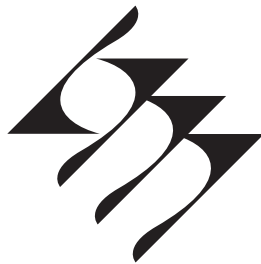


POLICE POWERS AND VSM: A REVIEW

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.

© Crime and Misconduct Commission 2005

Apart from any fair dealing for the purpose of private study, research, criticism or review, as permitted under the Copyright Act 1968, no part may be reproduced by any process without permission. Inquiries should be made to the publisher, the Crime and Misconduct Commission.

ISBN 1 876986 35 2

Crime and Misconduct Commission
140 Creek Street, Brisbane, Australia 4000

GPO Box 3123
Brisbane Qld 4001

Tel.: (07) 3360 6060
Fax: (07) 3360 6333
Email: mailbox@cmc.qld.gov.au

Note: This publication is accessible through the CMC website – www.cmc.qld.gov.au – for a limited period.

CRIME AND MISCONDUCT COMMISSION



GPO Box 3123
Brisbane Qld 4001

Level 3, Terrica Place
140 Creek St
(Cnr Creek and Adelaide)
Brisbane, Queensland

Tel: (07) 3360 6060
Fax: (07) 3360 6333

Toll Free:
1800 061 611

Email
mailbox@cmc.qld.gov.au

www.cmc.qld.gov.au

The Honourable A McGrady MP
Speaker of the Legislative Assembly
Parliament House
George Street
BRISBANE QLD 4000

Dear Sir

In accordance with section 371E of the *Police Powers and Responsibilities Act 2000*, the Crime and Misconduct Commission hereby furnishes to you its report, *Police powers and VSM: a review*.

The Commission has adopted the report.

Yours faithfully

ROBERT NEEDHAM
Chairperson

Foreword

Volatile substance misuse presents the Queensland Government with a complex challenge. While the inhalation of volatile substances such as petrol, paint, solvents or glue is not a criminal act, it does have serious negative consequences both for those engaging in such activity and for the community as a whole. For individuals engaging in this behaviour, the misuse of volatile substances is often a marker for more serious problems, including illicit drug use, other forms of substance abuse, and a range of welfare concerns. For the community, the safety and amenity of public places are important and relevant concerns, in addition to the broader responsibilities government has for the welfare and protection of citizens in need.

Under section 371E of the *Police Powers and Responsibilities Act 2000*, the CMC was required to undertake a review of the police powers contained in subsections 371B–371D of the Act. These powers were enacted as a response to the misuse of volatile substances, and were intended to enable police to provide an effective response to persons affected by a volatile substance by taking them to a safe place so that they may recover.

In conducting the review of the police powers over the last 18 months, the CMC is drawn to the view that the existing powers work well, but are capable of enhancement in the interest of a more effective police response to volatile substance misuse. The enhancements outlined in this report have been structured around three proposals. The first proposal is to augment the existing police powers to enable police to continue to hold an affected person in circumstances where no other appropriate agency or person is available. The second is to restructure the places of safety model into a more effective twin-model of sobering-up centres and client assistance services. The third is to require police to provide to the Department of Child Safety a record of all VSM-affected children apprehended by police.

These developments of the police powers are recommended expressly to promote the welfare of affected persons. The Commission views the recommendations offered in this report as consistent with the central aims of the government's broader policy framework for responding to volatile substance misuse.

I am confident that the report's recommendations will enable the government to more effectively respond to the volatile substance issue and provide affected persons with appropriate care and protection.

Robert Needham
Chairperson

Contents

Foreword	v
Terms and abbreviations	ix
Terms	ix
Abbreviations	ix
Acknowledgments	xi
Summary	xiii
Concerns about the trial powers	xiv
Enhancements required	xvi
Recommendations	xvi
Introduction	xxi
The legislation	xxi
An overview of this report	xxii
Background to the amendments	xxii
The government's trial response to VSM	xxiv
How the strategy was developed	xxiv
Scope of the CMC evaluation	xxv
Methodology	xxv
Quantitative methods	xxvi
Qualitative methods	xxix
Conclusion	xxxi
Chapter 1: Background: VSM explained	1
What is volatile substance misuse (VSM)?	1
Risks associated with VSM	2
Prevalence, patterns of VSM and associated populations	2
Interventions	3
Chapter 2: The role of the police	5
Introduction	5
Relationship with existing powers and approaches	6
Assessment of existing powers	6
Assessment of current approaches	8
Overview of current powers and approaches	11
Assessment of how the new powers have been implemented	12
Overview of the QPS process	15
Conclusion	15
Chapter 3: The trial powers in operation	17
Key objectives	17
Data sources	17
Police custody index data	18
Conclusion	25

Chapter 4: Stakeholder perceptions	27
Police perceptions	27
Designated places of safety staff perceptions	38
Queensland Ambulance Service staff perceptions	39
Hospital staff perceptions	40
Non-government sector perceptions	41
Perceptions in remote Indigenous communities	42
Conclusion	44
Chapter 5: Enhancing the police response to VSM	45
General findings	45
Concerns about the trial powers	46
Development of an enhanced approach	47
Modification to the designated places of safety model	49
The enhanced response explained	52
General police responsibility and related power within the broader VSM approach	52
Specific police powers and a better response to VSM	56
Clarification of other issues raised during the review	83
An important condition	87
Conclusion	88
Appendixes	91
Appendix A: Relevant legislation	91
Appendix B: Police online survey and analysis of results	94
Appendix C: Place of safety client information form	104
Appendix D: Place of safety client survey form	105
Appendix E: QAS information form	107
Appendix F: Queensland Health emergency department information form	109
Appendix G: Literature review	111
Appendix H: Analysis of QPS calls-for-service data and activity reporting index	125
Appendix I: Torres Strait Islands Health Management Committee organisational structure	128
References	129

Terms and abbreviations

Terms

chroming: sniffing or inhaling volatile substances for intoxication.

net-widening: activities by police that may result in increasing an individual's chance of becoming involved with the criminal justice system.

sniffing houses: private homes where young people meet to sniff or inhale volatile substances for intoxication.

volatile substances: substances that produce gases or fumes at room temperature; those that are misused include solvents, aerosols, gases and nitrates.

Abbreviations

AIHW	Australian Institute of Health and Welfare
ARI	activity reporting index
ATODS	Alcohol, Tobacco and Other Drug Services
CAD	computer-aided dispatch
CMC	Crime and Misconduct Commission
CRISP	Crime Reporting Information System for Police
OPM	Operational Procedures Manual (Queensland Police Service)
PPRA	<i>Police Powers and Responsibilities Act 2000</i>
QAS	Queensland Ambulance Service
QPS	Queensland Police Service
SOP	standard operating procedures
VSM	volatile substance misuse (also known as chroming)

Acknowledgments

The Commission is very grateful to the many people and agencies from both government and non-government sectors who contributed to the review. In particular, thanks are due to the Queensland Police Service, the Department of Communities, the Department of the Premier and Cabinet, the Queensland Ambulance Service, Queensland Health, the places of safety coordinators, the 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, Jennifer Epps and Derran Moss.

The evaluation of the operation of the trial police powers, however, required the dedication and commitment of a significant number of additional researchers. The research team responsible included Daniel Abednego, Kim Adams, Chris Cockerill, Eva Dacre, Kate Foote, Andrea Kanaris, Matt Vance, Jodie Walton, Jackie Wellen and Katrina Yettica-Bell, all of whom made important contributions.

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
Director, Research and Prevention
Crime and Misconduct Commission

Summary

Between 1 July 2004 and 31 March 2005, the Crime and Misconduct Commission (CMC) undertook a review of the use by police of new powers embodied in subsections 371B–D of the *Police Powers and Responsibilities Act 2000* (PPRA). These are ‘trial’ powers that can be exercised only for a defined period in five specified areas (Brisbane, Logan, Townsville, Mount Isa and Cairns). They were intended to provide police with an enhanced response to volatile substance misuse (VSM), as part of a broader government strategy aimed at more effectively directing welfare services needed by those engaging in VSM.

One key aspect of this broad strategic response is the ability for police to transfer children and young people intoxicated as a result of VSM to designated ‘places of safety’, which include special-purpose facilities managed by non-government organisations working on behalf of the government.

The success of the places of safety is not the focus of this report (it is covered instead in a separate report by the CMC, *The places of safety model: an evaluation*). This report focuses primarily on the police component of the government’s broader VSM strategy.

On the whole, the CMC review found that the trialled police powers have been useful as a central component of the broader government response to the difficult issue of VSM, but that there is scope for some enhancements. The Commission considers that the trial powers should be retained and extended statewide, subject to certain amendments and additions. Accordingly, it makes 26 recommendations, the first of which includes a proviso that the new powers be subject to a time limit. This is because it is important that agencies accept that the enhanced powers are not the solution to the problem of volatile substance misuse — they are designed to *support* a broader multi-agency response to VSM. A sunset clause will allow an opportunity to evaluate whether this has occurred. The CMC, which will be monitoring and reporting on the exercise of the powers, will be well placed to advise whether the sunset clause should be invoked or, alternatively, the life of the powers extended.

In advocating a sunset clause, the CMC is not calling into question the capacity of the police to use the powers appropriately when responding to VSM. Rather, it seeks to highlight the importance of stakeholders understanding that, although police are a critical contributor to the multi-agency response to VSM, they cannot be expected to assume primary responsibility for what is a welfare rather than law enforcement function. A failure to appreciate the significance of this point opens the way for the one major potential risk to effective implementation of the enhanced response to VSM favoured by the CMC. This risk is that the suggested changes to police powers come to be seen as an ‘end’ in themselves, rather than a ‘means to an end’.

The role of police when exercising new VSM-related powers is essentially to trigger the welfare-oriented therapeutic response. In most instances, primary responsibility for this response will be carried out either directly by the Department of Communities or indirectly by the non-government organisations funded by the department.

The CMC is also mindful of the fact that its enhanced response to VSM has workload implications for a range of agencies. In outlining a way forward, the CMC has therefore tried to ensure that any increases in workload do not fall disproportionately upon any single agency (such as police) and instead are part of already established core-business practices of a range of agencies in a way that is consistent with the broader policy objectives of government.

Concerns about the trial powers

It was obvious to evaluators early in the review that there were a number of problems with the operation of the trial police powers. These problems predominantly did not result from the way police used the powers; rather, they were a consequence of the limitations and resource demands that the powers placed on police. They can be summarised as follows:

- concerns over limits of current powers
- concerns over operation of current powers
- concerns over duty of care and liability in exercise of current powers
- concerns with the broader VSM approach.

Concerns over limits of current powers

There are limits to the police use of the current powers, and the scope and nature of the powers require clarification. For instance, under the current powers, police have:

- no power to require a person's correct name, address or date of birth
- no power to take further action where places of safety are not an option
- an obligation to transport potentially harmful things (confiscated volatile substances).

Concerns over operation of current powers

Police are confused about using the current powers in certain circumstances and are:

- uncertain of the interaction of the powers with questioning powers, issuing warrants and traditional arrest powers
- unclear of the scope of the search powers
- not convinced about the practical use of the specific Form 92 when releasing an affected person to a place of safety.

Concerns over duty of care and liability in exercise of current powers

The current powers do not empower police to respond effectively to protect affected people and the community. Issues raised include the following:

- Some places of safety are not safe and do not uphold a sufficient duty of care.
- There is a risk of injuries or deaths in custody.

Concerns with the broader VSM approach

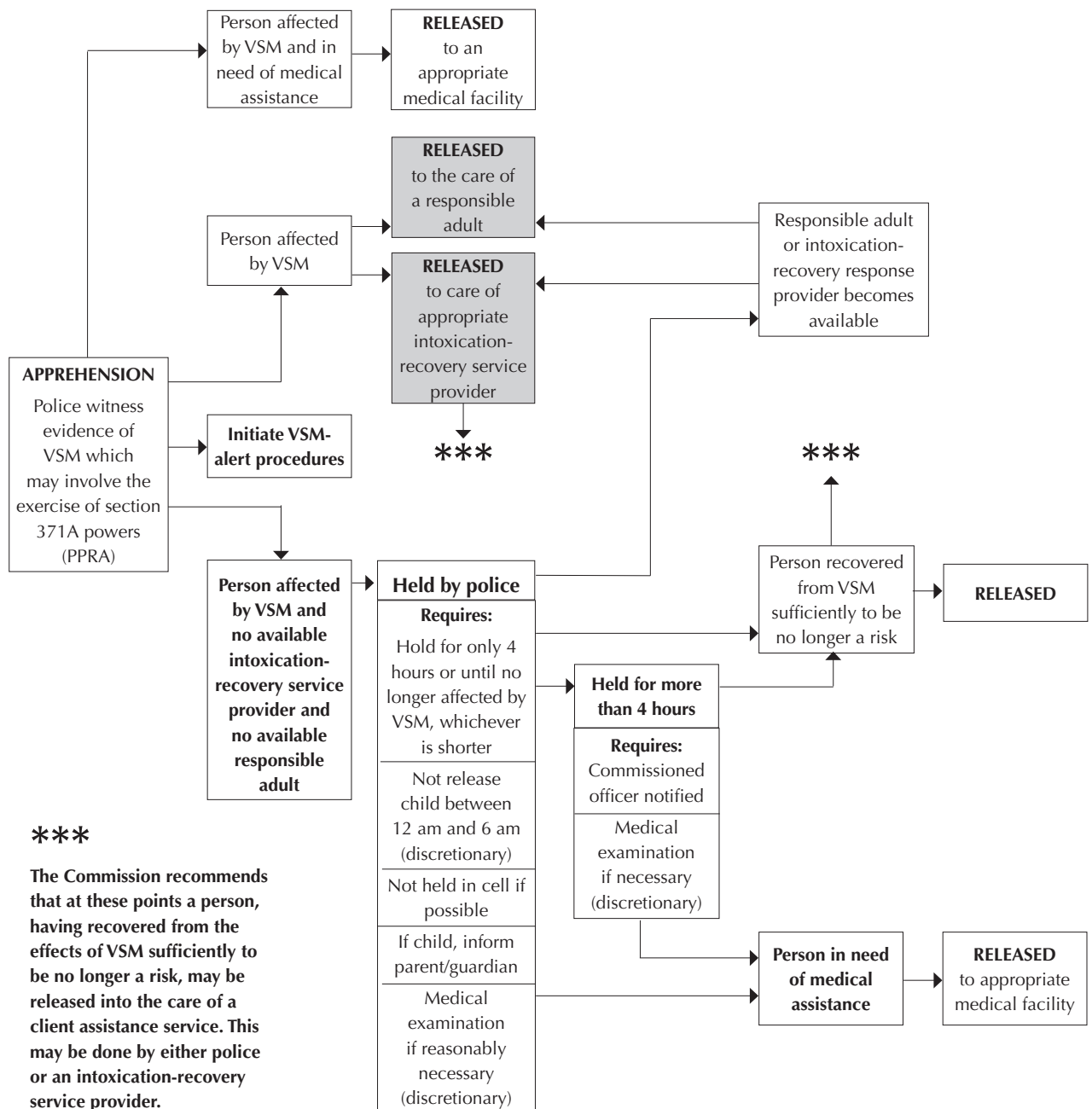
A recurrent issue was the need for increased coordination between police and other government agencies. It was felt that this would enable the development of appropriate immediate, medium-term and long-term responses to young people engaging in VSM and thereby provide a disincentive for use.

