRA. The legislation specifically states that the powers provided under these subsections should not be used to detain affected individuals for the purpose of transporting them to a police establishment or police station. Examples of 'places of safety' identified in relation to the new police powers include a hospital, a vehicle under the control of someone other than a police officer, the affected person's home, or the home of a relative or friend.²²

In each of the locations in which the new police powers are being trialled, a designated place of safety is provided for young people (aged 10–17 years) who do not require immediate medical treatment or hospitalisation, and who cannot be returned to the care of a family member or friend due to the unavailability or inappropriateness of such a placement. Each of these places of safety is funded by the Queensland Department of Communities. However, the operation of each place of safety varies according to the location and specific needs of the client group it serves.

The places of safety initiative began in 2003 when the Department of Communities called for submissions from community-based, non-government organisations to apply for funding if they were interested in establishing a place of safety for young people affected by VSM.

The Department of Communities information paper on which these submissions were based describes a place of safety as a safe, comfortable environment where:

- police can refer or take people detained under the new legislation
- people affected by volatile substances can be supported in the short term
- options for follow-up, case management and other relevant services may be provided.

20 Department of Communities 2004, p. 7.

21 QPS 2004c.

22 *ibid.*

The information paper defines the target client groups as people who:

- have come to the attention of police or the ambulance service
- are engaging in problematic use of volatile substances in public spaces
- are young and/or homeless and/or Indigenous and come from disadvantaged backgrounds.

Six service providers were ultimately selected to operate designated places of safety on behalf of the Department of Communities. Each provider operated according to hours of service that fitted best with the local context and the operational capacity of the service provider (see Table 1).

Table 1: Opening hours of places of safety

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Mission Australia (inner Brisbane)	Closed	Closed	8 pm – 6 am	Closed	Midnight – 8 am	10 pm – 8 am	10 pm – 6 am
Salvation Army (inner Brisbane)	Closed	9 pm – 8 am	Closed	9 pm – 8 am	9 pm – 8 am	Closed	Closed
Logan	8 am – 4 pm	8 am – 4 pm	24-hour service				
Townsville	24-hour service						
Mount Isa	24-hour service						
Cairns	Closed	Closed	3.30 pm – 9 am	3.30 pm – 9 am	3.30 pm – 9 am	6 pm – 9.30 am	6 pm – 9.30 am

Source: Places of safety

The places of safety in operation

Table 2 (next page) provides a summary of the combined place of safety quantitative data received by the CMC evaluators from place of safety, police, hospital and ambulance staff, and from place of safety clients, for the period 1 July 2004 – 31 March 2005 across the five trial sites.²³

As can be seen in the table, a total of 1848 contacts were made at the places of safety during the nine-month period of the review. However, a substantial number of individuals returned to the place of safety repeatedly, with only 316 separate individuals generating the 1848 contacts.

The data collected as part of the evaluation of the places of safety trial are consistent with the findings of previous research concerning young people who are involved in VSM. Specifically, the results reveal that Indigenous young people were very markedly over-represented as place of safety clients, with the majority of clients (64%) accessing the places of safety identifying as Aboriginal. Females (126) were shown to use the places of safety almost as often as males (188) during the trial. Clients were also of similar age groupings to those identified in the literature, with most 15 years of age.

Other data collected by the evaluators reveal a high level of residential instability and a low level of educational participation among users of volatile substances who accessed the places of safety. In turn, place of safety clients identified boredom, peer influence, family problems and the ready accessibility of volatile substances as significant factors contributing to their involvement in VSM. As was also expected, most clients of the places of safety arrived intoxicated (75%) and the main cause of intoxication was VSM (64%). Semi-structured interviews with clients revealed a common engagement in other drug use, with alcohol and cannabis being the most common substances of choice.

The data also indicate that, in terms of the age of individuals who used the place of safety, the service was effective in accessing its target client group. However, across a range of other measures, client use of the place of safety facilities was found to be inconsistent with the intention of the service. Specifically, repeat visits to a place of safety were common (316 clients were responsible for 1848 contacts) and some clients appeared to access the services as a source of medium- to long-term accommodation (1142 overnight stays), or in a manner suggestive of a drop-in centre. The finding that the primary referral source for clients accessing the house was the combination of self-referred and referral from outreach services (87%), as opposed to being referred by police or ambulance, supports these inferences. Police referrals (120) constitute only 7 per cent of all referrals to places of safety throughout the trial.

²³ For a complete list of figures and tables relating to the places of safety data analysis, see Appendix.

**Table 2: Summary place of safety quantitative data
(1 July 2004 – 31 March 2005)**

Total VSM-related contacts with services (place of safety, police, ambulance, hospitals) ^a	2210
Total place of safety contacts	1848
Total clients ^b	316
Gender ^c	
Male	188
Female	126
Median age ^d	16
Modal age	15
Ethnic group ^e	
Aboriginal	188
Torres Strait Islander	8
Both Aboriginal and Torres Strait Islander	15
'No'	92
Other ethnicity	20
Mode contacts with place of safety per client (also median) ^f	1
Total overnight stays ^g	1142
Median length of contact at place of safety (excl. overnight stays) ^h	45 minutes
Modal length of contact at place of safety (excl. overnight stays) ⁱ	60 minutes
Total contacts involving intoxicated client ^j	1387
Client referral sources ^k	
Self-referral ^l	807
Outreach ^m	806
Police ⁿ	120
Other ^o	103
Average contacts per client ^p	6
Modal client referrals ^q	1
Total funding ^r	\$1911 812
Funding 1 January to 31 March 2005 ^s	\$477 953
Total contacts 1 January to 31 March 2005 ^t	981
Total clients 1 January to 31 March 2005 ^u	203
Estimated average cost per contact 1 January – 31 March 2005 ^v	\$487.21
Estimated average cost per client 1 January – 31 March 2005 ^w	\$2354.45

Source: CMC place of safety client information forms, Department of Communities

Table notes:

- a This is a cumulative figure; i.e. an individual contact with police, ambulance and a place of safety could be recorded as a count of 3. Total count includes place of safety (1848); police (255); ambulance (32) and hospital (52).
- b Includes 19 clients from Cape York referred by the Department of Communities. Cape-referred clients were referred to stay at a place of safety during the trial (due to shortages in shelter accommodation) but were not part of the trial. The place of safety received separate funding for these clients. After removal the total number of clients is reduced to 297, and the total number of contacts to 1791.
- c For two place of safety clients gender was not recorded and is therefore unknown (missing data).
- d Excludes one client aged 70 removed from sample (obviously not representative of intended target group). Including such a marked 'outlier' would obviously skew the analysis to a degree that is misleading and unhelpful. For a further 27 clients no age was recorded (missing data).

- e CMC place of safety client information forms contained a question asking if the client identified as Aboriginal, Torres Strait Islander or both. Thirteen clients did not respond (missing data). Twenty clients indicated ethnicity and 92 clients responded 'no' to the question.
- f Equals the most frequent number of contacts with place of safety for clients; also the middle value of the list of the number of contacts.
- g Overnight stays represent a visit to a place of safety longer than 6 hours (a long contact), or any instance where the client made an early-morning contact with the place and used the facilities as accommodation for the period of a stay. This figure is a slight underestimate as it includes a count of 6 nights for 6 clients who have had consecutive overnight stays for durations of one week (1), one month (1), two months (1) and three months (2), and one who is currently still residing at place of safety (1). Full counts have been excluded from the total as these 6 contacts represent special cases; given their length of stay, they are not 'typical' clients.
- h Equals the middle value in a list of lengths of client contacts with place of safety during the trial period. Overnight stays were removed from this calculation. If overnight stays (longer than 6 hours) remained part of the analysis they would skew the data, obscuring the average length of stay of the remaining clients.
- i Equals the most frequent length of contact for a client with a place of safety during the trial period.
- j Place of safety staff were required to make a judgment as to whether a client was intoxicated on arrival. In 379 cases staff responded 'No' and for the remaining 82 cases information was not recorded (missing data).
- k 12 records are missing referral sources.
- l A self-referral indicates that clients arrived at the place of safety of their own accord (e.g. walking in off the street).
- m Includes Youth and Drug Outreach Services, Community Café and Youth Health Services.
- n These figures, however, are lower than the police referral data recorded by places of safety themselves. Each place of safety was required to maintain its own record of all police referrals. The evaluators combined records from the police and the places of safety within a main dataset in order to track the movement from police intercepts to place of safety arrivals. However, in a small number of instances this link could not be established, with the two data sources containing records that could not be reconciled with each other. Over the period from 1 July 2004 to 31 March 2005, a total of 40 police referrals to the place of safety did not result in a custody index record being located. Half of these missing records were detected through the provision of a copy of the police Form 92 relating to the referral to the place of safety, and the other half were identified through place of safety client information forms indicating that the client had been 'police referred' (a Form 92 is an undertaking from the signatory, in this case a place of safety, that the person released will be taken care of). Based on this information, the CMC believes that at least 20 matters were not recorded in the custody index or these records were not provided to the evaluators.
- o Includes ambulance (2); Cape York, Department of Communities (37); faxback (6); home visit (4); hospital (8); government department (4); family/friend/concerned citizen (13); shelter/clinic/other accommodation service (9); crisis care (3); city councils (3); Multilink (1); QuIVAA (2); detox/diversionary centre (6); YETI/youth link/other youth service (5).
- p Equals the average number of times a person was referred to a place of safety.
- q Equals the most frequent number of contacts with a place of safety for clients.
- r Equals total annual funding allocated to the places of safety.
- s Equals total funding for 1 January – 31 March 2005 for all places of safety (r divided by 12, multiplied by 3). Although the trial period officially began on 1 July 2004, some facilities did not become operational until months after that date. Therefore the fairest means of producing site cost comparisons is to base funding calculations on the final 3 months of the trial.
- t Equals total contacts for all places of safety between 1 January and 31 March 2005.
- u Equals total clients for all places of safety between 1 January and 31 March 2005.
- v Estimated average cost per contact equals funding for place of safety services between 1 January and 31 March 2005 (s) divided by total contacts in the corresponding period (t). The estimated average client costs per contact and client are calculated on the basis of the final 3 months of the evaluation period, in order to arrive at the most accurate possible real costs. That is, by drawing on the latest possible time period, the higher costs associated with the start-up phases of the trial are as far as possible excluded from the per contact/client cost estimates.
- w Estimated average cost per client equals funding for place of safety services between 1 January and 31 March 2005 (s) divided by total clients in the corresponding period (u).

More promisingly, place of safety staff reported that more than a third of all 1848 contacts (636, or 34%) resulted in reconnection of clients with more stable accommodation options (such as family or government sources of accommodation). In addition, just over half of all contacts (949, or 51%) were reported to have resulted in other accommodation options for clients. However, the figures for reconnection or accommodation management sum to more than three times the total number of all clients who actually used the service; this suggests that, in most cases, these reconnection or accommodation management processes did relatively little to address the ongoing accommodation needs of those engaging in VSM. Even if every one of the 316 clients had been subject to this reconnection or accommodation management process, the data suggest that each client returned to the place of safety on at least two occasions after reconnection/accommodation management had occurred.