Police are concerned that:

- they are viewed as a taxi service
- they are being expected to act as health and social workers
- they are uncertain about the role of Queensland Health
- there is little interaction between government services.

In addition, police were not convinced that there were sufficient disincentives to engaging in VSM.

Figure S.1: Enhanced response — the proposed new model



There was also a perception among a diverse group of stakeholders that the responsibility for addressing the problem of VSM fell primarily on police. Police expressed concern both that they had been given insufficient authority and operational guidelines to effectively manage initial contact with VSM-affected young people, and that police were only the initial level of response to the issue and should not be expected to provide the critical follow-up health or social-work response.

Effectively addressing these issues provides the basis for developing a significantly enhanced police response to VSM.

Enhancements required

In total, the Commission makes 26 recommendations. These recommendations are centred on the perceived necessity for the police to have the following two key powers:

- the power to hold a person affected by VSM for a limited period, for the person's own wellbeing and for the safety of others
- the power to require a person affected by VSM to supply their name and address.

The Commission's recommendations support and give effect to these powers; some support the proposed modifications to the overall places of safety model. The Commission's proposed new model is presented diagrammatically in Figure S.1.

It must be noted that the current trial powers, on the whole, worked well. The Commission's proposed changes will simply improve the existing structure.

Recommendations

The Commission makes the following recommendations:

Fundamental proposal

Recommendation 1 — Retain and extend powers statewide

That the trial police powers relating to VSM be retained and extended statewide, subject to modifications to the operation of the designated places of safety and some amendments and augmentation of the trial police powers. These powers should be subject to a sunset clause, whereby after a period of three years of operation a decision would be made as to their retention or expiration.

Powers to support the places of safety modifications

Recommendation 2 — New duty to issue a VSM-alert

That it be mandatory for police to initiate a VSM-alert process to the Department of Child Safety whenever an affected child is apprehended under the VSM powers.

The VSM-alert process should take place as soon as reasonably possible after a child is apprehended and should include the child's name, address and condition at time of apprehension, and the police response.

Recommendation 3 — New power to require name and address

That, in support of the VSM-alert process, police be given the power to require a person's correct name and address when apprehending a person under

the proposed powers. Criminal sanction for non-compliance should only be enforced in exceptional circumstances.

Amendments to the police powers

Recommendation 4 — Police must be satisfied of need to use powers

That the police authority to exercise the apprehension powers require officers to be reasonably satisfied not only that a person is affected by the inhalation or ingestion of a potentially harmful thing, but also that the apprehension is necessary to protect the health or safety of the affected person or other persons.

Recommendation 5 — New duty to inform affected person

That, in the course of exercising the power to apprehend and detain affected persons, police should be obliged to inform the affected person that they are not under arrest and that they have been apprehended to prevent them causing harm to themselves or others.

Recommendation 6 — Police duty to release affected person

That it be made explicit that, where an affected person requires medical attention, police must release the affected person to an appropriate medical facility, or cause the person to be released to an appropriate medical facility.

Recommendation 7 — Police duty to release affected person

That it be made explicit that, where no medical emergency exists, police have a duty to release an apprehended person into the care of:

- a parent or guardian
- an intoxication-recovery service provider, or
- another suitable adult who is willing and able to provide the affected person with care and protection.

Further, that an adult not be considered suitable where, for example:

- there is a reasonable suspicion that the person will be at risk of or expose others to risk of violence at that place
- the affected person is an adult and objects to being released to the suitable adult, or
- the affected person is a child and objects to being released to the suitable adult and the officer is satisfied that the child is of sufficient age and understanding to make such a decision.

Recommendation 8 — New authority to hold affected person as last resort

That police no longer be required to release an affected person and may continue to hold an affected person as a last resort where:

- there is no intoxication-recovery service provider, parent, guardian or suitable adult available and willing to take care of the affected person
- the affected person's condition is such that they would be a risk to themselves or others if released to an intoxication-recovery service provider, parent, guardian or suitable adult, and
- the affected person would be a risk to themselves or others if they were simply released.

Recommendation 9 — Duty to notify

That, where police hold an affected child as a last resort, police take all reasonable steps to contact the child's parents, guardian or other relative. Where police hold an affected person who is an adult, police should ensure that the affected person is given reasonable opportunity to contact an appropriate person. This responsibility is distinct from the police responsibility to initiate the VSM-alert procedure to the Department of Child Safety.

Recommendation 10 — Duty to arrange medical examination

That, whenever necessary, police arrange a medical examination of an affected person held by police as a last resort. Where necessary, police must release an affected person to an appropriate medical facility.

Recommendation 11 — Duty to release as soon as possible

That an apprehended person held by police as a last resort be held for the shortest reasonable time, and be released when they have recovered from the effects of VSM sufficiently that they no longer pose a risk to themselves or others.

Recommendation 12 — Duty to release as soon as possible

That an apprehended person held by police as a last resort be held for the shortest reasonable time, and at any time after apprehension be released into the care of an intoxication-recovery service provider or suitable adult even if the affected person has not recovered from the effects of VSM sufficiently that they no longer pose a risk to themselves or others.

Recommendation 13 — Duty to release as soon as possible

That an apprehended person held by police as a last resort be held for no longer than four hours, unless exceptional circumstances indicate that a person is still affected by VSM and still poses a risk to themselves or others. Where a person is held for more than four hours, the attending officer must inform a commissioned officer of the decision and that decision must be affirmed. A record of the reasons for holding the affected person for more than four hours must be made and a medical examination arranged if necessary.

Recommendation 14 — Duty to act in the interests of the child

That the duty to release a person is at all times subject to the overriding principle of protecting the best interests of the child. Where it is in the best interests of a child to do so, a police officer may elect not to release a child between the hours of midnight and 6 am where they are being held by police as a last resort. This applies only where a child is no longer affected by VSM and would otherwise be released. This discretion does not affect the police responsibility to release a child to an appropriate facility or person during the hours of midnight to 6 am.

Recommendation 15 — Duty not to hold children in a cell or lock-up

That an apprehended child held by police as a last resort be held in a place other than a police cell or lock-up unless exceptional circumstances arise. An apprehended adult held by police in the same circumstances must be held in a place other than a police cell or lock-up unless it is impractical to do otherwise.

Recommendation 16 — Duty to segregate affected persons from people in custody

That a child held by police as a last resort be segregated from contact with any adult in custody, and that any person held by police in the same circumstances should be segregated from any other person held in custody for the commission, or alleged commission, of an offence.

Recommendation 17 — Police have no authority to charge or question children held as a last resort

That a person held by police as a last resort cannot be:

- questioned about any offence
- charged with any offence, or
- fingerprinted, photographed or otherwise subjected to a forensic procedure

while being held under the VSM powers.

Police duties on releasing apprehended persons

Recommendation 18 — Duty to record

That, where an affected person is held as a last resort, police record:

- where and when affected persons are held by police
- steps taken to contact an affected child's parent, guardian or suitable adult
- any reasons for detaining a person beyond four hours, and
- the manner, place and time of a person's release.

Recommendation 19 — Duty to ensure appropriate release procedure

That, when a person is released, a police officer take responsibility for:

- releasing the person in an appropriate place
- ensuring that the released person acknowledges in writing the time, date and place of their release where practicable
- ensuring that any person or facility into whose care a person is released acknowledges in writing the time, date and place of the release, as well as the name of the released person, their apparent condition and the name and registered number of the officer attending, and
- returning to the released person or to another person to whom an affected person is released any items that have not been destroyed or forfeited to the state or that would be inappropriate to be returned at the time of their release to an intoxication-recovery service provider or medical facility.

Clarification of scope of police powers

Recommendation 20 — Where police can exercise powers

That police exercise the proposed apprehension powers where a person is:

- in a public place
- trespassing on private property, or
- on private property and where the police are invited onto the property by the occupier or owner of the property.

Recommendation 21 — Police should avoid charging with offences

That, where reasonable, police avoid charging a person with offences committed during the course of their apprehension or detention under the proposed powers.

Recommendation 22 — Apprehended persons not to be seen as in lawful custody

That an apprehended person not be considered to be in lawful custody for the purposes of any law relating to escape from lawful custody.

Recommendation 23 — Execution of warrants must not be impeded

That the proposed apprehension and detention powers not be exercised in a way that would unduly impede the ability of police to execute warrants. Any warrants should be executed at the point at which an apprehended person would otherwise be released.

Recommendation 24 — Searching apprehended persons

That police holding a person as a last resort be given the power to search an apprehended person, including any items seized from them. Any potentially harmful thing seized from a person may be dealt with in the same manner as under section 371A of the Police Powers and Responsibilities Act. Items that are seized and not destroyed or forfeited to the state must be returned to the person when they are released.

Recommendation 25 — New power to dispose of potentially harmful things

That police be given the power to dispose of or otherwise make safe potentially harmful things that they are given or have seized from persons in exercise of section 371A of the Police Powers and Responsibilities Act.

Recommendation 26 — QPS to develop operational guidelines

That the Queensland Police Service develop detailed operational guidelines for police officers about existing police powers and any proposed new police powers. These guidelines should cover the matters that are the subject of Commission recommendations, including:

- clarification of the interaction of existing police powers with the current or proposed VSM-related powers to search and seize potentially harmful things and to apprehend affected persons, including a direction to use apprehension and detention powers as opposed to move-on powers
- best practice guidelines for releasing affected persons
- clarification of the role of QPS officers with other government services in the broader VSM-response plan
- clarification of the duty of care owed by police officers to affected persons and the limits of this duty, and
- clarification of the duties owed by police officers to affected persons.

Introduction

The misuse of volatile substances for intoxication (also known as ‘chroming’) has been an issue of increasing concern in Queensland in recent years, particularly since it often involves children, frequently in public places. In an attempt to reduce the harm caused by volatile substance misuse (VSM) and to allay related public anxiety, the Queensland Government sought to make a number of legislative changes as part of a broader strategy to address this problem.

The legislation

In December 2003 the Queensland Parliament passed amendments to the *Police Powers and Responsibilities Act 2000* (PPRA). The resultant *Police Powers and Responsibilities and Other Legislation Amendment Act 2003* expanded the existing limited powers of police to deal with public misuse of volatile substances, especially by children. The new powers are contained in subsections 371A–F of the PPRA and enable police to:

- search people
- seize dangerous substances
- detain people misusing substances in public
- transport them to nominated places of safety (see Appendix A for the full amendments).¹

On 1 July 2004 police began a 12-month trial of the last two of these four powers in five areas across Queensland (central Brisbane, Logan, Cairns, Townsville and Mount Isa).

Another amendment to the PPRA, subsection 371E, made the CMC responsible for monitoring and reviewing the operation of this trial legislation for a period of nine months from its commencement. In addition:

(2) The conduct of the review and the preparation of the report is a function of the CMC for the *Crime and Misconduct Act 2001*.

(3) In the course of preparing the report, the CMC must consult with the Minister.

(4) The CMC must give a copy of the report to the Speaker for tabling in the Legislative Assembly.

In complying with these legislation requirements, the CMC has also undertaken a separate but closely related evaluation of the designated ‘place of safety’ component of the government’s broader response to VSM. The companion evaluation was requested by the Department of Communities, and contains the CMC’s assessment of the functioning of the places of safety administered by non-government organisations on behalf of the department.²

1 The *Vagrants Gaming and Other Offences Act 1931* was also amended to include a prohibition on the sale of potentially harmful things (s. 37D). This provision was subsequently transferred to the *Summary Offences Act 2005* (s. 23).

2 See *The places of safety model: an evaluation*, which was publicly released at the same time as this report was tabled in the Queensland Parliament.

An overview of this report

This report focuses primarily on the police component of the VSM strategy, and reveals the outcomes of a comprehensive CMC evaluation of the operation of the trial police powers (s. 371B–D).

- This introduction looks at the issues surrounding the new trial legislation in Queensland, and explains the methodology used in the evaluation.
- Chapter 1 provides a literature review of the general issue of VSM, covering the detrimental impact of the practice and the groups most at risk (an expanded version of this review is in Appendix G).
- Chapter 2 reviews the specific nature of Queensland's trial police powers.
- Chapter 3 presents a range of statistical data relating to police exercising the trial powers.
- Chapter 4 highlights stakeholder perceptions regarding the operation of the 'places of safety' trial.
- Chapter 5 concludes by making a number of recommendations about police powers and the role of these powers as part of a broader response by government to VSM.

Background to the amendments

Specific legislation aimed at empowering police to deal with VSM was first enacted in June 2000. It involved the insertion of subsection 371A into the *Police Powers and Responsibilities and Other Acts Amendment Act 2000*. This was a late addition to the Amendment Bill by the Minister for Police and Corrective Services, the Honourable T A Barton, and was made at the urging of the Member for Gladstone, Ms Liz Cunningham, with little or no debate. Ms Cunningham had noted that:

One of the issues that continued to stand out in my electorate was the fact that police had questionable powers to remove the product from a person who was using the paint, solvent or glue.³

The section dealt only with the power to seize potentially dangerous substances, and read as follows:

Power to seize potentially harmful things

371A(1) This section applies if a police officer finds a person in possession of a potentially harmful thing in circumstances in which the police officer reasonably suspects the person is inhaling, or is about to inhale, the thing.

(2) The police officer may ask the person to explain why the person is in possession of the potentially harmful thing.

(3) If the person does not give a reasonable explanation, the police officer may seize the potentially harmful thing.

(4) On the seizure of the potentially harmful thing, the thing is forfeited to the State.

(5) In this section—

‘potentially harmful thing’ means a thing—

- (a) that a person may lawfully possess; and
- (b) that is or contains a substance that may be harmful to a person if inhaled.

Examples—

1. Glue.
2. Paint.
3. A solvent.

3 Ms Liz Cunningham MP, 21 June 2000, Queensland Hansard, p. 1831.

In September 2002 the Queensland Commission for Children and Young People prepared a report, in response to apparent increased public misuse of volatile substances, particularly by Indigenous children. This report made a number of recommendations, but primarily that a community engagement model be used to address VSM.

Then, in December 2003, as part of a broader amendment proposal to the PPRA and other legislative schemes, the Queensland Parliament enacted the *Police Powers and Responsibilities and Other Legislation Amendment Act 2003*.

A perceived need to involve police in a coordinated community response to the issue of VSM was clearly articulated in the second reading speeches and explanatory notes to these amendments. The Minister for Police and Corrective Services, the Honourable T McGrady, introduced the new powers by saying:

[Chroming] is a relatively recent phenomena [*sic*] that we must now address in the interests of the welfare of our children ...

I stress that the amendments I propose do not create a criminal offence for misusing a volatile substance. Instead, they allow police to take immediate action in the interest of the persons affected by a volatile substance.

Police officers will be permitted to search a person who appears to be affected by a volatile substance or who may be about to use a volatile substance for the purpose of seizing that substance. This is the first step to removing the danger.

Additionally, a police officer will be given the power to detain a person affected by a volatile substance and take that person to a place of safety, such as a hospital or a place that can provide a suitable level of care to the affected person. The power is provided to police in the interests of the welfare of an affected person.⁴

Enabling police to act in the welfare of people not otherwise able to take care of themselves was a consistent theme of this speech. This was reflected in the goals of the amendments described in further speeches to parliament, in the explanatory memorandum and in media statements. These goals can be best summarised as follows:

- provision of powers to allow police to participate in a whole-of-community response to a complex social problem
- bringing young people misusing substances in contact with a place of safety and a case management regime
- not making VSM a criminal offence, so as to divert persons from the criminal justice system.

These objectives were to be achieved by giving police the ability to remove potentially dangerous substances from an individual, in order to prevent continued or immediate use; and the power to detain and remove such intoxicated individuals to an appropriate place for care. The operation of the first power (that of search and seizure) is not under review by the CMC; however, tracking its development in conjunction with the current amendments will contribute to a fuller understanding of the development of the legislative response to VSM within Queensland.

4 Hon. T McGrady, 28 October 2003, Queensland Hansard, p. 4364.

The government's trial response to VSM

It must be emphasised that expanding police powers to deal with VSM is just one component of the government's broader trial response to the problem. This approach, announced in October 2003, mixes immediate responses, such as police powers, with longer-term demand-reduction strategies to address the underlying causes.

Immediate-response strategy

To deal with the immediate problem of substance intoxication, four key government agencies were recognised as pivotal:

- the Queensland Police Service (QPS) — to keep public order
- the Queensland Ambulance Service (QAS) — to address health and safety
- Queensland Health — to provide hospital treatment, including the Alcohol, Tobacco and Other Drug Services (ATODS) response
- the (then) Department of Families — to provide child protection services.

Longer-term strategy

To help address the longer-term problems of VSM, the government advocated a demand-reduction approach centred on a 'places of safety' model. These places of safety would provide links to:

- crisis or social support
- assistance to remain in school or training
- help with alternative educational methods and options
- assistance with engaging in activities or otherwise finding a constructive alternative to VSM.

How the strategy was developed

The government's strategy was developed through various initiatives and with wide community input.

It was influenced by the CCYP's 2002 report on VSM. At the time, VSM was emerging as a highly visible issue in some communities, attracting media coverage and generating widespread community concern.

The CCYP had proposed that a community engagement strategy be adopted to combat substance misuse. This is based on the idea that localised community-based responses, involving collaboration between government agencies, non-government agencies and community members, are generally the most effective way of dealing with local problems. While the report outlined the phases involved in developing such a strategy, it did not make recommendations about any supporting legislative changes.

The government became formally aware of the increasing problems of VSM through the Ministerial Regional Communities Forum process,⁵ and subsequently flagged it as a priority issue. State government agencies such as the Community

5 A consultative process enabling people in regional Queensland to have a say in government policy, program development and decision making.

6 Examples of these groups include the Cairns Inhalant Action Group, the Mount Isa VSM Action Group, the Townsville Practitioners Group, the Wide Bay Interagency Working Group, the Brisbane City Region Inhalant Abuse Learning Project, the Inala Inhalants Working Group, the Ipswich Management of Public Intoxication Program and the Rockhampton-Capricornia Coast VSM Committee.

Engagement Division, Department of the Premier and Cabinet, QPS, Queensland Health and the then Department of Families became involved in the formation of local community-based working groups in several urban and regional centres.⁶

These working groups developed strategies for dealing with VSM and identified legislative issues that needed attention. The concerns included:

- only limited police powers to detain and move a person to a place of safety
- no ability to ensure that inhalant users seek or receive appropriate treatment
- uncertainty on the part of retailers about their rights to deny the sale of potentially harmful products to customers who, they suspect, will use the product as an inhalant
- restrictions on the capacity of the health system to provide treatment to minors under 15 years of age without parental consent.

In November 2002 the government set up the Queensland VSM Steering Group, with responsibility for developing a strategic, multifaceted framework for dealing with VSM.

The steering group designed a statewide immediate-response protocol to be used at the local level, and a longer-term demand-reduction strategy, based on places of safety.

The place of safety could be a hospital if medical treatment was needed, a person's home, or an alternative place if the home was unavailable or inappropriate.

In early 2004, funding of \$2.5 million was sought from the Commonwealth Government for a trial of a designated places of safety model. In May of that year, the Commonwealth sent a variation to the Deed of Agreement to the Queensland Illicit Drugs Initiative (QIDDI), confirming the approval to spend funds on the VSM prevention project.

After consultations between the Department of Communities and key stakeholders in five trial areas during March and April 2004, a select tender process was begun in May 2004 with non-government organisations for the place of safety service; this was finalised in July 2004.

Scope of the CMC evaluation

In its review of the trial police powers, the CMC used as a guide the wording of the PPRA legislation, which required that it keep the operation of subsections 371B–D under review for nine months after commencement. CMC evaluators therefore collected police and other data for the period 1 July 2004 – 31 March 2005.

Methodology

Evaluators used a wide range of qualitative and quantitative methods to monitor and review the operation of subsections 371B–D of the PPRA.

The evaluation consisted of the following key components:

- Measure the frequency with which the trial police powers are used.
- Analyse the context in which the powers are used.
- Identify the types of referrals to places of safety.
- Assess issues of potential 'net-widening'.
- Assess compliance by police with conditions of the trial police powers.

- Identify reasons for any noncompliance.
- Assess the nature of linkages with other stakeholders (ambulance and hospital).
- Assess perceptions of the overall usefulness and effectiveness of trial powers.
- Consider how the effectiveness of the trial powers could be improved.

Quantitative methods

CMC researchers used quantitative sources that included a range of administrative information from government agencies, as well as primary data collected through survey instruments and other paper-based evaluation collection forms developed specifically for this review.

They compiled identifying information from a number of sources, to determine both the overall number of police contacts and the number of individuals involved. This process revealed an individual's contacts with the police and also their interactions with other stakeholders, such as the places of safety.

As the police powers are only one component of the broader whole-of-government response to VSM, the evaluators also took into consideration the links between the operation of the police powers and the roles and responsibilities of three other government agencies in their response to VSM. These agencies were Queensland Health (emergency departments), the QAS and the Department of Communities (through the operation of the place of safety strategy).

Police data

Custody index

As part of police policy, a custody index record should have been made every time police detained a VSM-intoxicated person in the trial areas. Evaluators received monthly data from the Queensland Police Custody Index for the period of review (1 July 2004 – 31 March 2005). Details included:

- officer particulars
- intercepted person details
- full event details, including timings from the point when police first came into contact with and detained someone to the point when they released the person.

Each record describes the actions taken by police, using a series of codes.

The CMC received extracts that had been coded as VSM incidents. During the early stages of the trial they realised that some custody index records might have been missing or incomplete. Consequently, the evaluators requested additional data; from February 2005 all records met the amended criteria.

As well as recording core data in the custody index, police officers were asked to answer a series of questions in the comments field at the end of each VSM-related record. These questions were:

- type of potentially harmful things misused, or seized by police
- number of people approached
- the age, sex and Indigenous status of all group members
- reason for approaching the group or individual (e.g. observed person inhaling a substance)

- number of people suspected of inhaling or ingesting potentially harmful things
- number of people invited to take advantage of a place of safety
- number of people who accepted the invitation, and number detained
- reasons for accepting or rejecting the place of safety option (with age, sex and Indigenous status indicated)
- description of the incident
- description of the outcome, including release location
- any other matters the officer believed relevant.

Throughout the trial period, the QPS carried out an internal checking process of custody index entries. This involved ensuring that all records were correctly recorded as VSM, and that other entries which should have been recorded as VSM were amended. When an amendment was required, the district officers or the VSM contact officers in the trial areas were notified, and the responsible officer was asked to make the amendment. To enable the evaluators to take into account any changes made to custody index records, each monthly data extract was also accompanied by a backdated extract of data to 1 July 2004.

Even with these measures, there were some data limitations with the custody index information. These included:

- missing custody index records, where other data sources indicated that a custody index record should have been received
- possible data inaccuracies in the recording of name, address and date of birth in the custody index (due to inability of the police under the trial powers to require these details from a person)
- evidence of incomplete records (e.g. missing date)
- mistaken and/or incorrect use of the VSM code.

Activity reporting index

The activity reporting index is used by operational police to record details of observations or interactions with people. Police may opt to use this index to record details of when they have used section 371A (search and seize). As this is not mandatory, the data should be regarded as indicative only of the extent of police contacts with VSM-affected people.

Data from this index were for the period 1 July 2003 – 30 June 2004 and included the date, time, location and details of VSM. The extract given to the CMC was obtained using key VSM-based search words.

Calls-for-service data

The QPS calls-for-service data encompass information about incidents where police have been called to attend. They do not include information about officer-initiated 'jobs' such as those encountered by autonomous units like police beats. Details recorded in this system include location, day, time, reported job code, verified job code and action taken. As with the activity reporting index, there is no requirement to mention VSM in the job description, and, when it is mentioned, it may be described in a number of ways. Therefore these data should be regarded as indicative only of the nature and extent of police calls for service for VSM.

Police survey

Evaluators developed a survey for Queensland police officers to explore their experiences and perceptions of the operation of the trial police powers. The survey asked about officers' experiences when dealing with VSM-affected individuals, their level of understanding about the trial, the training they had received, and their perceptions of the effectiveness of the trial powers.

A total of 900 operational police officers, both within and outside the trial areas, were randomly sampled. Before the survey began, endorsement was received from the Police Commissioner; accordingly, officers were encouraged to participate. The survey was electronically administered. At the end of the three-week survey period in mid-March 2005, electronic data were forwarded to the CMC.

The response rate from the 900 officers was disappointing (60 officers, or 7%). Results (see Appendix B) are unlikely to be representative and must be interpreted with care. There is a range of possible explanations as to why operational police chose not to complete the survey, including the absence of any notable problems with VSM in their day-to-day operational duties or, conversely, a belief that any comments about problems with VSM would go unheard. In the absence of further information, it is not possible to know the reason.

Criminal histories

To assess any possible 'net-widening' effects⁷ of the trial police powers, evaluators carried out criminal history checks for all juveniles who had come into contact with the trial, through the police, ambulance, hospital or a place of safety. Criminal histories were coded to include total offences, the number of offences before first contact (with trial), the number of offences after first contact (with trial), and the number of offences that occurred on the same date as the first police contact.

Places of safety

From 1 July 2004 to 31 March 2005, each place of safety recorded information about clients using their services. A client information form and a self-administered client survey were developed for this purpose.

The client information form captured details such as date and time of arrival, the referral source, whether intoxicated on arrival, whether the client required medical treatment or crisis counselling, details of case management strategies considered and implemented, and the date and time of departure (see Appendix C). A client contact was defined as each appearance at a place of safety; therefore a person presenting at the service more than once on the same day would be counted as multiple contacts. Contacts could range from a few minutes to a number of weeks. Any discrepancies in data were followed up with the place of safety service provider.

The client survey recorded basic information about the person accessing the place of safety service and covered current accommodation, education and income status, levels of VSM, reasons for use, other people's awareness of the respondent's use of volatile substances, reasons if any for wanting to stop using volatile substances, other drug use and how the place of safety was perceived (see Appendix D). Evaluators received these surveys periodically throughout the trial.

7 'Net-widening' is a term used to describe activities by police that may result in increasing an individual's chance of becoming involved with the criminal justice system.

A monthly return, capturing aggregated client information, was used as a checking mechanism for the client information forms. Some services did not complete these returns.

Queensland Ambulance Service

Due to limitations in accessing ambulance data through administrative systems, a paper-based information collection form was designed for recording all contacts between paramedics and people affected by volatile substances. This form included personal information, time, date, location and source of contact, intoxication status and impairment, and ambulance response (see Appendix E). The QAS's medical director initially collated these forms before forwarding them to the CMC.

Queensland Health (emergency departments in trial areas)

There were similar limitations with extracting Queensland Health data, so a paper-based information collection form was also developed. The form was to be used with each new patient contact, to gather information about the date, time, method of referral, intoxication status and impairment, treatment provided, time they left the hospital, and whether the person had been collected by the place of safety (see Appendix F).

Additionally, some hospitals supplied electronic data from administrative systems at the end of each month. This information did not have the same level of detail as that of the paper-based forms.

Twenty Queensland hospital emergency departments also gave VSM presentations data for the review period. These gave a comprehensive statewide picture of emergency department interactions with VSM-affected individuals, but did not contain identifying personal details and therefore could not be used as a substitute for other information received.

Qualitative methods

The CMC carried out the qualitative component of the evaluation by structuring consultations with stakeholders around either two or three phases. In addition, contact between CMC researchers and stakeholders occurred throughout the entire trial period.

Before the data collection stage, CMC researchers visited each site to meet with stakeholders and describe the evaluation process. The consultation phases were held about two months apart and started in July 2004. Representation at these meetings depended on rostering and other operational priorities for government agencies, and on interest and availability for non-government and community stakeholders. The key findings from these consultations are presented in Chapter 4.

Police consultations

Three consultation phases were held with police officers; these consisted of meetings or workshops, according to the number of officers in attendance. Consultations were semi-structured and involved a presentation by CMC researchers about the trial and the evaluations, followed by open discussion about officers' experiences and concerns about the trial police powers. The first phase focused on police training, policies and procedures; the second phase covered experiences with the powers and any emerging issues; the third phase centred on the operation of the powers.

Places of safety

Consultations with places of safety coordinators took place during three visits to each trial site. There was also ongoing email and phone communication throughout the trial period, and all coordinators attended a meeting in Brisbane in April 2005 to discuss their overall perceptions of the trial. The CMC researchers were able to attend more regular face-to-face meetings at the Logan and Brisbane places of safety (which were also the highest-volume centres) because of their closer proximity to the CMC's premises.

Discussions with coordinators were semi-structured and explored all aspects of the operation of the service, interactions with other service providers (government), and outcomes of the service delivery.

Hospital and ambulance

Evaluators held three phases of consultations with hospital and ambulance staff, although some stakeholders did not participate in all three; this was due to unavailability, or limited interest in making these consultations a priority.

Consultations were a mixture of interviews and group discussions, depending on the number of staff involved and the topic.

Non-government and community sector consultations

Evaluators carried out two phases of consultations (input committees) with non-government and community stakeholders during September and October 2004 in each trial area. CMC researchers were also in contact with this group throughout the trial period.

Invitations to meetings were widely circulated throughout the youth and youth justice sectors through existing email networks, drug and alcohol forums, regional health networks, Indigenous email forums, local government networks, interagency community networks and Department of Communities networks. Stakeholders were encouraged to further circulate the invitation.

CMC researchers also asked organisations to attend interviews to discuss issues in more depth, or to raise other matters. Youth workers, outreach workers, Indigenous Elders, Indigenous health workers and crisis shelter staff were among the stakeholders who took up this opportunity.

Additionally, in November 2004, the Department of Communities set up and chaired a VSM Community Reference Panel. The purpose of this group was for key agencies from the non-government sector to meet monthly with the department and the CMC to discuss the VSM trial response.