In addition to connecting or reconnecting clients with sources of alternative accommodation, place of safety staff reported engaging clients in a range of case management activities. However, many of these activities were limited to provision of a bed, food, a shower, and/or a train ticket. Furthermore, although clients of the place of safety agreed that the place of safety staff had assisted them with access to those basic services, few reported that they had received any other forms of support, or referrals to agencies able to provide them with support regarding more general VSM-related needs. Importantly, however, this reported lack of assistance may have resulted from clients' unwillingness to change their behaviour and/or the fact that many of the clients were already being case managed by another government or non-government agency. In the latter case, the fact that most of these clients self-identified as needing accommodation and other basic services, and/or were involved in VSM, calls into question the effectiveness of these other existing case management arrangements.

In terms of other forms of intervention offered by the place of safety staff, crisis counselling was reported 328 times. However, given that many of the clients receiving this service remained at the place of safety for less than an hour and were intoxicated at the time of arrival, the likelihood of positive behavioural change resulting from the counselling process is questionable. Indeed, in the case of individuals who engaged in intake, crisis counselling and exit processes all within the space of 15 minutes while intoxicated, it is hard to comprehend how any meaningful outcomes could have resulted (see Appendix, Figure A-7).

It is noteworthy that in the final three months of the trial the estimated average cost of each contact amounted to \$487.21, and for the same period the estimated average cost of each client was \$2354.45. These costs are clearly substantial, and call for close scrutiny. On the one hand, they are not unexpected, given the difficulties associated with engaging with a difficult client group. On the other hand, however, the costs may be questioned in light of what is actually being provided. Whether or not these costs can be justified ultimately depends on how the places of safety are assessed as contributing to the longer-term processes encouraging desistance from VSM. In this context, the case management data reported above are highly pertinent.

Perceptions of the places of safety

In addition to the statistical data collected during the trial period, qualitative data were collected during consultation with place of safety, police, ambulance and hospital staff in each of the trial areas, and with members of local non-government organisations and representatives from government and non-government agencies outside the trial area. These data revealed that, despite similar goals, policies

and procedures, in practice each of the place of safety services operated distinct models of service delivery. The variations observed between services tended to reflect local differences in the nature of youth VSM and associated issues. For instance, in Brisbane the service was largely defined by a high incidence of client homelessness. This issue was perceived to have a significant impact on the physical and psychological wellbeing of those involved, as well as contributing to the potential for conflict during use of the place of safety. In other areas, most clients were identified as having a 'home'. However, the stability of these environments was frequently questioned. In Mount Isa and Cairns, movement between surrounding communities and the regional centres was reported to be contributing to high levels of youth displacement. Specifically, this displacement was associated with a perceived lack of capacity in Gulf and Cape York communities to manage issues associated with juvenile offending and the subsequent removal of young people from these communities to Mount Isa and Cairns. In addition, in Mount Isa, the introduction of alcohol management plans in communities such as Mornington Island was said to result in families demonstrating high levels of transience and mobility as they moved between 'dry' and 'wet' areas. This transience characterising the target client group obviously has the potential to create real difficulties for strategies such as providing places of safety.

Problems associated with VSM

All of the place of safety staff and associated stakeholders found their efforts at intervention hampered by the instability and/or mobility of their clients' family environments. The young people frequently lacked adequate or appropriate supervision, which contributed to their lack of school involvement and detrimental peer influences. These factors were said to contribute to boredom and social alienation. The use of volatile substances was perceived as a means of passing the time and forming social alliances with others who were in a similar situation, and whom they perceived as substitutes for family.

In addition, local climatic conditions in Mount Isa were considered influential in preventing youth participation in social activities offered through mainstream agencies. Specifically, place of safety staff reported that, because of the high daytime temperatures, young people tended to be most active during the evenings. As in other areas, night-time youth activity was also perceived to be influenced by a desire to avoid violence and abuse at home.

In all areas in which the place of safety was trialled, family dysfunction, domestic violence, abuse and neglect were identified as contributing to youth homelessness and displacement. Similarly, except in Cairns, intergenerational drug use was reported to be common, and it was suggested that the behaviours demonstrated by place of safety clients were being modelled by their caregivers. However, outside Brisbane, such behaviour primarily involved alcohol and cannabis. In Brisbane it was said to involve a broad range of substances.

Most place of safety clients did not identify a volatile substance as their drug of choice, and polydrug use was common. However, only in Brisbane did place of safety staff report a prevalence of young people using drugs other than alcohol, cannabis and volatile substances. Similarly, with the exception of Brisbane, clients' use of products containing volatile substances was reported to be limited to paint (most commonly in aerosol form). Although petrol sniffing was said to have increased in the communities surrounding Mount Isa and Cairns since the introduction of alcohol management plans, the practice was not reported to have spread to the main centres. Furthermore, Mount Isa place of safety staff stated that, although the misuse of glue had been common before local retailers removed it from their shelves, place of safety clients now rarely misused this product. In

Brisbane, an increase in the misuse of products containing butane had been noted since retailers had begun limiting access to paint, although paint use was still common. Of particular concern were comments by Brisbane place of safety staff that butane use had been associated with at least two serious accidents at the place of safety, and that users of different types of volatile substances often expressed animosity towards each other.

Concerns about the operation of the places of safety

Police, ambulance staff and most of the place of safety staff expressed concern about how safe clients actually were at the place of safety. Mount Isa and Cairns staff expressed associated fears about their capacity to deal adequately with medical incidents that occurred as a result of the clients' intoxication. Place of safety coordinators from Cairns, Mount Isa and Logan all identified difficulties in gaining access to appropriately skilled and trained staff, and said these difficulties had an adverse effect on the capacity and effectiveness of the place of safety service.

Mount Isa place of safety staff identified a need not only for medical training but also for additional training to deal with behavioural incidents and to protect staff from litigation. Although violent or threatening behaviour and the possession or use of intoxicating substances were banned at all of the places of safety, at least one such incident had occurred at four of the trial sites during the evaluation period.

Although each place of safety coordinator indicated they had the option of discharging and temporarily banning clients who behaved antisocially, they could not limit the number of times each client could come and go from the premises after being admitted, since attendance was voluntary. These excursions made it easy for clients to 'top up' on drugs. Most of the services had introduced 'lock-out' policies in an attempt to prevent such behaviours; ethically, however, these policies were considered problematic, and breaches occurred.

Voluntary attendance was also considered problematic in terms of allowing intoxicated clients to decide whether or not they needed to be taken to a place of safety. Police and place of safety staff expressed concern about the safety of clients after they left the facility as well as during the time they stayed there. When clients left before 'sobering up' there was the potential for accidents to occur as a result of perceptual disturbances due to intoxication. Brisbane place of safety staff also commented that bringing together young people with antisocial or self-destructive tendencies at the place of safety gave scope for peer influences that would provoke the expression of these tendencies. Similarly, most sites identified an association between criminal and antisocial behaviour and VSM, with the majority of place of safety clients being known to the police before their first contact with the place of safety.

Notably, although most place of safety staff agreed that the place of safety provided an important and necessary service for young people involved in VSM, they also expressed concern that the service communicated mixed messages about VSM itself. Specifically, they indicated that most youth services did not allow young people who were intoxicated access to their facilities; this restriction was intended to discourage drug use. It was suggested that providing a service that is intended to accept young people only if they are intoxicated — especially one that enables clients to access resources that they are otherwise unlikely to have (food, a bed, television etc.) — may actually encourage clients to become intoxicated as a means of gaining entry to the place of safety. Indeed, at least one such case was reported.

Similarly, cases of young people using the place of safety for long-term accommodation were noted in all areas. In these cases, place of safety staff suggested that young people might become dependent on the place of safety service, and limiting admission on the basis of intoxication might serve to maintain VSM involvement, regardless of any case management and referral activities undertaken to the contrary. Most places of safety had therefore widened their admission criteria to allow access to non-intoxicated youth who were experiencing VSM-related problems. Nevertheless, this development still does not provide young people with an incentive to cease VSM and, given ongoing contact with other clients who continue VSM involvement, any change is unlikely to be sustained. Furthermore, most place of safety staff stated that they did not have time to case-manage individual clients, and even those who did said that it was impossible to 'do any real work' when the clients were intoxicated. Then, as clients started to sober up and experience the effects of 'coming down', they tended to lose any motivation to engage in any activities other than seeking the 'next high'.

In terms of effecting long-term behavioural change, most place of safety staff stated that they relied on referrals to other agencies. Indeed, they commented that, as the majority of place of safety clients were already involved with the Department of Communities or the Department of Child Safety, they placed significant emphasis on liaising with the government caseworkers. However, they found these efforts too often unproductive. Care of these young people tended to fall back on others working in the non-government sector (Indigenous agencies in particular); and, in relatively remote or disadvantaged areas, such as Mount Isa and Logan, this sector was not perceived by key stakeholders to have the necessary resources to manage these cases effectively. Furthermore, even in areas reported to demonstrate a strong non-government sector, the inability of non-government agencies to enforce participation in the case management process was perceived as undermining the effectiveness of referrals.

Future development of the place of safety service

All of the place of safety services proposed continuation of the place of safety model, but all identified deficiencies in its effectiveness. Specifically, the model was believed to take insufficient account of the diverse nature of the client group. Although the place of safety service was perceived to benefit those young people who had nowhere else to go, all of the services, with the exception of Cairns, acknowledged that this need was not shared by all their clients. In Brisbane in particular, police and place of safety staff alike indicated that some young people were identified as using the service as a 'crash pad' during weekends in the city. Similarly, in Mount Isa a group of young people were said to limit their VSM and place of safety use to weekends because they attended school during the week.

Comments made by place of safety staff suggest that it may be impossible to meet the dual demands of providing both crisis accommodation and a long-term intervention service. Furthermore, in response to low client numbers, at least at the outset of service development, all of the place of safety services established an outreach service or took steps towards establishing one. At the same time, with the exception of Townsville, all said they did not have the time to do the follow-up work that they perceived necessary to bring about behavioural change in their clients. This work was perceived as crucial by police and ambulance staff, with many of the former advocating the power to make clients' participation in associated programs and activities mandatory. The Townsville place of safety is of particular interest because it did not have a place of safety facility for most of the trial period; and when this facility was eventually acquired it was not perceived by stakeholders to add significant value to the follow-up and referral service that was developed in the interim.

Generally, youth VSM was perceived to be the symptom of much deeper societal problems. These vary by location, but places of safety, police and ambulance staff are in agreement that work is needed with families and/or the wider sociocultural environment in which the young person lives. Each agency, however, identified barriers to doing work of this nature.

All the stakeholders indicated that long-term behavioural change will only occur if the government adopts a comprehensive, multi-agency approach to service delivery. They emphasised that such an approach may involve non-government organisations, but should not rely on them.

Out-of-area data

In line with the comments made by place of safety stakeholders, the results of surveys and consultations undertaken in areas outside the five 'place of safety' and 'police powers' trial sites suggest that problematic VSM levels exist in areas where access to social, health, justice and welfare services is limited. In addition, areas that attract young people in search of these services also appear to attract the problems associated with VSM itself. In order to address the issue of VSM, community representatives identify the need to develop community capacity to manage the deep-seated problems that are perceived to contribute to the emergence of VSM. These include family disintegration, sexual abuse, neglect, overcrowding, health problems, parental drug and alcohol abuse, welfare dependence, parental gambling problems, low levels of parental involvement in the upbringing of their children, boredom, unemployment and truancy.