Interviews with young people

Between September 2004 and January 2005, and again in May 2005, evaluators held two sets of interviews with young people involved in VSM.

The first round of interviews was semi-structured and took place at youth drop-in centres, places of safety or a park, in conjunction with outreach sessions. Researchers first explained the process and sought informed consent from the young person. Involvement was voluntary and participants could stop the interview at any time. Interviews were tape-recorded, although participants were given the option to refuse this. Participants were given chocolates and chips as an incentive and as a gesture of appreciation for their contribution.

The second interviews were held in May 2005 at the inner Brisbane places of safety after they had closed for the morning. These interviews were for young people aged between 12 and 17 years who had stayed overnight at either of the two sites at least once. Content was based on the client survey, with two additional questions on interactions with ambulance and police. Researchers explained the survey and asked for participants' consent. Interviews took from 10 to 15 minutes and were not tape-recorded. Interviewees received two movie tickets as thanks for their participation.

Conclusion

The misuse of volatile substances, particularly by young people, has been an issue of increasing concern in Queensland for several years.

To help address this issue, the Queensland Government developed a broad community engagement strategy. As part of this, amendments were made to the *Police Powers and Responsibilities Act 2000*, giving police trial powers to detain and subsequently transport VSM-intoxicated people to designated places of safety, even though VSM is not in itself a criminal offence.

The CMC was made responsible for monitoring and reviewing this trial legislation for a period of nine months after its commencement. CMC evaluators took a comprehensive and appropriate approach to objectively assess the operational effectiveness of the police response. Methods included collecting data from police systems, and conducting surveys of police officers and place of safety clients.

As well, evaluators carried out a comprehensive consultation process with stakeholders, to highlight operational problems or deficiencies in the places of safety service delivery model.

1

Background: VSM explained

This chapter provides a brief overview of the literature about volatile substance misuse. A fuller review of the academic and government literature on VSM, its related health effects, patterns of misuse, associated societal factors, and intervention programs aimed at responding to these issues is provided in Appendix G.

What is volatile substance misuse (VSM)?

VSM may be understood as ‘the deliberate inhalation of a gas or fumes released from a substance at room temperature, for the purpose of intoxication’.⁸ In Australia, approximately 250 products have been identified as containing potentially intoxicating inhalable substances.⁹ These are commonly divided into four main classes:¹⁰

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

Many of the products containing substances that may be inhaled for the purpose of intoxication are commonly used as part of everyday household maintenance and management. These products are both legal to possess and readily available for purchase in mainstream retail outlets. Each contains chemical compounds of varying degrees of toxicity, and many appear on Queensland Health’s list of common poisons.¹¹ The relative toxicity associated with the inhalation of volatile substances depends on the specific nature of the chemical compound(s) found in the product used, and each substance varies in terms of its pharmacological effects. However, all volatile substances have in common the short-term effect of depressing the central nervous system.¹²

The acute effects of VSM result from the suppression of inhibitory responses within the central nervous system.¹³ 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

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

9 *ibid.*

10 QPS 2004c.

11 Queensland Health 2003.

12 Chick & Cantwell 1994; Drugs & Crime Prevention Committee 2002a, p. 54.

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

coordination and headaches.¹⁴ In some instances, prolonged use of volatile substances has been reported to result in hallucinations of significant duration and intensity.¹⁵ The Drugs and Crime Prevention Committee (2002b) estimate that the short-term effects of VSM last approximately 5–45 minutes after inhalation.

Risks associated with VSM

Depending on the compound inhaled, this practice has been shown to be associated with increased risk of cardio, respiratory, renal, antenatal and neurological damage as well as neurobehavioural impairments.¹⁶

Of particular note are a number of clinical cases showing that ‘recreational’ inhalation of either trichlorofluoromethane or butane may contribute to a condition in which the heart becomes overly sensitive to adrenaline, so that exertion at the time of exposure may lead to a heart attack.¹⁷

In addition, the confusion and cognitive distortions that occur as an immediate result of VSM place those involved at increased risk of causing physical harm to themselves or others.¹⁸

Prevalence, patterns of VSM and associated populations

Involvement in VSM appears most common among young people aged between 13 and 15 years.¹⁹ The majority of young people who engage in VSM do so socially or experimentally, with a small proportion subjecting themselves to regular exposure over several years.²⁰

Volatile substances are seldom an individual’s drug of choice; rather, they are a cheap and easily accessible alternative when other drugs are not available.²¹ 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.²² Indeed, chronic VSM during youth is associated with polydrug use, and with substance abuse problems in later life.²³

Youth inhalant misuse is also associated with school failure and drop-out, family dysfunction and abuse, crime and delinquency, mental health problems and

14 Benignus 1981a; Bingham, Cohns & Powell 2001; Ellenhorn et al. 1997; Stollery & Flindt 1988; Zenz 1988; Zenz, Dickerson & Horvath 1994.

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

16 ATSDR 1993, 1995, 2000; Benignus 1981b; Bingham, Cohns & Powell 2001; Chalmers 1991, cited in HealthInfoNet 2001; Cleland & Kingsbury 1977; Doring et al. 2002; Echeverria et al. 1991; El-Menyar, El-Tawil & Al Suwaidi 2005; Foo, Jeyaratnam & Koh 1990; Gosselin, Smith & Hodge 1984; Gray & Lazarus 1993; Groppi et al. 1994; Lewis 1996; Siegel & Wason 1992; Stollery & Flindt 1988; US Air Force 1989; US Environmental Protection Agency 1994a, b; Watson, Gibler & Hassan 1986; Williams & Cole 1998; World Health Organisation 1989, 1990; Zenz 1988; Zenz, Dickerson & Horvath 1994.

17 American Conference of Governmental Industrial Hygienists 1991; Bland et al. 1998; Ellenhorn & Barceloux 1988; Fuke et al. 2002; Goodman & Gilman 1975; Haddad 1990; Rohrig 1997; Zenz, Dickerson & Horvath 1994.

18 Drugs & Crime Prevention Committee 2002b; Field-Smith et al. 2002; Garriott 1992.

19 Beauvais 1992; Beauvais & Oetting 1987, cited in Toumbourou, Dimsey & Rowland 2004; Indian and Inuit Health Committee 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 1999b.

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

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

22 Department of Human Services 1996; Makkai 1994.

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

cultural disintegration.²⁴ Rather than being the cause or result of any one of these issues, however, VSM is perceived to be just one of a number of psychosocial problems associated with vulnerable or socioeconomically disadvantaged populations.²⁵ 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.²⁶

Interventions

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.²⁷ 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, often more dangerous substances.²⁸ Similarly, although media campaigns in the United Kingdom targeting the parents and caregivers of young people have been found to be associated with a reduction in the recorded number of VSM-related fatalities,²⁹ those targeting children have been criticised for promoting the practice.³⁰

Researchers argue that a range of intervention strategies need to be employed to address VSM and associated issues. Specifically, it is suggested 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 peer and family interactions.³¹

Strategies that systematically respond to the problems associated with each of these factors are perceived to hold the greatest promise in terms of systematically reducing the prevalence and impact of VSM. It must be stressed, however, that in order to bring about interventions of this nature a strong commitment must be obtained both from the community and from government stakeholders.³² In particular, researchers highlight the need for these stakeholders to collaborate in the development and implementation of social change initiatives, and to ensure that the capacity and the infrastructure supporting these initiatives are sustainable and conducive to achieving the intended outcomes.³³

24 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.

25 Loxley, Toumbourou & Stockwell 2004.

26 Casswell 1992 & Gfeller 1994, both cited in World Health Organisation 1999b; Health Canada 1999.

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

28 Taylor et al. 1997.

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

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

31 d'Abbs & MacLean 2000.

32 *ibid.*

33 d'Abbs & Brady 2003.

2

The role of the police

This chapter outlines, in two parts, the role of the police in responding to VSM. It first describes components of the new police powers embodied in the PPRA and compares these with other powers and approaches that police can use to assist people in need of care. It then examines whether the QPS has set up an adequate process to help officers use the new powers.

Introduction

The amendments to the PPRA were made to fill a perceived gap in legislation and allow police to deal more effectively with VSM.

Some of the existing deficiencies were noted by the Member for Gladstone, Ms Liz Cunningham.

Previously, if young people were found by police officers not actually ingesting or inhaling the spray substance but it was evident that they were about to or had been but had hidden the implements or the actual paint, the police were powerless to act. The new power contained in this legislation gives the police the ability, where there is a reasonable suspicion, to be able to intervene. (Hansard, 25 November 2003, p. 5058)

The new section 371A search and seizure power enabled police to act in circumstances in which they had a ‘reasonable suspicion’ that a person was in possession of a potentially harmful substance. The provisions applied to both adults and children.

The amendments also empowered the police to apprehend and detain a person affected by a potentially harmful thing (s. 371B), and made them responsible for removing them to a place of safety (s. 371C). Both of these sections were only operable in the ‘declared locality’ (trial sites) stipulated in the Act; they are summarised below.

Section 371B:

Where a police officer is satisfied that a person is affected by the inhalation or ingestion of a potentially volatile substance, and the police officer considers that the person can be appropriately cared for at a place of safety, then the police officer may detain the affected person for the purpose of taking them to the place of safety. Thus, before apprehending and detaining a person, a police officer must be satisfied of two things: first, that the person is affected by a potentially harmful substance; and, second, that it is appropriate to take the person to a place of safety. Where these two elements are satisfied, a police officer may apprehend and detain a person, despite the fact they have committed no crime and otherwise been in breach of no law.

Section 371C:

Where a person has been apprehended and detained by a police officer under s. 371B, that person must be taken to a place of safety and released to that place of safety. However, a person must be simply released where a place of safety is unwilling or unable to take the person, the person may pose a risk to others at a place of safety or no place of safety can be located subsequent to the person being apprehended.

Relationship with existing powers and approaches

The amendments obviously sought to direct welfare to those affected by VSM, and to increase public safety in the Queensland communities where VSM was taking place. To test the success of these trial powers (PPRA, s. 371B–C), and consider the need for further changes, the CMC reviewed the range of other relevant powers and approaches that the police could potentially use to address VSM.

It is difficult, however, to draw direct parallels between existing police powers and the trial powers under review. For instance, police have clear powers to arrest and detain people, including children, without a warrant if there is a reasonable suspicion that the person has committed or is committing an offence (PPRA, s. 198; Juvenile Justice Act, s. 13); but the trial powers do not relate to whether an offence was involved. In fact, there is no Queensland law that makes the misuse of a volatile substance a criminal act, nor is intoxication as a result of VSM a criminal act. This means that, under the existing laws, police are unable to arrest or detain a person who is misusing a volatile substance unless they are also committing a criminal offence.

Police do have some powers to apprehend and detain for the purpose of an individual's welfare. Another section of the PPRA (s. 210) directs police officers to discontinue arrest proceedings of a person intoxicated by alcohol (including methylated spirits), where it is more appropriate to take the person to a place of safety. Although this can only be triggered through the arrest of the person for an offence (i.e. being drunk in a public place), the primary focus of the discontinuation power is to divert people who are intoxicated into a non-judicial response. More explicitly, the *Child Protection Act 1999* authorises police to take a child into custody where the officer reasonably believes that the child is at risk of harm (s. 18), and to move a child under the age of 12 years to a 'safe place' if they consider the child to be at risk and no parent is available (s. 21).

Assessment of existing powers

The CMC assessed the relevance and appropriateness of existing police powers used for dealing with people in need of care, as they apply to those affected by VSM. These are the:

- arrest power
- move-on power
- breach of the peace power
- prevention of offences power.

Arrest power

Arrest powers are an unsatisfactory response to VSM. People engaging in VSM cannot, and should not, be subjected to arrest, which focuses on preventing crime, enforcing laws and detaining suspected offenders. Moreover, arresting a person does not guarantee that they will consequently receive necessary therapeutic or welfare services.

Move-on power

The move-on powers do not authorise police to take a person into custody. Rather, they allow police to direct a person to move away from a designated area (PPRA, s. 39). Such a direction may be based on a person's behaviour or presence causing anxiety or concern to others. While this may achieve the goal of removing VSM-affected individuals from public sight in public spaces, it does nothing to address

the problem of VSM itself. The Commission can see little use in simply moving a VSM-affected person from one public space to another.

The Commission reiterates that any response to VSM must not only address the issue of maintaining public safety and public amenity, but also, and more importantly, must address the issue of the safety and welfare of affected people. Move-on powers are, at best, only a partial response to the former and provide no assistance for the latter. The Commission believes that VSM needs to be regarded as more than a public nuisance issue. Instead, it should be understood as symptomatic of deeper problems that need to be dealt with by way of social services, health care and community development.

Breach of the peace power

Section 42 of the PPRA authorises police to ‘take the steps the police officer considers reasonably necessary’ to prevent a breach of the peace occurring or continuing, even where such conduct may be otherwise legal. This power includes the right to detain a person until the need for the detention no longer exists. The Commission does not, however, view this power as being an appropriate response to VSM.

The QPS Operational Procedures Manual details what would constitute a breach of the peace, noting that:

In Halsbury’s Laws of England (4th ed.) para 108 it is stated: ‘for the purpose of the common law powers of arrest without warrant, a breach of the peace arises where there is an actual assault, or where public alarm and excitement are caused by the person’s wrongful act. Mere annoyance and disturbance or insult to a person or abusive language, or great heat and fury without personal violence, are not generally sufficient.’

It is therefore unlikely that the conduct of a VSM-affected person would ordinarily constitute a breach of the peace, and using these powers offers police insufficient operational capacity to respond effectively to these incidents. Perhaps more importantly, the breach of the peace powers give police no duty, nor capacity, to provide VSM-affected people with appropriate care and protection.

The Commission notes, however, that this power does authorise police to apprehend and detain an individual in circumstances where they have committed no offence. The reason for the detention is preventive, for the sake of both the detained person and others.

Prevention of offences power

Section 44 of the PPRA authorises police to ‘take steps the police officer considers reasonably necessary to prevent the commission, continuation or repetition of an offence’. No example is given of a police officer detaining a person, but it does include examples of giving a person direction to leave a place, forcibly removing a person from a place, or removing or defacing obscene or offensive placards at a place.

The principal concern of police attending a VSM incident may often be to prevent offences being committed. Dealing with an affected person by seizing potentially harmful things or removing the person to another place for care and protection is intended to achieve the same goal — ensure that the affected person does not commit criminal offences due to their altered state of mind. However, there are several difficulties in simply applying the section 44 approach:

- It is unclear whether the scope of this power was intended to authorise police to do more than move the person on, give them directions or take

other action short of detention. Simply directing them to move to a different location is insufficient to address either the VSM issue or the more general issues relating to an affected person's welfare.

- Assuming that the power could be used to apprehend and detain someone for the purpose of moving them to a safe place, it does not cover situations where the affected person presents no risk of harm to anyone other than themselves, and is therefore not going to commit an offence. Expanding this power to include the capacity to apprehend any person in apparent need would go beyond the original intention of the power.
- The power to 'take steps the police officer reasonably considers necessary' is a power to prevent an offence, and imposes no obligation on the officer to address the physical or psychological welfare of the affected person. The Commission is convinced that any response by police to VSM should provide not only for community safety and amenity, but also for the welfare of the affected person.