Representatives from remote Indigenous communities emphasise the necessity to encourage family and parental responsibility for their children. In Aurukun, community council representatives highlight a perceived need for parents to be able to better discipline their children; in the Torres Strait Islands, community leaders advocate training and development of 'uncles' to give discipline, guidance and support to young people who come in contact with law enforcement agencies. Aurukun council members also advocated removal from the community of young people who were involved in VSM, while others in this community suggested that interventions should focus on bringing an increased number of social and government service providers to the area to help address and prevent family dysfunction before VSM develops. Other remote Indigenous communities suggested the provision of counselling, education and activities for young people and their families, and the human resources to support these activities.

Training of professional and community staff (including Indigenous-specific workers) to deliver targeted services to young people and their families was also advocated by representatives from regional centres. They also supported increased access to information about the nature and extent of the problem in each local area, directives to local stakeholders specifying action to be undertaken, and sustainable funding for community initiatives (especially initiatives involving youth activities and events). In addition, representatives from remote communities and regional centres identified a need for greater commitment on the part of community and government stakeholders.

Evaluation findings

The Commission's evaluation of the operations of the places of safety considered the aspects of the trial model that worked well and those that did not operate as effectively as hoped. As documented here, the evaluation included analysis of the results of operational data collection processes, stakeholder consultations, and evidence regarding the effectiveness of other treatment programs targeting VSM.

The major challenge to the trial strategy

In the Commission's view, the major challenge to the trial strategy is the requirement for non-government organisations to fulfil two roles simultaneously. Although these roles are not incompatible, they cannot easily be reconciled under the current contractual arrangements between these organisations and government. The places of safety attempt to offer a sort of 'sobering up' facility, while also providing the means of connecting people engaging in VSM with welfare services that might help them desist from the practice.

Connecting the client group with welfare services depends in large part on providing them with a congenial environment that inclines them to enter into a more stable relationship with the organisation; this then allows the offering and acceptance of access to the necessary welfare services. The obvious difficulty here is that if a facility is made attractive to those engaging in VSM (because, for example, it offers food, clean clothes and overnight accommodation), it risks offering little real disincentive to VSM. More troublingly, it may actually offer an incentive to VSM as a way of obtaining access to the desired facilities.

The recognition of this difficulty at the heart of the current response to VSM leads the Commission to believe that there needs to be a clear separation between a medically oriented intoxication-recovery service and the more general welfare-oriented client assistance services that are typical of non-government organisations working on behalf of the government. Attempting to combine these two quite different endeavours into one service results in a situation where the designated places of safety are unable to perform either role well; instead, they are too easily reduced to providing an emergency accommodation service where the person has to be intoxicated in order to gain access to the service.

Importantly, however, separating an intoxication-recovery service from more general client assistance services does not preclude a single non-government organisation from accepting responsibility for providing both these services. The administrative systems, staff, facilities and funds associated with each do, however, need to be clearly distinguished.

This separation of functions is not the only major enhancement to the trial strategy that the evaluation data suggest. Although the trial strategy appears to have been successful in engaging the specified target group, it was not as successful in addressing the very specific issue of VSM in all trial sites. The client group is characterised by complex and wide-ranging needs for welfare services of various types (particularly emergency overnight accommodation). The strategy was able to meet some of these needs, and to that extent was useful and effective. However, there is no convincing indication that VSM itself was effectively discouraged.

It is possible that meeting associated welfare needs could, over time, result in meaningful reductions in VSM. Nevertheless, persevering with the current strategy in the hope that this will happen is, in the Commission's view, difficult to justify, given the expense involved and the lack of available supporting data. It seems preferable to focus on the aspects of the trial that worked well and apply them to a new, enhanced service delivery model that not only costs less and appears to work well but also lends itself to application statewide. The Commission suggests a service delivery model based on the one that was initially used in Townsville, building on the identified strengths of that model and circumventing some of the limitations of those trialled in other areas. The next chapter describes the proposed model in more detail.

An enhanced response to VSM

The proposed new response to VSM builds on the central messages of the preceding sections of this report. In proposing this model, the Commission has considered the aspects of the trial model that worked well and those that (for a variety of reasons, often beyond the control of the Department of Communities) did not work as well as hoped. Importantly, the Commission acknowledges the value of providing a place where young people can recover from the effects of VSM intoxication — which is at the heart of the government's new response to VSM. However, the Commission also recognises a range of operational difficulties associated with the existing model. These include:

- risks that young people may pose to themselves and others if they leave the place of safety or, if a place of safety is not available, they are released by the police before their level of intoxication has subsided
- difficulties inherent in attempting to encourage highly intoxicated young people to enter into longer-term intervention programs aimed at reducing their VSM
- risks associated with bringing together young people experiencing different levels of intoxication, drug use and social disadvantage in an environment conducive to the formation of socially reinforcing peer group alliances
- potential for the place of safety to be used as either a long-term accommodation option or a convenient 'crash pad' or 'drop-in centre'; and for such use to encourage ongoing VSM, through VSM intoxication being a requirement for access.

In response to these difficulties, the Commission advocates clearly separating the short-term intoxication-recovery function of the place of safety from the longer-term welfare intervention function, and providing police with the power to hold young people for up to four hours, until they are no longer intoxicated. In addition, the Commission does not believe that the merits of routinely allowing young people to self-refer to the places of safety are outweighed by the potential for this practice to distort the government's policy objectives.

On the basis of the available evidence, the Commission agrees with a view expressed by stakeholders consulted as part of the evaluation — that an effective long-term strategy for dealing with VSM cannot be set up until the reasons for youth involvement in VSM are recognised and addressed. In developing a model to facilitate this process, the Commission is drawn to the 'faxback' system used by one of the place of safety services before the place of safety facility opened.

In Townsville, setting up the faxback system was an interim response to difficulties in acquiring a suitable facility that would also meet the requirements for city council approval. There were significant delays, so the place of safety reference group developed an interim intervention model based on the faxback system that the police used to provide social support to victims of domestic violence. In the case of VSM, this system required that the police notify the place of safety staff of any VSM-affected young people whom they detained and transported (to family, friends or a medical facility). Once notified, place of safety staff were required to

‘follow up’ young people in these environments, provide them and their caregivers with information about the police powers and the risks associated with VSM involvement, and help the family to obtain any support they needed to handle the social and environmental problems contributing to the reason for the young person’s detection and detention. This assistance and the associated follow-up visits continued for as long as it took for families to gain access to the support they needed, and/or for the place of safety workers to decide that more extreme forms of intervention were needed, such as involvement of child protection agencies.

Of all the place of safety services considered by the evaluators, Townsville seemed to demonstrate the greatest capacity to meaningfully take into account the social environments in which VSM occurred or from which it had arisen. It also engaged in the most collaborative relationships with the QPS, Queensland Ambulance Service (QAS) and other government agencies, and received the greatest support from them. Furthermore, the Townsville place of safety staff were employed by an Indigenous medical centre, which meant that they were generally well accepted by clients’ families and community members, and they were able to influence the uptake of referrals to this facility and associated services (e.g. counselling, child protection, pregnancy support). The Commission therefore suggests incorporating the processes employed by the Townsville service into any enhancement to the Queensland Government’s long-term intervention strategy for VSM-affected young people. The remainder of this chapter outlines what should be taken into account in an extension to the Townsville service delivery model aimed at addressing VSM.

Multiple levels of intervention by multiple levels of service provision

The service delivery option proposed by the Commission encompasses three tiers of service delivery, which essentially correspond to the immediate, medium-term and long-term needs of young people engaging in VSM.

In carefully distinguishing between these levels of intervention, the Commission has considered the roles, responsibilities and expertise of government and non-government agencies that are required at each level. On the basis of these considerations, it is clear to the Commission that:

- 1 The public will continue to expect the police to respond to VSM incidents in the community, and there is a police responsibility to respond to their requests.
- 2 VSM is a form of drug use with the potential for significant adverse health consequences, and therefore requires the attention of health authorities operating collaboratively with welfare agencies.
- 3 VSM is a form of self-harm and is very frequently a marker of broader welfare needs, which may at times may be associated with child protection issues requiring the attention of the Department of Child Safety.
- 4 Many children and young people engaging in VSM are already involved in the youth justice system and may therefore also be clients of the Department of Communities, requiring ongoing support from this agency.
- 5 To effectively respond to the medium- to long-term needs of people engaging in VSM, accurate and timely information needs to be collected and shared across agencies.
- 6 Other government departments, such as Education, Employment and Housing, will in many instances need to be involved in providing services that aim to address the long-term needs of the client group.

- 7 Because of their links to members of the broader community, non-government agencies appear to be in the best position to engage the families and social associates of young people brought to the attention of government agencies, and direct them to government agencies that can help them with their long-term needs (e.g. education, health, housing). However, in order to achieve these goals, non-government agencies need to have earned the confidence of government agencies.

The response to VSM suggested by the Commission is structured with these seven points in mind. From consideration of the seven issues, the Commission has identified nine principles that it believes should guide the assessment of any option for a way forward by government.

Guiding principles for responding to VSM

To prove genuinely effective, any policy response to VSM should, in the Commission's view, take into account the following:

1 Distinguishing between immediate health needs and longer-term welfare needs

Responding to the immediate short-term needs of people intoxicated by volatile substances needs to be clearly distinguished from, and separated from, responding to their longer-term and more general welfare needs. Any immediate response should be clearly directed towards ensuring that the health of the intoxicated person is not unnecessarily compromised by any failure to provide an appropriate health-oriented response for the relatively short period of time that intoxication persists. This means:

Responding to the immediate consequences of inhalant intoxication is a first-order priority. Responding to more general welfare needs underpinning VSM is a longer-term second-order priority that needs to be clearly separated from any intoxication-recovery service.

2 VSM as a 'marker' of other issues, many of which are likely to be more serious than the actual VSM

VSM is not usually the only drug being used by those engaging in the practice, and is only rarely the 'drug of choice'. VSM is thus not only a marker of more general welfare needs underpinning the behaviour, but typically is also a marker of polydrug use. This means:

It is critical to recognise that any attempt to somehow isolate VSM from the use of other drugs is normally only possible in an abstract rather than practical sense.

3 VSM and existing case management plans

Those apprehended by authorities for engaging in VSM are likely to have pre-existing offender histories and to have already come to the attention of the police, the Department of Communities and (probably less commonly) the Department of Child Safety. This means that many of those engaging in VSM are likely to already have had some experience with case management efforts by some arm of government. Where such links exist, it is important that any new efforts to respond to VSM build on any promising aspects of current or previous case management initiatives, and address any identifiable deficits. This means:

New efforts to address VSM should take into account the strengths and limitations of any existing or previous case management initiatives.

4 Particular drugs and particular contexts

The characteristics of both the volatile substances being misused and those misusing them will vary markedly in different communities. Petrol sniffing by Indigenous young people in remote northern Queensland communities is very different from paint-based ‘chroming’ in the heart of Brisbane, for example. There is no single policy response that applies to these two situations, except in the most general and abstract sense. The real-world interventions required to reduce VSM need to be locally specific — to the point that their efficacy may be exclusively local and not transferable to other, different contexts. This means:

Despite some significant uniformities in the nature of the factors underpinning VSM, the local circumstances in which it occurs have a strong determining influence on the type of response that is likely to prove effective. Failure to recognise this fact may well prove highly detrimental to any response strategy deployed.

5 The importance of local community-based organisations

Although in principle there is no reason why any or all responses to VSM could not be provided by government entities, it is likely, given the localised nature of VSM and the localised nature of the responses required, that in many (though not all) instances it is the non-government organisations that are best equipped to respond to ‘local needs with local solutions’. This means:

The characteristics of the entity responsible for actually delivering a service response to VSM are just as important as the VSM response strategy itself. As much care needs to be taken with finding the most appropriate service deliverer as with the actual service to be delivered. The need for careful assessment of an organisation’s service delivery capacity is particularly great when that body is a non-government, community-based organisation.

6 Service delivery capacity of the non-government sector

The non-government sector cannot be expected to accept total responsibility for responding to VSM. The sector is characterised by organisations that believe themselves to be already stretched and under-resourced, which makes them ill-equipped to respond to the full range of welfare needs behind VSM. This means that local organisations delivering localised services on behalf of government (and as part of a wider policy framework developed by government) will often require a significant level of support — and not only funds (access to specialised training, for example). This means:

Where the government makes a non-government organisation responsible for giving effect to some aspect of its policy response to VSM, there is an attendant obligation to ensure that the designated non-government organisation either demonstrably has the requisite resources (both human and material) already, or is appropriately supported in the acquisition of those resources.

7 The ‘good purchaser’ in purchaser–provider arrangements

Government has a responsibility, when purchasing the services of non-government agencies to respond to VSM, to clearly specify the services it wishes to fund, and then monitor the funded agency’s level of compliance with the negotiated service agreement. This means:

When entering into contractual arrangements with a non-government service provider, the government must clearly, precisely and exhaustively specify the services it is purchasing (funding) and — equally clearly and precisely — monitor compliance with the terms of the negotiated agreement.

8 The 'good provider' in purchaser-provider arrangements

Negotiated service agreements between government and non-government agencies should clearly specify monitoring, reviewing and reporting requirements so that evaluation of the success or otherwise of the funded service is possible. This means:

When entering into contractual arrangements with government, non-government organisations must accept the necessity for clearly, precisely and exhaustively documenting the manner in which they give effect to the terms of negotiated agreements. This must be undertaken in such a way that it is possible for an independent external entity to make an empirically defensible assessment of the manner and consequences of the services provided by the non-government organisation.

9 The limits of any VSM response

It is critically important to recognise that neither police nor any other single agency (either government or non-government) can be expected to hold ultimate responsibility for responding to VSM. In situations such as may well exist in some more remote regional centres, where the VSM problem is serious and welfare service provision very limited, responding to VSM should not be seen as an acceptable or appropriate alternative to addressing whatever more general welfare services are required. If in certain communities the police are the only agency capable of responding to VSM, the problems besetting such a community are far greater than just VSM; and this fact should be acknowledged and addressed in a manner that goes beyond responding to VSM alone. This means:

No single agency can be made responsible for responding to VSM. Because VSM is just one of many possible manifestations of broader welfare needs, individual agencies can only ever provide specific contributions towards a larger strategy. The wider strategy must draw on a range of organisations, both within and outside government, with the collective aim of rectifying the community deficits that cause the emergence of VSM as a significant social problem.

The Commission's suggested option

On the basis of these nine principles, a new response to VSM is proposed; this is shown diagrammatically in Figure 1. The discussion that follows moves step by step, from top to bottom, through the various elements of the proposed service delivery model. In this way, it is possible to outline the precise nature of the service delivery response being suggested by the Commission, and clearly describe the underlying logic of each element presented.

Immediate response

The police, as those most likely to be contacted in circumstances where individuals are engaging in VSM, are, unavoidably and necessarily, central to service delivery at the first level. Indeed, the Commission recognises that the place of safety service delivery model was originally envisaged as a community-based response that would support the QPS in the operation of the trial powers. Many of the reasons that this did not occur as effectively as was hoped relate to the operation of the places of safety themselves; but they also concern the nature of the trial police powers.

Figure 1: Proposed new model (place of safety)

Immediate response	<p>Police:</p> <ul style="list-style-type: none"> • take person home • take person to emergency department • take person to intoxication-recovery service • hold person until one of the above is available or person is no longer affected • alert the Department of Child Safety.
Medium-term response	<p>Department of Child Safety:</p> <ul style="list-style-type: none"> • manages intake and screening process • develops and coordinates case management plans (where necessary/appropriate, due to child protection concerns) • forwards details of the VSM alert to an appropriate follow-up service such as the Department of Communities.
Long-term response	<p>Designated community agency:</p> <ul style="list-style-type: none"> • follows up with child and family; provides support/counselling • provides information back to Department of Child Safety regarding case management. <p>Designated government entity:*</p> <ul style="list-style-type: none"> • follows up with child and family; provides support/counselling • coordinates, where necessary/appropriate, multi-agency provision of welfare services (e.g. accommodation, education, employment, health).

* The Commission for Children and Young People and Child Guardian should be responsible for overseeing all levels of VSM alerts and subsequent responses, including ongoing monitoring of all alert-related activities carried out by the Department of Child Safety.

The nature of the response provided by police will be determined by the nature and extent of the lawful authority they have available to them when dealing with VSM. The Commission has proposed a model for police powers which it believes will address the core issues that emerged during the review of the current police powers undertaken by the Commission at the same time as the evaluation of the places of safety. Moreover, the proposed model provides for a more effective and workable entry point into the broader government response to VSM based on the use of non-government organisations and designated places of safety.

By proposing changes to police powers, the Commission does not seek to dispense with current police powers; rather, it seeks to retain the strengths of the current system but add some new powers and responsibilities. These proposed new powers, while only exercised by police, expressly provide for direct engagement with a range of other agencies — in particular the Department of Child Safety, the Department of Communities and Queensland Health.

The Commission proposes two substantial additions to current powers enabling police to search and seize any potentially harmful thing (e.g. products containing volatile substances) from people suspected of being involved in VSM, and to apprehend and detain people affected by VSM for the purpose of transporting them to a safe place.

The first addition would give police the power to hold VSM-affected people for up to four hours, or between the hours of midnight and 6 am, until they are sober. This power is to be exercised only under a restricted set of circumstances, most notably where no other reasonable alternative exists for the care and protection of the VSM-affected person. In effect, this power would be exercised at the point in the current police powers model where an officer would be required to release an affected person in the absence of a parent, guardian or place of safety. In order to limit the number of cases in which this power would need to be exercised, the Commission proposes the establishment of designated intoxication-recovery

services. These services are to be used for the express purpose of providing intoxicated individuals with a supervised space in which to recover from the transitory effects of VSM intoxication.

The second proposal is that police will have a duty to alert the Department of Child Safety about all children and young people apprehended as a result of VSM. The Commission believes it is of critical importance that accurate information concerning children engaging in VSM is received by the appropriate agencies and acted upon. It is envisaged that, by providing the Department of Child Safety with immediate and accurate information concerning affected young people, medium- and long-term management of cases can be ensured.

Adding the proposed power to hold an affected person, and the VSM-alert responsibility, in turn necessitates a series of further changes, including the power to require a person's correct name and address, and the use of reasonably necessary force. Similarly, the proposed new powers require the introduction of a series of new responsibilities for police in the exercise of these powers, including limitations on the time a person may be held by police, the manner in which a person is held, and the powers police have to question, charge and subsequently arrest them.

The Commission proposes that three core ideals be borne in mind for the operation of any police powers response model to VSM:

- The powers should be exercised in the interests of the affected person's welfare and care, and be balanced by appropriate and reasonable responsibilities.
- The response to VSM should be therapeutic and not punitive.
- Perhaps most critically, the actions of police should be one part of a broader whole-of-government response to the issue of VSM (see the companion volume, *Police powers and VSM: a review*).

VSM-alert response

1 Goals

The VSM alerts proposed by the Commission are intended to ensure that children and young people engaging in VSM are brought to the attention of the Department of Child Safety so that, where necessary, an appropriate longer-term case-management process can be implemented. The model has two tiers:

- The first tier requires police to send relevant data to the Department of Child Safety whenever a child is apprehended under the police powers.
- The second tier requires the Department of Child Safety to act appropriately on the information they receive from police.

It is essential to recognise that the first tier of the system by itself is not designed to provide case-management or care for the affected child or young person. Rather, it is intended as a collection and collation mechanism whereby information about affected children obtained at the point of first contact (most often police) can be made available to whatever agency (government or non-government) is best equipped to provide follow-up service. It is at the second tier that the information should be received and assessed with the appropriate level of urgency by the Department of Child Safety.²⁴

²⁴ The reasoning behind designating the Department of Child Safety as the agency to assume this role is discussed under the second tier of the proposed service delivery model.

2 Responsibilities

The mechanics of the alert system itself are relatively straightforward. When police apprehend a child affected by VSM, they have a mandatory responsibility to provide the Department of Child Safety with a 'VSM alert' outlining the following details:

- the child's name, address and age
- the child's apparent condition when apprehended
- the child's location when apprehended
- the police response to the child after apprehension (i.e. released to a parent, guardian or other suitable adult; transferred to an intoxication-recovery service; held by police because of a significant level of intoxication; or simply released because they were no longer intoxicated and no longer a risk to themselves or others)
- any further details as to the child's condition, interaction with police, or the nature of the place to which the child was released.

These details should be recorded on a standard form, or, where no standard form is available, in another appropriate format. Police should then forward these details to the Department of Child Safety (e.g. by fax or email) at the earliest reasonable opportunity after the young person is released. Release must be to a parent, guardian or other suitable adult, or to an intoxication-recovery service. If none of these is available, the young person should be temporarily held until an appropriate person or facility can be found. Where no appropriate person or facility is available, and once the level of inhalant intoxication has subsided to the point where the police reasonably believe the person is no longer a risk to themselves, others or property, they may be released.

3 Staff

The Commission makes no submission on the staffing levels required to ensure that VSM alerts occur, beyond noting that, had the 'faxback' system developed in Townsville been in operation in all sites during the evaluation period, fewer than 300 alerts would have been sent by police and these would have related to only 157 separate individuals.

4 Relationships with other agencies and services

The police would be required to liaise with the Department of Child Safety as necessary about the operation of the VSM-alert system.

5 Funding

Funding for the first tier of the model should not, in the Commission's view, be overly problematic, because it would consist primarily of the provision of the appropriate forms (paper-based or electronic) and training to police.

Intoxication-recovery service

1 Goals

The VSM-alert system and intoxication-recovery service model substantially modify the role and functions of the currently designated places of safety operated by non-government organisations. In contrast to the current model, in which a single agency is expected to provide both immediate and longer-term intervention, the intoxication-recovery service model is intended to provide nothing more than a place for affected individuals to recover from the effects of VSM intoxication. In addition, where intoxication-recovery service staff observe behaviours or obtain

information through their contact with VSM-affected people that they consider justify an ongoing welfare response, they should inform the Department of Child Safety or the Department of Communities (as appropriate) as a follow-up to the alert from police.