Assessment of current approaches

In addition to the existing powers that the Queensland police could (at least in principle) use to respond to a VSM incident, the Commission also considered some more general approaches to police powers, which could possibly be adopted or extended in the context of VSM. These are the:

- public drunkenness approach
- public drunkenness approach for children
- public intoxication approach
- Child Protection Act approach
- Mental Health Act approach.

These approaches, even where clearly inapplicable in a practical sense, still give insight into the current operation of policing in Queensland in response to a range of roughly comparable situations, and reveal the options available.

Public drunkenness approach

Section 10 of the *Summary Offences Act 2005* makes it an offence to be drunk in a public place. The Commissioner's Circular 05/2005 describes the appropriate police response to public drunkenness as follows:

Officers should use their discretion when considering what action is to be taken against a person who is found drunk in a public place. Should a person be located in need of assistance, then referral to the appropriate agency should first be considered ...

Officers should carefully consider whether, in all of the circumstances, the drunk person if arrested is placed in a more difficult position as a result of the arrest.

Officers should not arrest persons for being drunk in a public place unless they consider that it is necessary to arrest the person to preserve the safety or welfare of any person, including the person arrested ...

Officers who arrest a person for being drunk in a public place are to comply with the provisions of s. 16.6.3: 'Drunkenness' of the OPM.

If a person is arrested for public drunkenness, police have a duty (under the PPRA, s. 210) to discontinue the arrest at the earliest opportunity and release the person at a place of safety. This should occur only if the officer is satisfied that it is more appropriate to take the person to a place of safety; it would therefore not apply if the officer believed that the place of safety could not provide care for the person,

or if the person's behaviour would pose a risk of harm to others at the place of safety (this is outlined in the QPS Operational Procedures Manual). A place of safety includes:

- a hospital
- a place other than a hospital that provides care for persons who are drunk
- a vehicle used to transport persons to a place of safety
- the person's home, or the home of a relative or friend.

When releasing a person to a place of safety, police have some attendant responsibilities, including receiving a signed undertaking from the person in charge of the place of safety. This is similar to the approach adopted in section 371B–C of the PPRA. The clear difference, however, is in situations where it is inappropriate for an apprehended person to be taken to a place of safety. A person apprehended for VSM will then be released, whereas a person who has been arrested for public drunkenness will continue to be subject to the arrest procedure. Criminal charges, an arrest record and criminal proceedings might follow.

The Commission views both of these situations as inappropriate and unhelpful outcomes when dealing with VSM. Criminalising VSM is obviously not an option. Similarly, merely releasing an affected person does not provide for their welfare, nor does it solve community amenity and safety issues.

The existing public drunkenness approach, therefore, will not meet welfare concerns or the government's stated policy objectives. It is the Commission's view that a person should be apprehended expressly to provide them with assistance as a first priority, and not arrested and perhaps later given assistance as a second priority.

Public drunkenness approach for children

The OPM details the procedure for arresting a child, such as for being drunk in a public place. Police must apply section 198 of the PPRA, read in light of the *Juvenile Justice Act 1992*, section 13.

Public intoxication is a summary offence and not an indictable offence, so a child may be arrested without a warrant where the officer reasonably suspects the child is committing or has committed an offence, and the officer believes the arrest is necessary on reasonable grounds.

However, police have a duty to discontinue the arrest of a child at the earliest reasonable opportunity if there is a more appropriate way of dealing with the child, or if the reason for arrest no longer exists. Other appropriate ways include taking no action, administering a caution, or referring the child to a youth justice conference. This duty to discontinue arrest does not apply if it would be inappropriate to release the child in view of the nature or seriousness of the offence.

While this approach does seek to divert the child out of the criminal justice system and into alternative, though not therapeutic, care systems, it also retains what the Commission considers to be an inappropriate risk of criminalisation.

The Commission has been informed that operational police take the following general course of action with a drunk or drug-affected juvenile who does not need to be taken into custody straight away:

- First, they take the affected child home to parents, or have parents come to the police establishment to pick up the child. This can be a problem if the child will not identify parents or supplies false residential or contact details;

or if the parents are not home, or are unable to be contacted, or live a distance away.

- If the child cannot be taken home, or the parents cannot collect the child, officers will find out whether there is another suitable adult who can care for the child. This can be a problem, because children in these sorts of circumstances may associate with unsuitable people. The child may, however, have a juvenile friend whose parents are suitable and are prepared to care for the affected child.
- If the above options are not available, police will contact Family Services (during office hours) or Crisis Care (after hours) to see whether there is an available placement for the child. This can be problematic, as placements are rarely available in these situations.
- If none of the above are possible, and taking into account an affected child's need for protection and care, consideration will be given to lodging the child in the watch-house. If this happens, Family Services or Crisis Care is informed. To lodge a child at a watch-house, the child has to be charged with an offence because there is no provision to detain without charge in these circumstances. However, a prosecution can later be discontinued.

The Commission has also heard anecdotal reports of police holding VSM-affected people at police facilities until other arrangements can be made, or until such time as the person is no longer affected by the volatile substance. The data received from the custody index support this finding, with 34 recorded instances where a person has been 'released' to a police establishment. Under section 371B–C, this should not occur. It is, however, an action that is completely consistent with the police officer's duty of care (to both the general public and the individual concerned).

The Commission therefore notes the distinction between dealing with children who are drunk and dealing with children who are affected by VSM. In the former situation, a police officer has arrested the child and therefore has the power to hold them until such time as alternative arrangements can be made and arrest can appropriately be discontinued. In the latter situation, the affected child should, strictly speaking, be released, despite still being intoxicated. The Commission believes that this is an unsatisfactory outcome.

Public intoxication approach

Police currently have no operational guidelines for dealing with people who are not driving and are affected by a drug. There is no offence in Queensland for being intoxicated in public by a drug other than alcohol, nor is it an offence to be intoxicated on an illicit substance.

An arrest for a minor drug offence (i.e. involving cannabis) can be discontinued (PPRA, s. 211), and the person, including a child, can be given the opportunity to attend a drug diversion assessment program.

Given the government's intent to take an active role in addressing VSM in Queensland, it is inappropriate to adopt a position such as that currently in operation for public intoxication (i.e. dealing with it on an ad hoc basis without express legislative authority). Further, while intoxication through illicit drug use involves the use of an illegal substance for the purpose for which it was intended, intoxication through VSM involves the use of a legal substance for a purpose for which it was not intended.

Child Protection Act approach

Section 21 of the *Child Protection Act 1999* authorises a police officer to apprehend a child under the age of 12 years and move them to a place of safety, when the officer reasonably believes the child is at risk of harm and the child's parents or other family member cannot be contacted. This power is to be exercised in the interests of the child and to prevent harm or further harm.

The Commission views this approach as specific to the situation of very young children in situations of risk, and is therefore not in favour of interfering with the operation of this Act.

Mental Health Act approach

Section 33 of the *Mental Health Act 2000* authorises police to take a series of actions with a person they reasonably believe to be suffering from a mental health condition, and who consequently poses a risk of harm. Primarily, the Act lets police take the person to an authorised mental health service for examination, to decide whether assessment documents should be made. The person can be detained for up to six hours in the authorised mental health service.

There are some distinctions between a situation where a person is affected by a mental health condition and one where the person is affected by VSM. In particular, a mental health condition may be ongoing and long-term, whereas VSM will affect a person for only a short period (1–4 hours). Further, the medical response to VSM does not treat VSM directly, but instead treats associated conditions or health problems caused by a person's situation, of which VSM may be an indicator; and it provides a person with a safe environment in which to recover from the more immediate effects of intoxication. VSM is not a treatable condition in the way that a mental illness may be, but is a signal or indicator of broader welfare needs, which are usually quite different from those of a person with a mental illness.

The Commission notes that the Mental Health Act does not envisage police holding mentally ill people. This appears to be because the level of need for medical assessment of a mentally ill person is high, and the infrastructure to support authorised mental health facilities is expansive. Apart from cases of immediate emergency, people affected by VSM are not a high priority for Queensland Health, and there are not enough cases to warrant a blanket response across all of Queensland. Consequently, where the Mental Health approach can safely assume that an 'authorised mental health service' will be available, no such assumption can be made about support facilities for VSM.

The reality is that, while Queensland Health can be reasonably expected to provide a sufficient response to VSM, it cannot be expected to offer a level of service remotely comparable to that for people with mental illnesses. In 2000–01, an average of 184 people per day received mental health treatment in Queensland. Although the number of people affected by VSM may at times be high in specific local areas, and may at times receive considerable media attention, no comparison can be drawn between the expected service levels for mental health and VSM.

Overview of current powers and approaches

While these existing legislative provisions and police approaches allow a firm comparative basis on which to assess the trial powers enacted through section 371B–C of the PPRA, it is important to note that none of them specifically considers VSM. There are therefore no powers or approaches currently available to police outside the trial legislation that are effectively applicable to VSM alone.

Putting the 2003 amendments within the broader legislative framework of police powers, however, does reveal that police have some existing powers that may be of use for dealing with VSM. For instance, police are currently empowered to arrest or move on individuals for behaviour that is a threat to public safety or public amenity.

The operation of these other powers and approaches lets police take action against people who have committed, or are about to commit, an offence, through arrest, temporary detention or a direction to move on. The difficulty with all of these, however, is that none addresses the question of an affected person's welfare. The move-on powers, in particular, do not offer an affected person any access to services to help them to overcome VSM behaviour. Such powers merely have the result of removing affected people from one public area and depositing them in another. Such action does not address the underlying problems leading to VSM, nor does it provide any therapeutic response to those in need. Finally, it is unclear whether it has any impact on public safety or amenity in the long term, as it simply relocates a behaviour that is not location-specific and provides little if any incentive to stop VSM.

Section 371B–C, on the other hand, was enacted as a direct effort to address these issues of personal health and welfare. The powers allow police to offer affected people a therapeutic option for recovery and care. No other Queensland legislation has given police this power.

Assessment of how the new powers have been implemented

The CMC also assessed whether the QPS adopted an effective process for implementing the new police trial powers.

The QPS used a number of mechanisms to communicate policies and procedures and train police officers to use the trial police powers. These included:

- the Police Commissioner's Circular 8/2004, released 29 June 2004
- standard operating procedures to supplement the Police Commissioner's circular (each trial area)
 - Townsville: developed early June 2004 and completed 22 August 2004, released 10 September 2004
 - Cairns: developed early September 2004, released 16 September 2004
 - Mount Isa: developed September 2004, released 10 September 2004
 - Metropolitan North: developed late June 2004, released 1 July 2004 (revised 31 August 2004)
 - Metropolitan South: developed late June 2004, released 1 July 2004 (revised 20 July 2004)
 - Logan: developed 19 May 2004, released 1 July 2004
- computer-based training package (made available to all police officers via the QPS bulletin board on the intranet), released 20 June 2004.
- the joint QPS/QAS VSM immediate response protocol (Z-card):³⁴ all QPS and QAS officers
- face-to-face, train-the-trainer package (roll-out late 2004 to early 2005), funded by Alcohol Education and Rehabilitation Foundation Ltd
- the appointment of a QPS contact officer in each trial zone
- statewide email from Deputy Commissioner (29 July 2004) to increase awareness among operational police

³⁴ A small card, the size of a business card, which, when folded out, presents information on an A4 insert.

- checking of custody/search index by Drug and Alcohol Coordination Branch and subsequent liaison with trial area contact officers and operational police.

Essentially, each trial area developed its own set of standard operating procedures for the trial powers. These procedures were based on the policy detailed in the Police Commissioner's circular, and provided area-specific information such as the contact information and hours of operation for the designated place of safety.

Commissioner's circular and Operational Procedures Manual

The Police Commissioner's circular was subsequently incorporated into the QPS Operational Procedures Manual (OPM). It is useful to highlight a number of issues raised in both the circular and the OPM, and note their relation to existing QPS policy recommendations.

- Most notably, the circular gives guidelines to police operations both generally and within the declared locality. Where an affected person is within a declared locality that is one of the five trial sites under the Act, police have the option of detaining that person and taking them to a place of safety. This is in addition to the other options available to police more generally (i.e. to suggest the person attend a place of safety, to provide referral material and to remove potentially harmful substances).
- The circular notes that the QPS and the QAS have developed an immediate response protocol to VSM (see discussion next page). As a result, when police are dealing with an affected person, the officer should assess the person's level of consciousness and request QAS assistance where appropriate.
- The circular notes that, in many cases, a QAS vehicle may be a place of safety where an affected person is unconscious or has an altered level of consciousness.
- Due to the risk of injury to the affected person as a result of their condition, police should avoid unnecessarily chasing or agitating an affected person.
- Where a child is under the age of 12 years, police should consider taking the child to a place of safety under the *Child Protection Act 1999*, regardless of whether they are in a declared locality.
- Where a person cannot be left in a place of safety (due to the place of safety being unable or unwilling to provide care, the affected person presenting a risk of harm, or the absence of a place of safety), the circular affirms that police must release the affected person.

Standard operating procedures

On the basis of the recommendations made in the circular and the guidelines in the OPM, the trial zones then adopted a set of standard operating procedures, though such procedures could differ from district to district. On the whole, these standard operating procedures simply reflect the details of the circular and the OPM. It is worth noting a number of features, however:

- **South Brisbane:** includes an 11-point action plan for dealing with an affected person, such as conducting normal computer checks, and noting that a person must be released if they cannot be lodged with a place of safety because the affected person is violent.
- **Townsville:** states that police should consider the affected person's home as the most appropriate place of safety, and relatives the next most appropriate place of safety. Police also have a duty to initiate a faxback service in every instance where police have contact with an affected person.
- **Brisbane Central District:** outlines that, where an affected person is suspected of having committed a crime, police should be aware of the policy

recommendations in the OPM regarding the questioning of people with special needs.

In essence, the combination of the Police Commissioner's circular, the OPM and the standard operating procedures offered police little guidance to interpreting and implementing the new powers, beyond the content of the legislation. Some guidance was given for arrest powers, but the recommendation to avoid chasing an affected person was reported by officers as being largely unhelpful. Similarly, the repeated duty to release an affected person where no place of safety could be found gave police little instruction about how best to do so and also provide for a person's welfare. Finally, the power to search, question or arrest a person was not clarified in any of the documents, beyond a note to bear in mind a person's altered state of consciousness.

Computer-based training package

Officers also had access to a computer-based training package. The web-based VSM legislation training was mandatory for all operational police in the trial zones, and available to all police officers via the QPS bulletin board (intranet). It reiterated QPS policy and provided some specific guidance on the use of the trial powers.

Similarly to the Police Commissioner's circular and the standard operating procedures, the computer-based training offered police little in the way of detailed operational guidelines. There was no explanation of the interaction that the new powers should have with existing police powers, or the manner in which officers were permitted to search, question or arrest a person in situations involving VSM. Some guidance was given about the circumstances in which a person must be released where no place of safety was available or willing to provide care and protection, but there was no discussion about the best-practice method or place for such a release.

Queensland Ambulance Service protocol

In recognition of the increased need for liaison between police and ambulance officers to deal with VSM, the QAS and QPS developed a joint immediate response protocol. This protocol, in the form of a Z-card, was distributed to operational police in the trial areas in October 2004.