The Department of Child Safety intake and screening staff will usually not be in a position to respond immediately to the more general welfare needs of people as intoxication subsides, so it is important that intoxication-recovery service staff have the capacity to 'trigger' more general assistance services necessary once the person is no longer intoxicated. In practice this means that intoxication-recovery service staff need to be knowledgeable about the locally available welfare services, and able to connect children and young people with these services quickly and efficiently. Anyone presenting at an intoxication-recovery service should thus be provided with the following services:

- a safe environment for as long as necessary for recovery from the effects of VSM
- immediate attention to VSM-related minor illnesses or injuries that have not warranted the services of hospital or ambulance service staff, but nevertheless require treatment
- immediate first aid treatment where appropriate
- diversion to an appropriate medical facility if indications emerge that such a transfer is advisable
- information about the adverse health consequences of VSM
- information about other government and non-government services available to VSM-affected people and their families
- access to other government and non-government services and agencies, as appropriate, in response to the immediate and longer-term welfare needs of the affected person.

It is critical to recognise that the intoxication-recovery service envisaged by the Commission is not to be used as a means of obtaining emergency accommodation; neither is it in any way intended to offer an overly congenial environment to people routinely self-referring as an associated aspect of VSM. In the normal course of events, access to an intoxication-recovery facility should depend on a formal referral from the police, ambulance or another designated agency.

It must also be recognised that a decision will need to be made about the appropriateness of providing intoxication-recovery services for both children and adults in the same facility. When adults are detained in response to VSM, the intoxication-recovery service should refer them on to an appropriate accredited drug and alcohol service such as ATODS (Alcohol, Tobacco and Other Drug Services) for ongoing case management.

2 Responsibilities

The core responsibility of an intoxication-recovery service is to provide an appropriate standard of care to affected individuals so that the goals outlined above can be achieved. This standard of care includes ensuring that the premises are safe, and appropriately staffed and located.

In addition to the requisite standard of care owed to affected people, the intoxication-recovery services must ensure an appropriate level of accountability. It is important that intoxication-recovery services are established only where a definite need for such a service is identified, and only used to respond to the immediate recovery needs of VSM-affected individuals.

Although it is feasible for non-government agencies to provide intoxication-recovery services, the service provided through these facilities needs to be kept separate, both physically and conceptually, from the more socially oriented welfare services typically provided by non-government organisations. In some parts of Queensland it is possible that only a medical service (which might be operated by a community organisation rather than by Queensland Health) could offer the necessary infrastructure for such a facility. One likely consequence of the operation favoured by the Commission for responding to VSM is thus a somewhat broadened role for Queensland Health.

The present situation is that police or ambulance officers may take a person to an emergency department for medical assessment if such a response is considered justified. Given the transitory nature of the effects of VSM, as well as long waiting times for hospital emergency treatment, and the risks that VSM-affected individuals pose to others in hospital waiting rooms, this happens only in situations where the level of intoxication is considered life-threatening. However, VSM-affected individuals commonly have more general medical needs. These include the need for first aid in response to injuries sustained as a result of the lack of inhibitions or cognitive disturbances caused by intoxication. For those residing in crowded or unsanitary conditions, or in conditions where physical or sexual abuse is common, pre-existing ailments or injuries may also require attention.

It is important to recognise that broadening the role of Queensland Health would not be inconsistent with the current strategic priorities of that department. Queensland Health identifies five primary strategic intents: healthier staff, healthier partnerships, healthier people and communities, healthier hospitals, and healthier resources.²⁵ The Commission believes that, through these strategic intents, there is scope for Queensland Health to provide a somewhat broader response to VSM than it currently gives. Two of these strategic intents are particularly relevant: 'healthier partnerships' and 'healthier people and communities'.

The **healthier partnerships** strategic intent is 'to work with others to harmonise programs and activities that impact on health'. The department undertakes to:

... work in partnership with other federal, state and local governments and non-government organisations to ensure their policies, programs and activities actively support good health ...

and:

... work in partnership with other health care providers to plan and deliver innovative, cost-effective and integrated health services.

The other important strategic intent is **healthier people and communities**, to:

... increase our focus on promoting healthier lifestyles and environments for individuals, families and communities, and improve community-based chronic disease management.

This is in line with the provision of public health services that focus on issues impacting on populations.²⁶ Specifically the undertaking is that Queensland Health will:

... inform, support and provide Queenslanders with information and skills to improve, maintain and manage their health; will invest more in strategies to

25 Queensland Health 2004.

26 Public health is distinguished from other roles of the health system by its focus on the health and wellbeing of populations rather than individuals. The objectives of public health are: protecting health, preventing disease, illness and injury, and promoting health and wellbeing. (Source: Queensland Health 2004, Public Health Services Branch, viewed 2 June 2005, <www.health.qld.gov.au/phs/>)

prevent illness and injury in the areas we can make the greatest difference; will systematically identify people at greatest risk of illness, injury or complications from existing health conditions and take steps to reduce their risk and improve their quality of life and will work with other health care providers, both government and non-government, and community controlled organisations, to build a stronger and more responsive primary health care sector.

These strategic interests suggest that some real scope exists for Queensland Health to work collaboratively with departments such as Child Safety and Communities, as well as with community-based non-government organisations, with the aim of providing a more coordinated response to the needs of those engaging in VSM.

3 Staff

The Commission recommends that intoxication-recovery services be staffed by people who have training in first aid and demonstrable knowledge of the physical and psychological effects of VSM. It is recommended that a basic level of training on the effects of substance abuse, intoxication and inhalant abuse should be undertaken by intoxication-recovery service staff.

4 Location

Precisely where an intoxication-recovery service should be located is a matter to be determined on the basis of community need and existing infrastructure. Resources should be provided by government to meet the needs of communities, taking into account existing capacity and infrastructure. In some areas the capacity of non-government organisations will already be sufficiently well developed that (with support) taking on the extra responsibility of providing an intoxication-recovery service presents no great challenge. In areas where there is a less well-developed non-government sector, it may be necessary to take advantage of infrastructure and services provided by a government entity such as Queensland Health. And there may be some other areas where it is local government that proves best equipped to offer and maintain such a service. However, regardless of any existing infrastructure, the Commission reiterates that the government should base decisions about both the location and the utility of an intoxication-recovery service on demonstrable community need.

5 Relationship with police

The current model allows affected individuals to self-refer to the place of safety. The Commission strongly believes that this practice should be discontinued, and only referrals by police or other designated government agencies such as the QAS, the Department of Communities and the Department of Child Safety should be routinely accepted by the intoxication-recovery service. Police attending an intoxication-recovery service with an affected person should require the person in charge of the service to sign a form indicating that the affected person was released into their care, and giving relevant details such as the person's name, age, apparent condition, location when apprehended, time of apprehension and release, and the name, rank and badge number of the officer. Personnel at the intoxication-recovery service would then take custody of the affected person and provide them with the services indicated above, as appropriate.

Where a person in charge of an intoxication-recovery service, or the attending police officer, has a reasonable concern that the affected person poses a risk to the health or safety of staff or others, the person in charge should have the option of requesting that the police officer making the referral stay with the affected person at the intoxication-recovery service until the risk has passed.

6 Relationship with other agencies and services

The Commission reiterates its central goal of ensuring that any response to VSM in Queensland involves multiple agencies. The intoxication-recovery service is not intended to provide a complete solution to the VSM. Affected individuals should be provided with any immediately necessary medical and welfare care at an intoxication-recovery service, but they cannot expect, for example, to use it as an accommodation service. Importantly, the Commission recognises that a number of other services may be co-located with an intoxication-recovery service for administrative convenience and operational efficiency, and views this as desirable (although not necessary). For instance, where the intoxication-recovery service is provided by a non-government agency, co-location with other services that specifically provide longer-term social intervention could make movement between the services easier, and their use, more likely. However, these services must remain clearly separated from the intoxication-recovery service, and only accessible to clients once they are no longer intoxicated and no longer in its care. Under no circumstances should clients be allowed to leave the intoxication-recovery service to 'top up' on volatile substances before returning to make use of the more socially oriented services. Furthermore, even if the services are co-located, they should not be perceived as replacing the client assistance service facilitated through the VSM-alert system.

7 Funding

Funding for an intoxication-recovery service may be provided from a range of sources. The Commission makes no recommendation as to the most appropriate source of funding or the nature of the funding arrangement that should be set up, except to stress the view that the decision to establish an intoxication-recovery service should depend on community need, and that the authority to declare an entity as being an intoxication-recovery service to which police and other agencies may release an affected person should be vested in the government. The Commission also notes that there is no obvious problem with agencies (government or otherwise) being funded according to the level of service indicated necessary by a properly conducted needs assessment. What this would typically mean is that a non-government organisation already providing more general client assistance welfare services on behalf of the government could simply apply for additional funds to support the provision of an intoxication-recovery service.

Medium-term response

The next response tier in the model involves coordinating resources to respond to the medium-term needs of individuals affected by VSM — specifically, mental health and welfare assessment, and development of an appropriate case-management plan. In the model, the Department of Child Safety is responsible for the initial handling of VSM-alert information from the QPS regarding children and young people affected by VSM, as well as any information received from the intoxication-recovery service about health or welfare concerns relating to the individuals involved.

1 Responsibilities

For the goal of effective and efficient case management to be achieved, both tiers of the proposed model need to function. Police have the primary responsibility for the first tier of the model, but the Department of Child Safety must ensure that it is capable of receiving information and then acting on the information it receives.

On receipt of the VSM alert, the Department of Child Safety is then responsible for:

- determining whether or not the child has previously come to the attention of the Department of Child Safety (including by way of previous VSM alerts)
- determining what actions have been taken previously
- determining what actions are appropriate in light of the apprehension for VSM if the person concerned is already a client of the department, or if the circumstances of the VSM alert raise child protection concerns that make it necessary for the person to become a client of the department
- developing an appropriate case-management plan, which takes account of the VSM alert from police, for the young person and their family, if the person concerned either is, or will be, a client of the department
- forwarding the details of the VSM alert to the appropriate agency to provide appropriate follow-up services. In many instances this agency will be the Department of Communities; but, in some communities, the most appropriate entity will be a designated non-government organisation providing general welfare services on behalf of the government.

These responsibilities should follow the procedure that the department already institutes with respect to notifications of harm under the *Child Protection Act 1999*, even though the VSM alerts do not in themselves constitute a 'notification'. What is meant here is that the same intake and screening procedures should be employed for VSM alerts as for formal notifications. This would mean in practice that the Department of Child Safety would 'screen in' matters with child protection implications and requiring its formal attention, and 'screen out' those matters that do not reach the threshold required for a child protection response. All matters 'screened in' would thus be retained by the Department of Child Safety, whereas those 'screened out' would be forwarded to the most appropriate agency to provide a follow-up service.

The Commission recognises it might be argued that it is the Department of Communities, and not the Department of Child Safety, that should be the recipient of the VSM alerts; this is because the subjects of these alerts and the circumstances surrounding them occupy a sort of grey area between the jurisdiction of Child Safety and Communities. The Commission is aware that government is in the process of defining the respective jurisdictions of these two departments more clearly. Once this is resolved, the Department of Communities may prove to be the more appropriate recipient of the proposed alerts. In the meantime, however, the Commission considers that responsibility is most appropriately carried by the Department of Child Safety.

It is anticipated that, in most instances, once a VSM alert had been received and processed (including organisation of follow-up and development of a case-management plan) by the Department of Child Safety, the involvement of that department would cease.

2 Staff

The Commission makes no submission on the staffing levels required to ensure the operation of the alert model, except to note that the Department of Child Safety should be able to receive and act on VSM alerts from the police service quickly and effectively. In addition, if follow-up is provided by a non-government agency, staff should be trained to identify issues associated with VSM, including mental health and child protection matters, and should be capable of providing associated assessment, counselling and referral services. In addition, and as noted with respect to the police workload associated with the VSM-alert procedure, the

Commission notes that the number of alerts likely to be processed is not as great as might at first be assumed.

3 Funding

The Commission believes that funding for the second tier should reflect the staffing and organisational requirements of the Department of Child Safety, so that staff are trained to receive VSM alerts, and staff capacity is increased to meet the needs of effective case management. The Commission makes no recommendation as to the most appropriate source of funding or the nature of the funding arrangement.

Long-term response

The long-term response involves providing ongoing support, assistance and monitoring of clients identified by VSM alerts through the first and second tiers of the model. Where the first or next contact results in identification of specific social, familial, mental or physical health factors impacting on VSM involvement, the long-term tier of the model provides for ongoing assistance and intervention aimed at remedying or mitigating the effects of these problems.

1 Responsibilities

The exact nature of any ongoing assistance provided to young people identified as involved in VSM (and their families) will be determined by the exact nature of any problems identified during immediate follow-up after police detection and faxback to the Department of Child Safety. In some cases follow-up may include counselling. In others, it may involve assistance and support in accessing housing and education, as well as mental health, drug and alcohol, and other specialist services. Where child protection issues are identified it may also be necessary to involve Department of Child Safety officers. Where follow-up is given by a non-government agency, the relevant government agency (usually the Department of Child Safety or the Department of Communities) will need to monitor the nature and outcomes of the service being provided during the ongoing support process.

2 Relationships with other agencies

Other agencies identified during the evaluation as potentially playing an important role in the medium- to long-term treatment and case management of young people who have been involved in VSM (and their families) include the Department of Housing, Education Queensland and local government authorities. The Commission believes that this multi-agency response to VSM is likely to prove especially important. The potential roles of these agencies and their relevance in long-term responses to VSM are briefly described below.

Department of Housing

The Commission believes that the Department of Housing has a critical role to play in supporting the response to youth involvement in VSM. Community stakeholders consulted as part of this evaluation, as well as statistics showing that many youth used the places of safety as a form of medium- term accommodation, clearly point to a need for medium- to long-term supported accommodation options for 15–16-year-olds who have no access to stable home environments, or whose return to immediate family would place themselves or other family members at risk. These young people are often too old to be placed in foster or group living arrangements, but too young to be expected to manage on their own. Investment is therefore needed in facilities that provide them with the security of a place to live and the means to develop and obtain skills and resources conducive to more stable living arrangements.

Such an investment conforms to the Department of Housing's 2004–09 statement of strategic direction:

The Queensland Government seeks to improve Queenslanders' access to safe, secure, appropriate and affordable housing. The Department of Housing achieves this objective in a range of ways, from delivering traditional housing assistance to influencing the development of an effective and responsive housing system.²⁷

As part of this statement, the Department of Housing makes specific reference to meeting the housing needs of young people. The department's 'young people's housing statement' commits the department to the following principles 'to guide improved housing options for young people in Queensland':

- recognising the right to access secure, appropriate and affordable housing
- maximising the range of suitable housing choices
- ensuring housing is connected with support services, where necessary
- ensuring equity for all Queenslanders.²⁸

In order to achieve these goals, the department recognises the need to take 'a responsive, integrated and flexible service approach in developing solutions for unmet housing needs; it aims to improve people's access to secure, affordable and appropriate housing, which in turn will contribute to individual, family and community sustainability'.²⁹ It also emphasises commitment 'to working in partnership with industry, community and the private sector to help individuals find appropriate housing solutions'. These goals seem highly compatible with an enhanced contribution by the Department of Housing to the government's broader response to VSM.

Education Queensland

The preventive aspects of youth involvement in educational activities are highlighted both in the literature review and in observations made by community stakeholders consulted as part of the evaluation. In addition to alleviating the boredom identified as a major contributor to VSM, and developing social ties to teachers and peers, educational involvement is identified as a means of reducing other negative outcomes associated with VSM, such as antisocial behaviour, involvement in the criminal justice system, and unemployment. Community stakeholders from the non-government sector, the police, the ambulance service, and the health sector all identified the need for alternative education options for children and young people who are not engaged in any form of schooling. There is a strong argument for giving increased attention to expanding the range available, and for focusing these forms of education on re-entry, retention and flexibility in education approaches.

In line with these assertions, Education Queensland's 'Destination 2010' 10-year action plan acknowledges the need for schools to work with parents and the local communities to develop appropriate alternative forms of education that are conducive to achieving successful educational outcomes for all students.³⁰ Objectives identified as part of this vision include the creation of 'learning communities that meet diverse student and community needs' (p. 10) and ensuring that 'relationships with other government departments and statutory authorities

27 Department of Housing 2005a.

28 Department of Housing 2005b.

29 Department of Housing, <www.housing.qld.gov.au/about_us/oview_of_depart.htm>, viewed 20 June 2005.

30 Education Queensland 2004.

are focused to support the work of teachers and benefit diverse student pathways' (p. 15). In order to achieve these objectives, Education Queensland states that it will:

- develop innovative and distinctive approaches to schooling that are based on a clear education rationale reflecting the needs of students, the community, and the identified market segment
- support the successful transition of students between the stages of schooling
- work with school communities to select and implement the most appropriate school-based management option
- implement behaviour-management approaches that create safe, tolerant and disciplined environments for all students
- cooperate with other government agencies and expand community partnerships to provide supportive learning environments
- promote the successful progression, participation and attainment of students through Years 1–12 so they can make a successful transition to their preferred post-school destinations
- implement partners for success to promote genuine partnerships between schools and Indigenous communities
- improve students' access to a range of resources and cross-government services that support their social needs and improve their capacity to complete 12 years of schooling
- improve the coordination of services with other government departments and sharing of resources to help students achieve better academic and social outcomes
- coordinate approaches to achieving the vision of Education Queensland by strengthening links between school education and government economic and social policy objectives.

Again, these government policy objectives appear to be very compatible with an enhanced response to VSM of the form suggested by the Commission.

These policy objectives are also consistent with the spirit of the *Education and training reforms for the future* White Paper, which outlines an undertaking by the government to foster a 'community commitment to young people by building partnerships at the local level'.³¹ This White Paper constitutes the 'action plan' for the more general policy framework outlined in the Destination 2010 document.

Local government role

The third tier of the proposed community response to VSM emphasises the links between government and non-government agencies in terms of developing and implementing programs and resources conducive to managing and preventing VSM and associated problems in the longer term. Given differences in the manifestation of VSM and associated problems across the five 'place of safety' trial sites (and other communities consulted as part of the evaluation) the types of programs and resources that will be required to facilitate this process are likely to vary considerably in different geographical areas. Similarly, the degree to which existing agencies are able to meet these needs will also vary. In some cases, this may require the development of new programs and services, or new orientations to service delivery.

31 Queensland Government 2002, p. 24

In its 2002 report on VSM, the (then) Commission for Children and Young People advocated a community engagement strategy to respond to the issue. From the evaluation process, the Commission has arrived at a similar view and agrees that, providing the relevant legislative and best-practice program and service delivery frameworks exist, a community engagement strategy is well placed both to identify needs and to support local strategies to respond to VSM.

For a community engagement process to be effective, however, a lead agency must be identified. The Commission believes that, in some communities, local government authorities may be well placed to play this role in the development of community engagement strategies. Not only are these authorities locally based, and therefore accessible to other local stakeholders, but also their local focus provides them with essential knowledge and experience of community dynamics for managing this process. Furthermore, local government agencies in some Queensland areas already employ community development, crime prevention and youth workers among their staff. Arguably, these local authorities could play a greater role in community engagement strategies specifically focused on long-term VSM intervention than has been the case to date.

The mechanisms through which local authorities take on or increase community engagement strategies regarding VSM will vary according to the size of the community and the VSM situation that prevails there. The Commission believes that a useful first step in this process could be greater local authority representation on interagency government working groups focusing on the development and the management of responses to VSM. In at least some communities, local government may well prove to be best placed to assume the role of lead agency in such working groups.

Department of Communities

Among its key functions, the Department of Communities lists:

- community safety and support policy
- youth participation and development
- youth justice program support and youth justice conferencing
- community safety program development, including crime and violence prevention, homelessness services, and family and individual support.³²

Given the identified association between the involvement of young people in VSM and criminal activities, domestic violence and summary offences, the Commission believes that the Department of Communities has a very significant role to play in the development of long-term intervention strategies to address and prevent VSM and associated issues. This role includes providing support services for young people and their families who are already involved in the criminal justice system, as well as developing prevention programs specifically targeting VSM through youth participation, development and community safety programs.

In addition, the Department of Communities clearly needs to play a significant role in coordinating whole-of-government approaches to strategic policy and intervention, and community capacity building within the non-government sector. The department is in an ideal position to work in partnership with local government authorities and non-government organisations to respond to local needs associated with VSM.

³² Department of Communities, <www.communities.qld.gov.au/department/about/functions.html>, viewed 21 June 2005.

Skills of workers providing VSM-related support services

Defining the appropriate skills and training for responding to VSM is far from straightforward. Where the substance abuse is endangering the immediate safety of someone, there is a clear need for the services of a health professional. At present, and in the model suggested by the CMC, this need is being met by the QAS and hospital emergency staff. Responding to the more deep-seated welfare needs of volatile substance abusers is far more complex.

The CMC believes that one of the strengths of the system it is proposing is that it readily accommodates 'local solutions for local problems'. Part of this flexibility is the capacity to recognise the need for, and draw upon, disparate skills that suit the local context. To take advantage of this flexibility, the government must act as a 'good purchaser' — it must recognise the characteristics of the local problem, then translate this recognition into the specification of appropriate skills when supporting a service provider (typically by agreeing to fund a local government organisation).

However, and notwithstanding this concern with maximising the flexibility (and responsibility) the government has when determining the nature of its response to VSM, the CMC does have some general views about appropriate skills.

Any response to VSM by an agency on behalf of the government would seem to the CMC to require the following skills (not necessarily vested in a single individual):

- tertiary qualifications in social work or a related discipline (or, in certain contexts, demonstrable equivalent work experience)
- experience as a youth worker
- sound links with key local community stakeholders
- demonstrable understanding of the nature of the local target client group
- demonstrable familiarity (or the capacity to quickly acquire such) with organisational governance issues
- demonstrable preparedness to act as a 'good provider' in terms of complying with any service delivery agreements negotiated with government.

In the CMC's view, service delivery responses to VSM negotiated between the Department of Communities and local agencies which make these six general criteria central to brokering a partnership between a 'good purchaser' and a 'good provider' offer the most promising basis for effective longer-term responses to VSM.

Coordination of the proposed model

Although the obligations of government agencies, as described in the option for enhanced service delivery favoured by the Commission, do not diverge from their current statutory roles and responsibilities, it may be less clear how they would implement some elements of the proposal in practical terms.

The Commission sees three major elements of the model that it believes warrant consideration. Only one of these elements, however, presents challenges in terms of developing a viable policy framework capable of supporting an enhanced response to VSM.