Its purpose was to help the QPS and QAS offer a coordinated response to VSM and minimise the harmful effects associated with this behaviour.

The protocol includes a summary of the police powers, the role of ambulance officers and information about immediate assessment, treatment and possible referral to Project Drug Overdose Visitation. Additionally, it notes the risk of 'sudden sniffing death syndrome' (SSDS), which can occur as a result of heart failure if a person does strenuous exercise or has a sudden fright after sniffing.

Other information about VSM, including results from an officer survey, was also made available to all police via the Drug and Alcohol Coordination VSM Bulletin Board site and the QPS internet site, <www.police.qld.gov.au/pr/services/drugs/vsm/index.shtml>.

Overview of the QPS process

In all, the QPS process of explaining to police officers how and why to use the

trial powers does not seem to have been entirely adequate. It did not provide officers with an expanded discussion of VSM behaviour, or an explanation of the core application of the new powers. It appears that none of the official documents gave police clear guidance about the operation of the new powers in the broader context of police operations. It was these deficiencies that ultimately troubled police in each of the trial zones. Such concerns appear to have had a range of effects on police responses to VSM, including:

- police being overly cautious or reluctant about implementing the new powers
- police having to interpret the limits of the new powers themselves
- police seeking to adopt the spirit of the VSM prevention policy, though working around its legislative form.

Conclusion

No existing legislation other than section 371B–C of the PPRA gives police an adequate response to VSM in public places. The trial legislation is based on a primary concern for the welfare of the affected person, and acts in tandem with the existing police power to search an affected person and seize potentially dangerous things. In reviewing the operation of the powers, the CMC has considered the legislative description of the powers in the PPRA, the operation of the powers in the trial zones, the training and guidelines given to police to make the powers operational, and the practice of other states to address the issue of VSM.

There is concern, however, that the trial powers may be too limited in some situations to allow police to respond effectively to VSM. For example, where a person is affected by VSM and no place of safety is available, willing or appropriate to care for the person, police must simply release the person. This limitation is obviously unsatisfactory.

Further, police have received little guidance as to the effect of the new powers on their existing powers to arrest, question or search a person. There is some material (e.g. the protocol for VSM response between QAS and QPS) that sets up workable arrangements, at least for the time being; but there is little other formal confirmation of the importance of police as part of a broader policy response to VSM involving the Department of Health, the Department of Child Safety, and other government and non-government agencies.

3

The trial powers in operation

This chapter presents statistical data, primarily gained from the QPS custody index, revealing how the trial police powers were used during the nine-month review period. An analysis of this information gives answers to seven of the nine key components of the CMC evaluation, summarised at the end of the chapter.

Key objectives

As outlined in the Introduction to this report, the CMC's evaluation of the trial police powers consisted of the following nine key components:

- Measure the frequency with which the trial police powers are used.
- Analyse the context in which the powers are used.
- Identify the types of referrals to places of safety.
- Assess issues of potential net-widening.
- Assess compliance by police with conditions of the trial police powers.
- Identify reasons for any noncompliance.
- Assess the nature of linkages with other stakeholders (ambulance and hospital).
- Assess perceptions of the overall usefulness and effectiveness of trial powers.
- Consider how the effectiveness of the trial powers could be improved.

Data analysis presented in this chapter will supply answers to the first seven of these components. (The final two items are discussed in Chapter 5.)

Data sources

The QPS custody index was the primary source of the data for this evaluation. This index is an administrative dataset containing all records of people detained by police in Queensland. In accordance with police policy, a custody index record should have been made each time police operating in the trial sites used the new powers to detain a person affected by volatile substances.

In addition, criminal history data were studied. Criminal charge and court appearance histories (Queensland Person Histories) were checked for all people who had contact with core stakeholders (police, ambulance, hospital and safe places) during the trial.

Other police information sources analysed included the activity reporting index and calls-for-service data. Due to various limitations with these sources, they are not included in this chapter. However, information from these additional data sources is provided in Appendix H.

Police custody index data

Summary of police data

Table 3.1 presents a summary of police contacts with VSM-affected people within the trial sites for the period 1 July 2004 – 31 March 2005, where section 371B of the PPRA was used.

Table 3.1: Summary of police data (1 July 2004 – 31 March 2005)

Total contacts with services (place of safety, police, ambulance, hospital) ^a	2210
Total number of police contacts	255
Total number of non-trial site police contacts ^b	118
Total number of affected persons involved in police contacts	157
Gender	
Male	87
Female	70
Median age	15
Modal age	15
Racial appearance ^c	
Aboriginal	110
Pacific Islander	1
Caucasian	45
Mode number contacts with police per client (also median) ^d	1
Median length of contact with police (excludes stays longer than 24 hours) ^e	29 minutes
Modal length of contact with police (excludes stays longer than 24 hours) ^f	15 minutes
Contact locations	
Public space ^g	150
Residence ^h	23
Street name only specified ⁱ	75
Other ^j	7
Release locations	
Designated place of safety ^k	75
Residential address ^l	50
Police establishment ^m	34
Other ⁿ	96

Source: QPS Custody Index

Table notes:

- a This is a cumulative figure, i.e. an individual contact with police, ambulance and a place of safety is recorded as a count of 3. Total count includes place of safety (1848), police (255), ambulance (32) and hospital (52).
- b These 118 cases were based on police contact locations and have been removed from all further analyses.
- c Racial appearance requires police to either ask the person or make a judgment based on appearance. One record did not contain details of racial appearance (missing data).
- d Equals the most frequent number of contacts with police for a person, also the middle value of the list of the number of contacts.
- e Equals the middle value in a list of lengths of contacts with police during the trial period.
- f Equals the most frequently recorded length of contact with police during the trial period.
- g Includes railway stations (16), shopping centres and malls (46), parks, footpaths, under bridges etc. (88).

As shown in Table 3.1, during the nine-month period of review police exercised their trial powers on 255 occasions with respect to 157 individuals (within the designated trial sites). To place these figures in context, police contacts constitute 11.5 per cent of all contacts (2210) made as part of the trial legislation.

There are a number of noteworthy aspects of the police use of the trial powers that have been revealed. In particular:

- Police made only 75 referrals to the places of safety operated by non-government service providers (29% of all trial site exercises of the new powers) and those 75 referrals actually represent only 54 individuals. This means police referrals made up only 4 per cent of all referrals to the places of safety.
- More than two-thirds (70%) of all police VSM responses involved Indigenous persons.
- Almost as many females (70) as males (87) were responded to by police for VSM (45% and 55% respectively).
- Most young people responded to by the police were 15 years of age.
- The primary places of contact for VSM were parks, footpaths, under bridges and railway stations etc. (41%), followed by shopping centres or malls (18%).

Although this provides an illuminating summary account of police response to VSM in the trial sites, it is useful to ‘unpack’ the summary data in order to obtain a more fine-grained understanding of how the new trial powers operated between 1 July 2004 and 31 March 2005. More detailed information is provided in the sections that follow.

As can be seen in Table 3.2 (next page), most police responses to VSM occurred either in or close to the heart of Brisbane (55%), with 86 individuals in this area being responded to by police. The smallest number of police contacts occurred in Logan, with 19 contacts (16 people). However, in Mount Isa, although there were 42 police contacts, this represented the smallest number of people — only 14 individuals.

Table notes (continued):

- h Includes residential address of person, person’s friends and person’s family.
- i Includes where police have identified a particular street, but no further information (such as landmark or street number) was entered in the index, making identification of a specific location impossible.
- j Includes medical facility/clinic/residential drug treatment centre (1); refuge/shelter/boarding house (4); place of safety (1) and police station (1).
- k Refers to trial area places of safety.
- l Includes residential address of person, person’s friends and person’s family.
- m Includes police stations, police watch-houses, police beats/shopfronts and youth detention centres. Seventeen of the 34 chroming contacts also involved ‘other matters’ (e.g. warrants, arrests for other offences, failure to appear in court); 11 cases involved providing affected people with somewhere to ‘sober up’, enabling police to organise transportation to a safe place. In the remaining six cases, custody records indicate that the person was chroming, but no further details are provided regarding detention.
- n Includes refuge/shelter/boarding house (8); medical facility/clinic/residential drug treatment (18); public space (19); and not specified (51).

Table 3.2: Police contacts by area (1 July 2004 – 31 March 2005)

Trial site	Number of contacts	%	Number of individuals	%
Brisbane	139	55	86	55
Mount Isa	42	16	14	9
Townsville	29	11	23	15
Cairns	26	10	18	11
Logan	19	8	16	10
Total	255	100	157	100

Source: QPS Custody Index

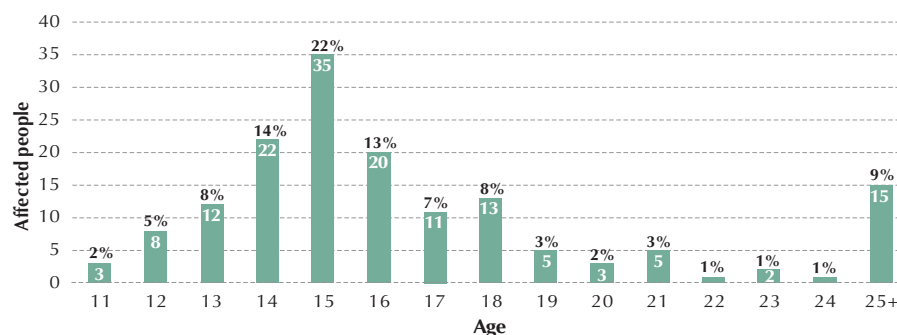
Table 3.3 below highlights the fact that most people (62%) who came to the attention of the police had only one VSM-related contact with police. However, 9 per cent of people who came to the attention of the police for VSM did so on four or more occasions.

As can be seen in Figure 3.1 below, it is not surprising to find that 22 per cent of the police contacts were with people aged 15 years, and 64 per cent of all contacts were between 13 and 17 years.

Table 3.3: Police contacts per client (1 July 2004 – 31 March 2005)

Contacts	Affected individuals	%
1	98	62.4
2	33	21.0
3	12	7.6
4	7	4.5
5	5	3.2
6	1	0.6
10	1	0.6
Total	157	100

Source: QPS Custody Index

Figure 3.1: Age of VSM-affected people in contact with police (1 July 2004 – 31 March 2005)

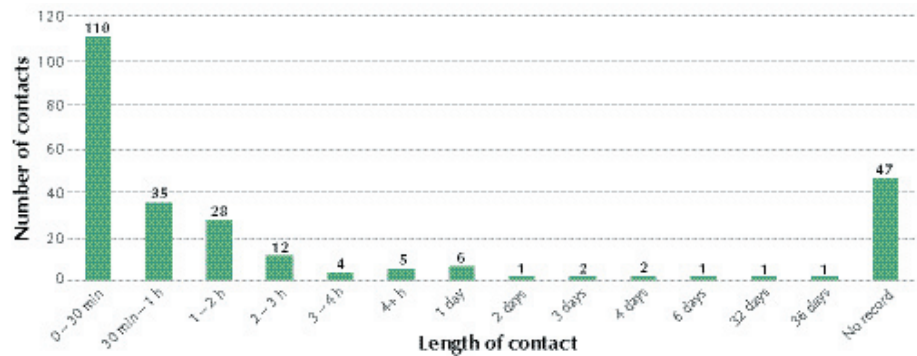
Source: QPS Custody Index

Note: For one record, age was not recorded (missing data).

As shown in Figure 3.2 below, the majority of contacts (76%) between police and affected people lasted less than 24 hours, and more than half (145) lasted no longer than an hour. Longer timeframes may indicate transportation of more than one person to more than one safe place, arrival at a safe place with no occupants or outside operating hours, problems with availability of resources (e.g. no car available), difficulties establishing correct identifying information, medical intervention and/or follow-up of other matters (e.g. outstanding warrants). In the 14 cases where length of contact exceeded 24 hours, 10 resulted in police dealing with other matters (e.g. outstanding warrants, domestic violence, hospitalisation), and in one case police allowed the affected person to 'sober up' before transportation; three records provide no further information.

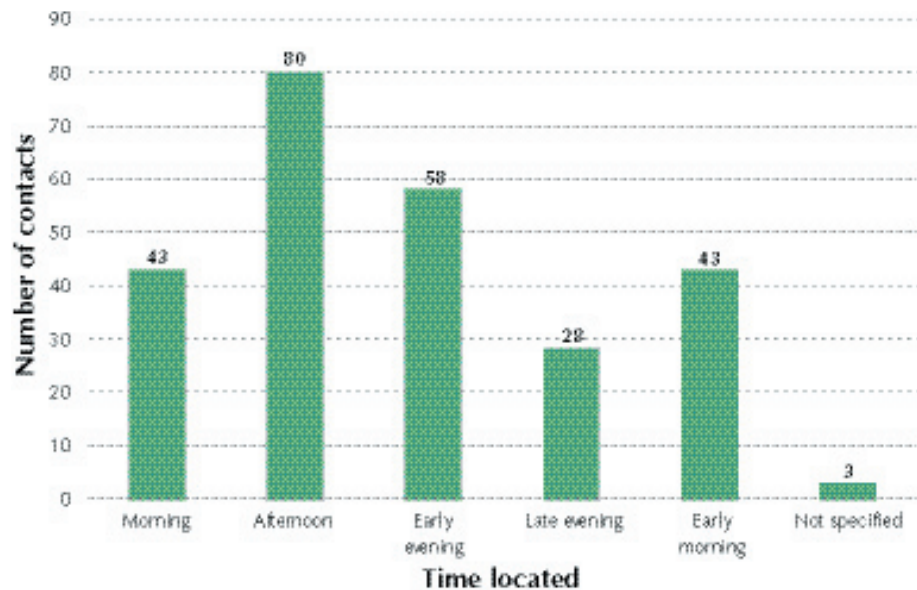
As can be seen in Figure 3.3 below, most police contacts occurred in the afternoon or early evening. However, a substantial proportion (17%) of contacts occurred in the early morning (midnight to 6 am).

Figure 3.2: Length of contact with police (1 July 2004 – 31 March 2005)



Source: QPS Custody Index

Figure 3.3: Police contacts by time located (1 July 2004 – 31 March 2005)

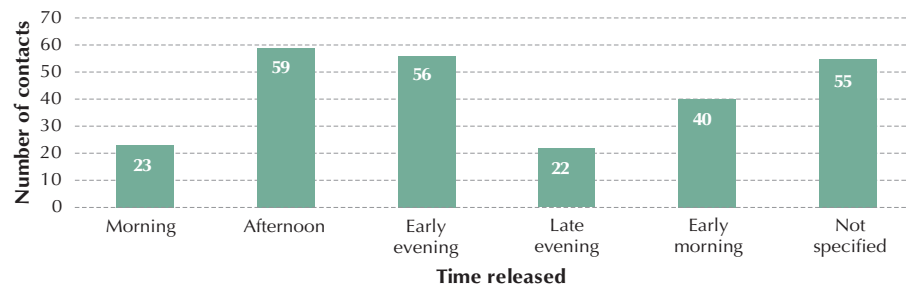


Source: QPS Custody Index

Note: Morning (6 am – 12 noon); afternoon (12 noon – 5 pm); early evening (5 pm – 9 pm); late evening (9 pm – 12 midnight); early morning (12 midnight – 6 am).