- The first element of the option favoured by the Commission consists of the changes to police powers that underpin the broader VSM strategy. Despite some potentially contentious aspects, the Commission does not believe these changes present any insurmountable difficulties legislatively, administratively or operationally.

- The second (and related) element is the use of a VSM-alert system involving the Department of Child Safety and operational police. Again, despite some increase in the workload of the Department of Child Safety, the Commission can see no real obstacle to successful implementation of the scheme.
- The third element of the option favoured by the Commission involves longer-term community-based responses to VSM, and various agencies. The Commission concedes that there is a greater degree of uncertainty about successful implementation of this aspect of the model.

One of the greatest difficulties in implementing a new community-based response to VSM is likely to be coordination of the diverse range of government and non-government agencies and services needed to meet the immediate, medium-term and long-term needs of people engaging in VSM. As is evident from the results of the evaluation, one agency cannot meet all of these needs, nor does it appear feasible to expect one agency to coordinate the responses of all others in meeting these needs. Furthermore, it is possible that, if primary responsibility for a response to VSM were to be given to a single lead agency, that agency would be left 'holding the baby' in relation to all aspects of the intervention.

This difficulty of determining 'who does what' and 'who is responsible to whom' is one that arises very commonly whenever multi-agency responses to an issue are attempted. Not surprisingly, individual agencies have their own understanding of what constitutes core business, and at times are reluctant (or unable) to contribute to broader initiatives that appear to them to fall outside or beyond their generally accepted role.

The Commission has been mindful of this issue in its endeavour to identify how best to enhance the government's response to VSM; and it believes that the option it is suggesting provides a clear guide to how a diverse range of agencies could work together towards a common objective without having to take on new roles that depart significantly from their existing understanding of what constitutes their core business. Specifically:

- The police are given responsibility for detaining and transporting people affected by VSM to places where they will receive the care they need to recover safely from the effects of VSM, and to ensure that their release to any such place does not put themselves or others at risk. Police are also responsible for alerting the Department of Child Safety about any young people detained in response to VSM.
- The Department of Health and the QAS are given responsibility for ensuring that, if needed, medical staff are immediately available to police or the staff of an intoxication-recovery service.
- The Department of Child Safety is given responsibility for triggering any necessary follow-up and case management of young people (and their families) through its response to alerts by the police or QAS staff. In most instances this would involve forwarding the alert to the Department of Communities or a local agency designated by that department

The Department of Communities would in most instances be responsible for identifying and contracting non-government and government agencies (e.g. Education, Housing, Communities) to be part of any necessary follow-up processes. In turn, non-government and government agencies identified and contracted by the Department of Communities or the Department of Child Safety would have the responsibility to respond to requests made by that department and to provide information to the department about the outcomes of their involvement in the process. Where necessary, these agencies might also request assistance from

government entities, and these bodies would have a responsibility to respond to such requests.

If, in the course of follow-up and case management of individuals involved in VSM, a need were to be identified for programs and services not otherwise available in the community in which the individuals resided, local government authorities would have the responsibility of engaging the wider community in providing these services. In turn, state government and non-government agencies would be responsible for working with local government authorities to support this process.

The flexibility of this service delivery response to VSM is one of the most important aspects of the way forward being suggested in this report. This degree of flexibility is especially important with respect to responding to the issue of petrol sniffing. During the evaluation period, petrol sniffing was not apparent in any of the trial sites; however, this is not to say there are not Queensland communities in which petrol sniffing either is or might become a problem. In the unwelcome event that a Queensland response to significant levels of petrol sniffing should prove necessary, the CMC believes the approach it is advocating is capable of supporting any intervention strategy deemed necessary.

The Commission also recognises the need for overarching monitoring of the response to VSM across the state, and considers that the Commission for Children and Young People and Child Guardian is best placed to serve this function. The monitoring could be achieved by bringing to their attention all data relating to young people who are detained by the police, referred to the intoxication recovery centre and brought to the attention of the departments of Child Safety and Communities in response to VSM; the data should also be reviewed annually. This responsibility is generally consistent with the role of the commission's Systemic Monitoring and Audit Unit:

Proactive monitoring and auditing services provided to children by the Department of Child Safety (DChS) and non-government organisations licensed under the *Child Protection Act 1999* (service providers); monitoring, auditing and reviewing the systems, policies and practices of DChS and service providers that affect children in the child safety system; investigating significant complaints and possible systemic failings in relation to a child within the jurisdiction of DChS; appealing administrative decisions of DChS to the Children Services Tribunal, where agreement cannot be reached on what actions are in the best interests of a child, and monitoring DChS's compliance with the indigenous child placement principle.³³

Identification of need and capacity

The Commission believes that reliance on anecdotal reports of VSM incidence in communities is neither accurate nor helpful to government in its decision-making about where to establish VSM services such as intoxication-recovery services, more general VSM-related client assistance and follow-up services.

In the Commission's view, identifying a need for services to respond to VSM in communities must be based on defensible empirical evidence of the nature and extent of the problem. The Commission recognises that the problem in many communities is cyclical, and decisions about establishing VSM-related services must therefore draw on data that are accurate and up-to-date. Such evidence includes data from the police, hospital, ambulance, Child Safety and Communities contacts regarding VSM-related incidents in the community.

33 Commission for Children and Young People and Child Guardian 2002–05, *Systemic monitoring and investigations: investigative functions*, <www.childcomm.qld.gov.au/monitoring/index.html>, viewed 25 May 2005.

Conclusion

In this report the Commission has sought to outline an option for a more effective response to VSM, which it believes is not only practicable in its application throughout a state with diverse needs and resources, but also sustainable, and embodying the flexibility necessary to ensure that local problems are responded to in ways that are appropriate in the local context. The option described has the capacity to 'expand and contract' in line with the typically cyclical VSM-related needs in communities and, in the Commission's view, offers an appropriate and fiscally responsible way to address the issue of VSM.

The option described recognises that, although it is the police and Department of Child Safety that are responsible for triggering a meaningful medium- to long-term response for VSM-affected children, it is other government agencies (in particular the Department of Communities), working with a wide range of non-government entities, that will carry forward this response (unless very specific child protection issues requiring attention are involved).

Having outlined its favoured option for a better response to VSM, the Commission offers in conclusion some further observations that it believes are both pertinent and important.

Responding to VSM has consistently proved to be a difficult exercise elsewhere in Australia and overseas. The Queensland Government is to be commended for sponsoring an innovative approach to the problem, and subjecting itself to an independent external evaluation of this new approach, despite the very real possibility that the trial would not prove as successful in all aspects as hoped.

Although there will be disappointment on the part of some that the trial response to VSM is not ultimately assessed by the Commission as one that should be continued in its current form, this overlooks the very real value of attempting new strategies and rigorously evaluating the consequences of such attempts. The trial response and its associated evaluation have yielded much valuable information, both about the nature of VSM in Queensland and about the nature of the response to VSM that shows most promise.

It is critically important to recognise and acknowledge that the enhanced service delivery model proposed by the Commission is a very clear expansion of the service delivery models developed and implemented in one of the trial sites. Had the Commission not been able to draw on the evaluation data relating to this particular site in comparison with data from other sites, its ability to develop the VSM response option described in this report would probably have been greatly reduced.

Finally, the Commission accepts without reservation that there are no easy answers to the problem of VSM. In outlining an option for a new service delivery model, the Commission has sought to find a way forward that builds on the strengths of the approach trialled by government but also addresses the unwelcome (albeit unintentionally so) aspects of the current approach.

It is unlikely that the approach to VSM advocated by the Commission in this report will find support in all quarters. For some, the approach suggested will be seen as insufficient, and for others it will be seen as an undesirable extension of government involvement in the lives of vulnerable children and young people. The Commission is well aware of the breadth of perspectives that will be brought to bear in assessing the appropriateness of the option described in this report, and has endeavoured to take account of the substance of these divergent perspectives as far as possible.

In attempting to balance divergent and competing perspectives, the Commission has been guided by the nine principles outlined earlier. In the event that the government is not ultimately convinced of the appropriateness of the new service delivery model suggested in this report, the Commission believes it essential that any amendments made to the current model are consistent with the intent of those nine guiding principles.

APPENDIX: Charts and tables

Client information

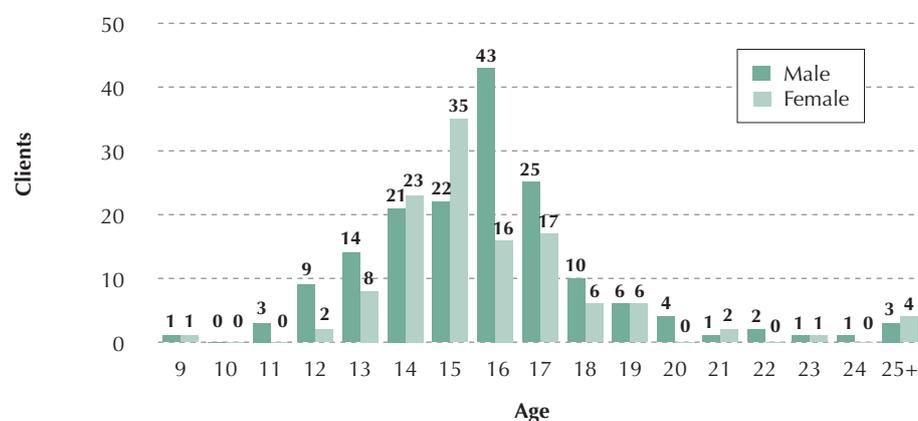
Table A-1: Total number of contacts per client (1 July 2004 – 31 March 2005)

Contacts	Number of clients	%
1	162	51
2	45	14
3	9	3
4	15	5
5	10	3
6–9	25	8
10+	50	16

Source: CMC place of safety client information forms

Note: Includes Cape York Department of Communities referrals (19 clients).

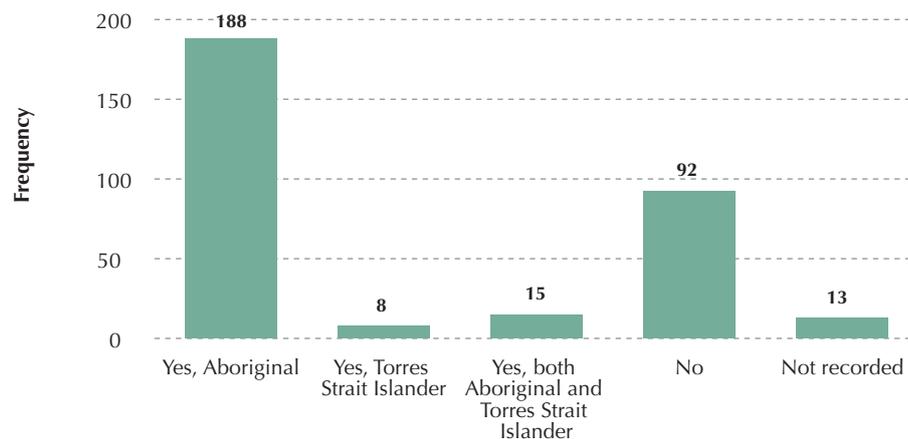
Figure A-1: Client age and gender (1 July 2004 – 31 March 2005)



Source: CMC place of safety client information forms

Note: A 70-year-old person was recorded by a place of safety as a client, but was removed from the analysis on the grounds of clearly not representing the intended target group. Including such a marked 'outlier' would obviously skew the analysis to a degree that is misleading and unhelpful. For a further 27 clients, no age was recorded (missing data). Additionally, the gender of two clients was not recorded and is therefore unknown (missing data).

**Figure A-2: Aboriginal and Torres Strait Islander origin of clients
(1 July 2004 – 31 March 2005)**



Source: CMC place of safety client information forms

Note: CMC place of safety client information forms contained a question asking if the client identified as Aboriginal, Torres Strait Islander or both; 13 clients did not respond (missing data); 20 indicated ethnicity and 92 responded 'No' to the question.

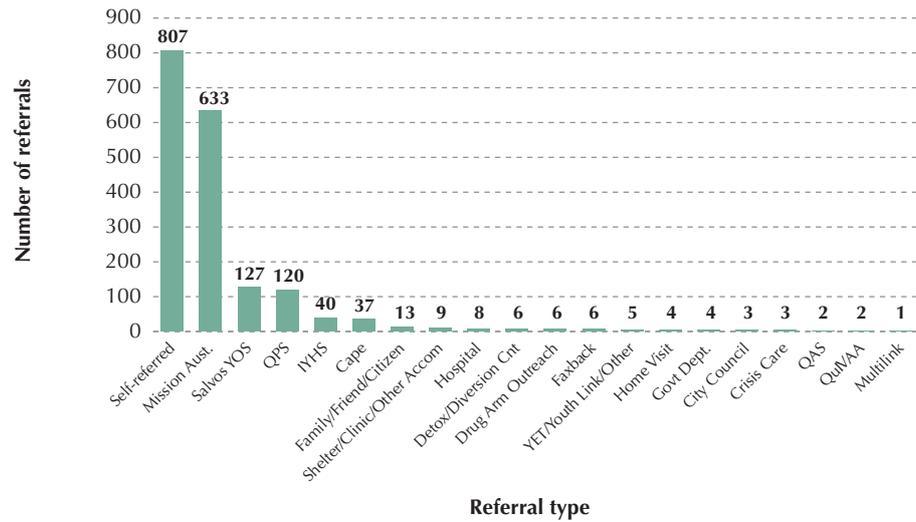
Table A-2: Contacts by designated places of safety (1 July 2004 – 31 March 2005)

Designated place of safety	Opening dates	Number of contacts	%
Cairns	1 July 2004	86	4.7
Brisbane — Salvation Army	3 September 2004	591	32
Brisbane — Mission Australia	3 September 2004	860	46.5
Logan	15 September 2004	257	13.9
Townsville	22 November 2004	28	1.5
Mount Isa	Early September 2004	26	1.4
Total		1848	100

Source: CMC place of safety client information forms

Note: Includes 19 Cape York clients referred by the Department of Communities (37 contacts). Cape York referred clients were referred to stay at a place of safety during the trial (due to shortages in shelter accommodation) but were not part of the trial. The place of safety received separate funding for these clients and they were removed in the individual trial site analysis.

Figure A-3: Client referral sources (1 July 2004 – 31 March 2005)



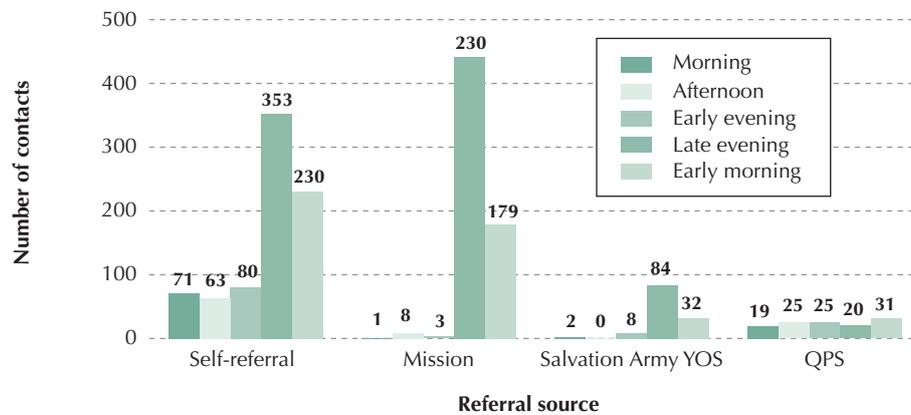
Source: CMC place of safety client information forms

Table A-3: Time of arrival (1 July 2004 – 31 March 2005)

Times	Frequency of contact	%
Morning (6 am – noon)	98	5.3
Afternoon (12.01 pm – 5 pm)	126	6.8
Early evening (5.01 pm – 9 pm)	162	8.8
Late evening (9.01 pm – midnight)	956	51.7
Early morning (12.01 am – 6 am)	494	26.7
No time specified	12	0.7
Total	1 848	100

Source: CMC place of safety client information forms

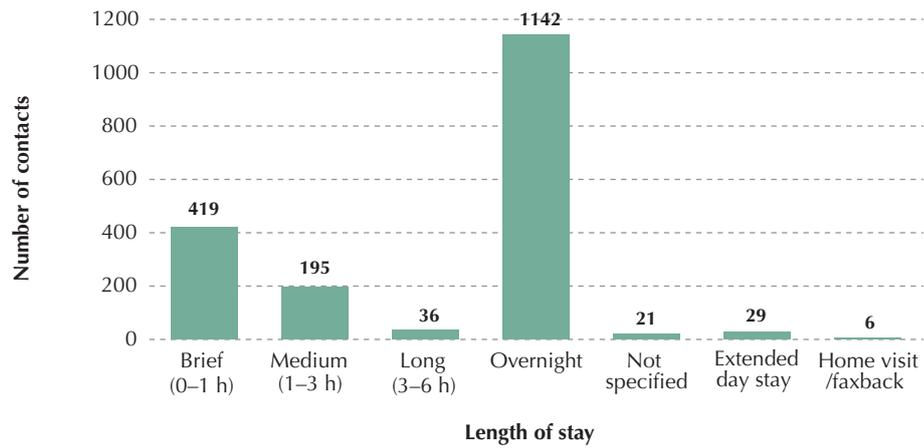
Figure A-4: Time of arrival by type of referral (1 July 2004 – 31 March 2005)



Source: CMC place of safety client information forms

Note: Only referral sources that resulted in more than 50 total contacts have been included; 12 records are missing referral sources, and in a further 12 cases time of arrival was not noted.

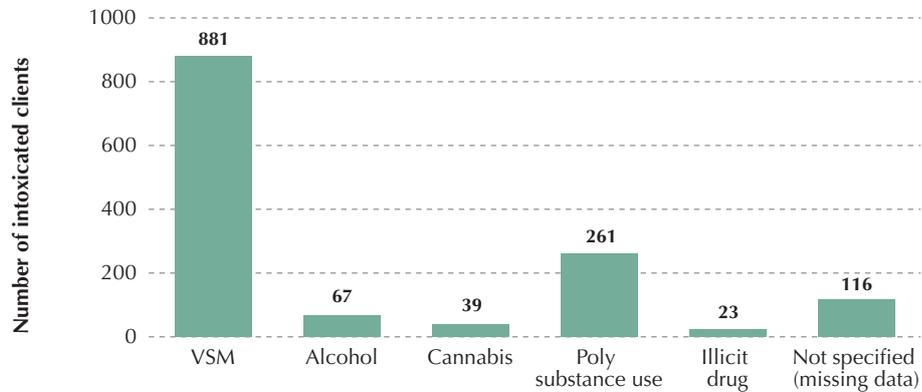
Figure A-5: Length of stay (1 July 2004 – 31 March 2005)



Source: CMC place of safety client information forms

Note: Extended day stays include longer than 6 hours but not overnight. Overnight stays represent a visit to a place of safety longer than six hours (a long contact), or any instance where the client made an early-morning contact with the place and used the facilities as accommodation for the period of a stay. This figure is a slight underestimate, as it includes a count of six nights for six clients who had consecutive overnight stays for durations of one week (1), one month (1), two months (1), three months (2), and one who currently still resides at the place of safety. Full counts have been excluded from the total as these six contacts are special cases; given their length of stay, they are not 'typical' clients.

Figure A-6: Type of intoxication (1 July 2004 – 31 March 2005)

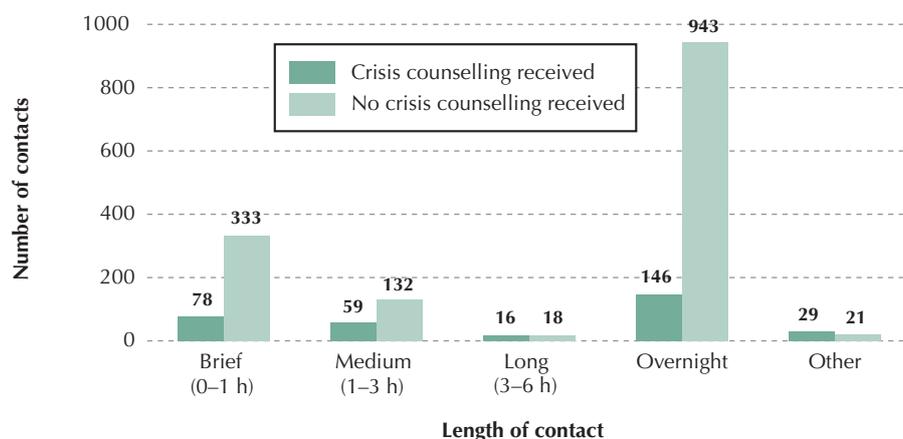


Source: CMC place of safety client information forms

Note: Information was not requested in 19 cases (1%), and for 63 cases (3%) the information was missing. In 379 cases (21%) clients were not intoxicated.

Crisis counselling

Figure A-7: Crisis counselling for length of stay (1 July 2004 – 31 March 2005)



Source: CMC place of safety client information forms

Notes:

- 1 'Other' represents extended day stays, faxbacks and time of stay not specified.
- 2 In 78 cases where crisis counselling was received, length of contact was brief. Broken down further, these cases represent: 11 contacts (15 minutes or less), 25 contacts (15–30 minutes), 11 contacts (30–45 minutes) and 31 contacts (45–60 minutes).

Client reconnection

Table A-4: Details of reconnection (1 July 2004 – 31 March 2005)

Type of reconnection	Frequency	%
Family/friends	507	79.7
Referral options provided	48	7.5
Refuge/shelter/place of safety/boarding house	16	2.5
Department of Communities	8	1.3
Department of Corrective Services	2	0.3
Crisis Care	3	0.5
Medical facility	10	1.6
Police	1	0.2
Own accommodation	4	0.6
Queensland Health	7	1.1
Department of Child Safety	2	0.3
Salvation Army	6	0.9
JPET (job placement, employment and training)	3	0.5
Not specified	19	3
Total	636	100

Source: CMC place of safety client information forms

Table A-5: Details of other accommodation (1 July 2004 – 31 March 2005)

Type of accommodation	Frequency	%
Family/friends	10	1.1
Refuge/shelter/place of safety/boarding house	11	1.2
Hostel	1	0.1
Indigenous Youth Health Service	1	0.1
Medical facility	1	0.1
Referral options provided	400	42.2
Own accommodation	6	0.6
Refused accommodation	7	0.7
Not specified	498	52.5
Not applicable	14	1.5
Total	949	100

Source: CMC place of safety client information forms

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