Figure 3.4 below shows that most people were released by the police in the afternoon and early evening. Given that the majority of contacts with police (145) lasted no longer than an hour, and the most common time was in the afternoon and early evening, these release times are not surprising.

Figure 3.4: Police contacts by time released (1 July 2004 – 31 March 2005)



Source: QPS Custody Index

Note: Morning (6 am – 12 noon); afternoon (12 noon – 5 pm); early evening (5 pm – 9 pm); late evening (9 pm – 12 midnight); early morning (12 midnight – 6 am).

Table 3.4 highlights that the most common places where police intercept VSM-affected people are public spaces (34.5%).

Table 3.4: Location of police contact (1 July 2004 to 31 March 2005)

Contact location	Number of contacts	%
Public space ^a	88	34.5
Shopping centre/mall	46	18.0
Designated place of safety ^b	1	0.4
Police establishment ^c	1	0.4
Residence ^d	23	9.0
Railway station	16	6.3
Refuge/shelter/boarding house	4	1.6
Medical facility/clinic/residential drug treatment	1	0.4
Street name only specified ^e	75	29.4
Total	255	100

Source: QPS Custody Index

Table notes:

- a Includes parks, squares (e.g. Brisbane's King George Square), central business districts, under bridges etc.
- b Refers to trial area places of safety.
- c Includes police stations, police watch-houses, police beats and/or police shopfronts.
- d Includes residential address of person, person's friends and/or person's family.
- e Includes where police have identified a particular street, but no further information (such as landmark or street number) was entered in the index, making identification of a specific location impossible.

The police release data revealed in Table 3.5 shows that, under the new powers, the most common location for police to release people was a place of safety operated by a non-government service provider (29%). 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 which could not be reconciled with each other.³⁵

One surprising finding is that on 34 occasions people were released at a 'police establishment' and youth detention centres. Seventeen of the 34 chroming contacts involved 'other matters' (e.g. warrants, arrests for other offences, failure to appear in court); 11 cases involved providing VSM-affected people somewhere to 'sober up', enabling police to organise transportation to a safe place. In the remaining six cases, while custody records indicate that the person was chroming, no further details are provided regarding detention.

Table 3.5: Police contact by location released (1 July 2004 – 31 March 2005)

Release location	Number of contacts	%
Public space ^a	16	6.3
Designated place of safety ^b	75	29.4
Police establishment ^c	34	13.3
Residence ^d	50	19.6
Railway station	3	1.2
Refuge/shelter/boarding house	8	3.1
Medical facility/clinic/residential drug treatment	18	7.1
Not specified ^e	51	20.0
Total	255	100

Source: QPS Custody Index

Table notes:

- a Includes parks, squares (e.g. Brisbane's King George Square), central business districts, under bridges etc.
- b Refers to trial area places of safety.
- c Includes police station, police watch-house, police beats, youth detention centres and/or police shopfronts.
- d Includes residential address of person, person's friends and/or person's family.
- e Custody index records did not specify location of release.

³⁵ Over the period 1 July 2004 – 31 March 2005 a total of 40 police referrals to the place of safety did not result in a custody index record being found. Half of these missing records were detected from a copy of the police Form 92 relating to the referral to the place of safety and the other half were found in 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 either were not recorded in the custody index or these records were not provided to the evaluators.

Criminal histories

Criminal history checks were undertaken for all individuals who came into contact with any of the four core stakeholders (police, ambulance, hospital emergency departments and places of safety) during the review period. Criminal histories were accessed and coded using a methodology previously used in CMC research.³⁶

The key rationale for checking the criminal histories of people involved in the trial was to determine if any indications could be seen of net-widening due to the VSM-related contact with police. Net-widening was one of the major concerns raised by community stakeholders, the fear being that to increase police contact with juveniles regarding volatile substance misuse (which is not a criminal offence) entails an increased likelihood of some young people entering the criminal justice system, which might not have otherwise occurred. If a first contact with police for VSM was used as the basis for laying charges related to other matters such as 'disturbing the peace' or 'abusive language', this might well be seen as an indication of a net-widening effect.

Table 3.6 below shows there were no persuasive indicators of net-widening in the trial sample revealed by the criminal history checks. A total of 531 people's details were extracted and searched for criminal histories. Of these records 361 (68%) had criminal histories (i.e. charges heard before a court of law). The majority of these (346, 96%) were histories established before the trial period began. Only 22 per cent (117) of the sample had no official criminal history.³⁷

If individuals participating in the government's new response are separated into two groups — those who participated by way of a police contact and those who participated by way of a non-police referral to a designated place of safety — it emerges that 80 per cent of those who participated by way of a police contact had a pre-existing offender history, compared with 56 per cent of the non-police referrals. These data do not support the argument that the trial police powers widen the net because police 'scoop up' people who otherwise would not have come to the attention of the authorities. The data are reasonably clear in suggesting that VSM contacts by police are largely associated with people who have a pre-existing offender history.

Of those individuals in the trial sample who had a criminal history (351),³⁸ the majority (71%) had between one and 25 charges recorded. See Table 3.7 for counts of charges made.

Table 3.6: Criminal histories

Status	Count	%
Offender history located	361	68
No history located	117	22
Insufficient search information	53	10
Total	531	100

Source: QPS Polaris

³⁶ Breach of bail charges and application for care and control not recorded; breach of D&FVP breach of order were included.

³⁷ In 10 per cent of the sample there was insufficient information (date of birth, surname etc.) to establish the identity of the person and therefore access a potential criminal history.

³⁸ Fifty people within the sample had evidence of charges detailed in CRISP but were not yet recorded in the criminal history database. On request, the QPS added a further 10 people to the offender history located count, and 40 had no history located. These 10 people have been excluded here as no charge count was provided.

Table 3.7: Number of charges in criminal histories

Number of charges	Count	%
1–25	251	71
26–50	53	15
51–75	21	6
76–100	13	4
101+	13	4
Total	351	100

Source: QPS Polaris

Conclusion

This chapter considers seven of the nine key components of the CMC’s review of the trial police powers, as follows:

- Measure the frequency with which the trial police powers are used.
- Analyse the context in which the powers are used.
- Identify the types of referrals to places of safety.
- Assess issues of potential net-widening.
- Assess compliance by police with conditions of the trial police powers.
- Identify reasons for any noncompliance.
- Assess the nature of linkages with other stakeholders (ambulance and hospital).

As there is some overlap in the analysis of these components, answers will be presented as a whole, not separately.

In terms of the frequency with which the trial powers were used, perhaps the most notable findings were the relatively small number of occasions in which police exercised the powers (255),³⁹ and the even smaller number of people involved (157). This may be interpreted in either of two ways. It may indicate that public perceptions of the pervasiveness of youth involvement in VSM overestimate the size of the problem and the number of people involved. Alternatively, it may show that, due to the nature of VSM, police are unlikely to encounter the majority of people involved in this practice during their regular duties. Data on the context in which the trial powers were used support both of these conclusions. Specifically, the data show that the powers were most likely to be used in public spaces (150), which are both the main areas of jurisdiction of police and places where members of the public would be witnessing VSM. The finding that about 10 per cent of contacts occurred in private residences, to which police must be invited, suggests that VSM involvement may often go unnoticed by government authorities.

Information about the context of the powers is also of interest for the types of referrals made to the places of safety. Notably, although police were more likely to release young people at a place of safety than anywhere else, police referrals (75) accounted for a minority of place of safety clients. Since most police contacts were in Brisbane (139) during the afternoon (59) or early evening (56), yet none of the Brisbane places of safety opened before 8 pm,⁴⁰ this is not surprising.

³⁹ Within trial site records.

⁴⁰ The Brisbane places of safety opened from 8 pm on Wednesday nights, 9 pm on Tuesday, Thursday and Friday nights, and 10 pm on Saturday and Sunday nights.

After places of safety, the locations in which police most commonly released young people detained under the trial powers were private residences (50) and police establishments (34). The latter finding is of particular concern as it is specifically restricted under the trial legislation. Indeed, given that in half of these cases the reason for the release to a police establishment was to deal with 'other matters' (including arrests for other offences, warrants and failure to appear in court), these outcomes lead to questions about whether the trial powers had a net-widening effect for young people entering the justice system. However, an assessment of the criminal histories of young people detained using the trial powers reveals that most had already entered the juvenile justice system, so it does not appear that net-widening was an issue. In line with this conclusion, the mean age of people detained at police establishments (19 years) was markedly older than the mean age of people referred to a place of safety (15 years). Similarly, there was a much larger proportion of young people referred to a place of safety who identified as Aboriginal (76%) than Caucasian (22.7%). The proportions of Aboriginal and Caucasian people detained at a police establishment were relatively similar (58.8% and 41.2% respectively).

The number of releases to police establishments does suggest that police did not always comply with the conditions of the trial powers. However, this could be a direct result of the conflicting demands that these conditions placed on police. Specifically, in the case of young people who were subject to warrants or who had committed a crime of a serious nature, it is hard to imagine that the public would condone the police ignoring these issues and releasing people who might very well go on to commit further offences. In turn, while detention of young people for periods of more than 24 hours might also be regarded as noncompliance, in these 10 cases the duration of contact was attributed to police needing to deal with other matters of a criminal nature. In one case, police stated that the length of contact resulted from the need to allow the affected person to 'sober up' before being transported. This was the reason in most cases for keeping VSM-affected people at police establishments, suggesting that concerns for the safety of those involved outweighed that of legislative compliance.

Another compliance issue relates to the location of contact. There were 255 contacts within trial sites, and another 118 contacts recorded outside the trial boundaries. Evaluators could find no real indicators of police action that warranted concern. In some instances incorrect codes were entered in the custody index and in others there was confusion about the precise borders of the trial sites. On a few occasions it appeared that police operating well outside the trial areas did not understand the geographical limits of the powers. These issues will be discussed in the following chapter.

Finally, in terms of the nature of linkages with other stakeholders in the trial, it is noteworthy that during the nine-month evaluation period there were only 18 occasions where police transferred and released VSM-affected people to medical facilities. Similarly, on only one occasion was the location of contact a 'medical facility/clinic'. It may be concluded that, generally, the trial powers did not have a significant impact on ambulance and hospital stakeholder groups. The nature of these linkages, and stakeholders' perceptions of the trial, are further explored in the following chapter.

4

Stakeholder perceptions

This chapter presents a summary of the qualitative data collected to assist with the evaluation of the trial police powers and the associated designated places of safety. It includes perceptions from a broad range of stakeholders, including police, ambulance, hospital and places of safety staff as well as representatives from non-government organisations and remote Indigenous communities.

It needs to be emphasised from the outset that the material reported in this chapter is stakeholders' perceptions. In some cases these perceptions clearly reflect specific interests, and on occasion they demonstrate an incomplete appreciation of how the police powers and the places of safety model were both intended to, and in fact did, operate. Documenting these perceptions is nevertheless useful because they have the potential to shed light on the responses of the stakeholders to the trial, and in doing so highlight issues that may need to be taken into account in any future government response to VSM.

Documenting these stakeholder perceptions is also critical to determine, in a broad rather than narrow sense, the effectiveness of the police implementation of the trial powers. That is, it would be possible to arrive at the conclusion that the police implementation of the trial powers was entirely satisfactory because the powers were exercised in full accordance with all legislative and policy requirements. Such a conclusion, however, would provide little basis for determining whether or not the powers should be extended or curtailed, because the broader consequences of the exercise of the powers are left unexamined. It is only by taking into account the experiences and perceptions of a broader set of stakeholders, and looking at the operation of the broad VSM-response model, that an assessment can sensibly be made about the final usefulness of the powers.

While all views are considered important, it is nevertheless the police who are the primary stakeholder of interest in this report, and for that reason their experiences and perceptions about the implementation of the trial powers form the central focus of this chapter.

Police perceptions

Contact was made with each police district involved in the trial and police were invited to attend and participate in meetings with researchers. The purpose of these consultations was to provide operational police with the opportunity to give feedback about the trial response to VSM.

In total, over 100 police officers participated in workshops and meetings with CMC researchers. Additionally, a number of police officers contacted researchers during the trial period to provide information about the trial. The number, seniority and specialisation of officers who participated in consultations varied across each data-collection phase and depended largely on rostering and operational priorities at the time.

Despite the variations in format and participants, five major themes consistently emerged during the police consultation process:

- nature and extent of VSM in the trial areas
- police training, policies and procedures
- operation of the trial powers
- legislative and policy issues
- interactions with other government agencies.

Nature and extent of VSM

Police in all areas, with the exception of Brisbane, experienced VSM as a cyclical problem. The drivers of VSM in most areas appeared to police to be the arrival of a new family, group or individual with pre-existing VSM issues. This triggered more widespread VSM in a contagion effect.

Police identified groups of VSM ‘instigators’ in all areas. However, the number of these instigators varied considerably. In Brisbane the group was said to be 15–20 young people who were chronic inhaler misusers and who appeared to influence others in this regard.

Police noted climatic differences in VSM use across all sites. Interestingly, Logan and Brisbane noted increases during the warmer months, while Cairns, Townsville and Mount Isa noted increases in the cooler months.

VSM was seen to take place mostly in public places where young people ‘hang out’, including shopping centres and parks. In the regional centres, VSM was more noticeable in low socioeconomic suburbs. In Brisbane, VSM was commonly observed throughout Fortitude Valley and Brisbane city areas, including immediately outside the places of safety premises and in neighbouring properties and streets. Perhaps significantly, police stated that there was an escalation of problems associated with VSM and the places of safety (especially in Fortitude Valley). In contrast, police in Townsville and Mount Isa reported the tendency of some young people to congregate at ‘sniffing houses’ to avoid detection by police.

VSM users in Brisbane and Logan were the most transient, commonly using the train network to move from place to place. Users from outer Brisbane suburbs were also known by police to be using trains to come into Fortitude Valley in order to hang out with other young people using volatile substances. This trend represents a form of reverse displacement, whereby young people using volatile substances entered a designated trial area with the specific objective of using volatile substances. This movement coincided with the availability of the place of safety in Fortitude Valley and was obviously an issue of concern to the police.

The volatile substances most often used by young people were reported by police to be paint (in aerosol form), and other aerosols were reported in Cairns. However, police indicated that petrol sniffing was a serious issue in far northern Indigenous communities.

Polydrug use was a widespread concern of police, particularly in Brisbane, where young people were reportedly using a greater range of licit and illicit substances. Other trial areas reported cannabis and alcohol as the main two other substances being used by young people.

Although, in the experience of police, the reasons for VSM were mixed, volatile substances were typically regarded as ‘just another type of drug’. VSM was attractive because of its cost, availability and legality.

Police in all sites viewed substance abuse as a sign of deeper problems such as dysfunctional or abusive families, boredom, a sense of helplessness and myriad other social, health and educational difficulties.

Police were uniformly of the view that chronic substance abusers of school age were unlikely to be attending school, either through choice or due to expulsion. Police flagged the absence of schooling for these young people as a major concern.

Volatile substances being used by young people were said by police to be mainly stolen or provided by adults (including parents in Townsville). Some retailers had been proactive in locking up substances, which reportedly had an impact on reducing theft in the store generally. However, the retailers' legislation was perceived as ineffective and unenforceable.

Ultimately, it would be great if certain procedures could be legislated to assist in reducing juveniles having access to buying/stealing the cans. Ideally it would be similar to legislation used for tobacco, for example, only to be sold to persons over 18 with proof of ID and cans must be stored in locked receptacles or behind the counter. There is no legislation in place to make these shops comply — they are doing this off their own backs.

Police in all areas noted that children who were engaging in VSM were by and large also known juvenile offenders. VSM and criminal behaviour were said to be highly correlated, with police often detecting VSM when called to attend a disturbance.

I have received numerous complaints from businesses in Baxter Street, Fortitude Valley ... in relation to property crime, personal safety and general sense of threat. VSM use has now escalated to wilful damage (spray painting vehicles), using toilet facilities and desecrating the walls with human faeces, cutting phone cables located in the storage room, threatening staff, and generally loitering in and around the premises.

The presence of groups engaging in VSM 'roaming the streets intoxicated' affected the public's perception of general personal safety, particularly in Brisbane. These groups were described as 'worse than drunks' and police reported that they received numerous complaints from the public about this issue.

Police in Brisbane reported that many of those engaging in VSM were homeless. Brisbane homeless youth were reported to be willingly prostituting themselves to adult 'predators' in exchange for food, shelter and money. The risk of sexual victimisation for homeless young people engaging in VSM and other drug use was flagged as a real concern by police.

Training, policies and procedures

This section reflects what occurred during the first six months of the trial. The official policy document for the trial police powers, the commissioner's circular, was launched in late June 2004 (only days before the trial began). Senior officers suggested to the evaluators that, due to the hurried nature of the policy, there was little or no opportunity to request that additional information be incorporated into it to clarify what was required of police.

There are things missing — where is the risk management strategy? Where are the compulsory training checks?

For a whole of government response, specification of the 'nuts and bolts' of the trial were extremely sketchy. It was left up to each individual trial area to figure a lot of these out.

Trial areas were responsible for the development of their local standard operating procedures and the interagency protocols. The interagency protocol between the QPS and the QAS was the only protocol developed at the state level. However,

it was not released and distributed to police in the trial areas until mid-October 2004.

Officers suggested that there appeared to be a lack of coordination at the state level and that interagency protocols with key stakeholders (hospital, ambulance and places of safety) could usefully have been established well before the trial began on 1 July 2004.

If officers are not clear about what it is they are doing, then they will avoid doing it or do it incorrectly. Either of which is not what we are seeking.

However, police noted that the establishment of VSM reference groups in the trial areas did provide a mechanism for the development of the necessary interagency protocols and for the sharing of information by local stakeholders. Townsville was the first trial area to establish a VSM reference group. This group consisted of representatives from the QAS, Townsville Hospital, the QPS and the Department of Communities and the place of safety coordinator. Other sites soon adopted the concept of the reference group. The establishment, timing and membership of the groups varied considerably, which was thought to contribute to their effectiveness. For instance, the Townsville reference group paved the way for the efficient development of a comprehensive standard operating procedure, interagency protocols and greater overall police awareness about the trial.

A computer-based training package was the main form of training received by police in the trial areas. In most sites there was no system for checking that all relevant officers had undertaken VSM training. The training package was generally well regarded by the police who spoke to the evaluators, but was consistently viewed as not especially practical. Many officers suggested that they would have preferred face-to-face training, so that there could have been discussion of the logistics of giving effect to legislation through associated policies and procedures.

All it did was go over the legislation. We know what the legislation is — what we needed was practical and concise guidance as to how we were expected to use the powers.

We need something on paper for in the car. We need all the contact numbers, addresses and a simple flow chart that assists in decision making.

It's clear that no-one sat down and thought all the operational issues through.

Overall, the VSM policies and training were viewed as comprehensive but lacking the necessary level of detail to ensure consistent and proper application of the powers.

Operation of the trial powers

Brisbane police reported a steady flow of VSM incidents throughout the trial period. However, they reported much more frequent use of the search and seizure power (s. 371A) than of the power to detain (s. 371B). The number of contacts that police had with VSM and the decision to use the powers depended considerably on response time. VSM would be allocated a code 3, which would reasonably take officers up to an hour to attend, by which time the person was likely to have moved on.

The majority of VSM contacts we deal with are related to disturbances, e.g. disorder, nuisance, wilful damage.

Police in the trial areas queried whether VSM should even be something that they should be dealing with, since in their view it was primarily an issue for the welfare agencies, particularly Queensland Health.

VSM is different to other drugs, we can take a person who has been using heroin straight to the watch-house, but with VSM we must get them medically checked first.

... the police are not a health service, what if kids have a seizure in the back of the car? ... We don't transport pregnant women — we have no training to transport medical problems ... volatile substances are not a policing issue but a health problem.

It's hard for police to take seriously, it's not an offence. We don't pick up kids with hepatitis C or the flu and take them to the doctor.

Moreover, some police were unconvinced that it was even worth responding to VSM at all:

The kids know they are not going to get in trouble for their VSM, so they do it in front of us and then demand a taxi [police car] to take them home. They are laughing at police — it's a big joke.

Chromer 1: What time is it?

Me: About six o'clock.

Chromer 2: Cool, you can take us to JPET. They'll give us a feed now.

Me: No, I don't think they're open till about 9 tonight.

Chromer 1: No, on Saturdays they open at 5.30 and they'll give us a feed and we can hang out.

Chromer 3: C'mon, get our taxi here so we can get a feed. Will it be a paddy wagon?

From their own comments it would seem that they feel they are being rewarded for their bad behaviour. They know if they sniff paint and find the police, we'll take them free of charge to a place where they'll get a feed, watch TV and hang out with their chroming buddies. Obviously the place of safety concept was never meant to encourage chroming but that's what I'm finding. Maybe these kids would be sniffing paint regardless but it's concerning when they approach you in such a fashion, immediately hand over their chroming bottles and more or less demand to be taxied to JPET for their free feed.

Legislative and policy issues

The consultations highlighted that operational police needed clarification of a number of legislative issues regarding the operation of the new powers. These issues were:

- dealing with warrants and other offences
- using the Form 92
- search and seizure powers
- disposal of seized items
- no power to request name and address
- power to detain
- voluntary nature of response
- drain on resources
- discretion
- non-public places
- forming the view of what is appropriate
- polydrug use.

Dealing with warrants and other offences

Police reported mixed concerns about executing warrants on young people detained under section 371B of the trial powers.

Once we find out they are wanted on warrants, it overrides everything else including the VSM legislation.

Most have warrants on them and if we don't follow up on them it comes back on us — we are legally obliged to execute warrants.

Some police acknowledged that, while they were unable to question an intoxicated young person about offences, they nevertheless believed they still had an obligation to hold the person on any warrants. However, other police said that they would wait until the person was no longer be intoxicated and then execute any warrants. Still other police stated that they would take the intoxicated young person to a safe place and then return at a later time and attempt to follow up on warrants.

There was also the question of what police were supposed to do in cases where offences had been committed in connection with VSM. Police said they always looked at the offence and the person's demeanour before deciding whether to take a person to a place of safety.

If the offence is public nuisance related in connection with volatile substance misuse, it's likely that we'd focus on the VSM, but if the offence is violent or a serious criminal offence it's likely we'd focus on the offence and then the VSM.

We consider all the factors, if they are violent towards us [police] then this overrides everything else.

The majority of contacts we have are in relation to disturbances like disorder, nuisance and wilful damage. Under the previous regime we would have arrested or taken them home to their parents but now we consider taking them to a place of safety.

Using the Form 92

Under section 371C(4) a police officer is required to obtain a signed undertaking from the person in charge of the relevant place of safety, to provide care for the relevant person. Police acknowledged the purpose of obtaining a signed undertaking as relating to documenting the discharge of their duty of care, but raised several issues about using the appropriate form (Form 92).

Form 92 is a loose, one-sided form with space for the officer to record the person's name, the date, the time, the location of the place of safety, the officer's name and signature and the responsible person's name and signature. Police suggested it was unnecessary and inconvenient to use a piece of paper to get the signed undertaking. Police said that in similar circumstances they were permitted to use their official notebook.

What do we do if we have five kids and only three forms in the car with us? We're not allowed to go to a police station to get more forms, but need forms for each child before we can sign them over.

We use our official notebooks for everything else — statements and statutory declarations ... why shouldn't we be allowed to use our notebooks for this? We can record details of the book number on the custody index.

Additionally, police queried the circumstances in which they were to obtain a signed undertaking and what recourse they had if the person refused or was unable to sign the undertaking.

It's fair enough that we get them from the ambos, the hospital and the [designated] place of safety but from the aunty or neighbour ...? What if they refuse?

If we're supposed to get a signed undertaking from the parent at home, this is completely inconsistent with what we do when we take drunks home.

There was also some confusion reported by police as to the action that could be taken if a person either refused to, or was unable to, sign the undertaking.

A lot of people won't understand why they have to sign and will be suspicious that it's going to come back on them. They will refuse.

What are we supposed to do when the parent won't sign? Why have something like a signed undertaking if we can't enforce it being completed?

Search and seizure powers

Police in all the trial areas were in favour of the search and seizure powers (ss. 371A), stating that these searches were not resource-intensive to administer, and achieved an immediate harm-reduction effect. However, concerns were raised about the search powers and the restrictions on when a search could take place.

The legislation indicates we're not allowed to take them to a police station for any purpose including when we need to do a search that would not be appropriate to conduct in a public place.

When environmental constraints precluded carrying out a full search, police very commonly perceived this limitation as something that compromised the safety of both the officers and any young people they subsequently detained.

Most of these kids are known to carry knives and other objects. If we have to transport them but haven't been able to search them properly, we are placing ourselves at greater risk.

If we can't search a person properly before taking them to a place of safety we effectively put the kids and the staff at the place of safety at risk.

Disposal of seized volatile items

Brisbane police raised concerns about the disposal of volatile substances. The current operational procedures direct police to dispose of substances in either one of only two depots in Brisbane. However, police may not have an opportunity to get to one of these depots during their shift. Until the substances are able to be disposed of they are in the police car, where officers or other passengers could be at risk. Police requested that a more practical approach be adopted, and that they be permitted to dispose of the items in specific bins located at police stations or other establishments.

No power to request name and address

Under the trial powers, police do not have the authority to request a person's name and address, because volatile substance misuse is not an offence. This provision is problematic for police, particularly when attempting to properly identify the person for the purposes of selecting the most suitable referral, whether this is the person's home, a medical facility or a designated place of safety.

Designated places of safety accept young people aged between 12 and 17 years. This means it is important that police are able to verify the personal details and assess the suitability of options for the person before transporting them.

In addition, police are subject to a policy requirement to complete the custody index each time they exercise the power to detain. If police are not able to verify a person's details, it is likely that inaccurate information will be recorded on the custody index about the exercise of these powers, thereby reducing the accountability of the process. The implications include police making decisions about a person based on incorrect information, which may increase the risk of harm to the person, to others or to property. For example, there could be a domestic violence order or another court-imposed order or condition on the person, and/or the presence of a mental illness or other health condition.

Power to detain

The police consulted frequently advanced the view that the legislation and the policy regarding the power to detain were somewhat contradictory. Although it is lawful for a police officer to detain a person, according to the policy a police officer must not chase or agitate a person during the course of exercising that power. Police asserted that, unless a person agrees to the detainment, there would be few examples where detaining would not cause an agitated response. Therefore, the power to detain was not seen as a real power to detain but a power to have a person in detention.

It's not a real power to detain; embedded in the policy is the direction not to agitate a person. If a person doesn't want to come with us, all they need to do is kick up a fuss.

Police also said they were unsure about the exact nature of their response to detaining.

If we have the powers to detain but can't make the person and they get hit by a car — wouldn't it be better not to have the powers at all? We're damned if we do and damned if we don't. If we wrestle a person into the car we risk cardiac arrest but if we leave them on the street the person is at risk of other harm.

Re-detaining

On arrival at a place of safety, police must release the affected person. Under the powers, however, if a safe place and/or an appropriate person cannot be found to care for the affected person, the officers must also release the affected person. There is no power to continue detention, or to re-detain. Officers argued that this can at times place the affected person at some risk.

For some of these kids finding a responsible adult is difficult. Parents are out, intoxicated or fighting.

Police commented that if they take someone home but then determine that there is a risk of domestic violence they are not permitted to take the person to another place of safety — they have to release the person. In a situation like this, police are not to release the person into the home but must release them elsewhere, presumably outside the dwelling or place of safety.

If it means re-detaining a person to make sure they get to a place of safety, I am going to do it. What good is the legislation, if the kid can walk in front of a car as soon as they are out of the police car?

Voluntary nature of response

Police consistently raised concerns with the evaluators about the voluntary nature of the place of safety response. There is no requirement for an affected person to stay at a place of safety. This means that an affected person can leave the place of safety soon after police have released them. Police were concerned that this was not in the interests of the affected person's health or safety.

It's not worth exercising the powers because it's time consuming and kids just leave straightaway.

They need to be made to stay for a minimum period of time to sober up, otherwise what's the point?

The voluntary nature of each and every step in this trial means that kids just do what they want. Where's the intervention, the case management, the outcomes? They're non-existent.

Drain on resources

All police who met with the evaluators commented that the powers took a considerable amount of time to administer. None considered the powers to be a particularly good use of their time.

The powers are part of a revolving door. There are not real outcomes. We see the same kids over and over.

All police gave examples of situations where it took hours to exercise the powers.

If you have a whole family in a park — you're stuffed — each person has to go to a different place, so we just end up taking the stuff off them.

After being turned away from the Princess Alexandra [Hospital], I sat with a child for two hours at the Mater Hospital waiting for an assessment. After that I had to process an outstanding warrant at the watch-house. All of this took four hours.

Due to the time required to exercise the powers and the perception of no worthwhile outcomes, many police indicated they were electing not to use the powers and were simply removing any intoxicating substances.

If there are 20 kids we are just taking the paint off them and not transporting them as there are too many people and not enough resources.

One officer confiscated at least 60 cans from six kids.

I would come across 15 juveniles using volatile substances in a day. If I detained 10 juveniles I would have to wait up to two hours for transport, and then I'd have to do all the paperwork — at least another hour and a half.

We came across a group of 10 Indigenous kids that wouldn't go to a place of safety. We needed the whole city crew to move them. We've got very little support from other agencies — the whole thing is totally unworkable.

Discretion

While it is clear in the subsections of the PPRA [s. 371B(1–3)] that police have the discretion to make a decision about the appropriateness of detaining and transporting a person to a place of safety, some police expressed concern over possible ramifications if they chose not to detain and transport.

If we seize paint but don't detain, are we going to be blamed for any adverse consequences that arise because we didn't detain?

In addition, some police expressed concern about the risk of civil liability, particularly in circumstances that were operationally necessary.

We were called by the ambulance to transport a chromer to hospital because he was behaving aggressively. We detained the child, we helped the ambulance out ... but if something had happened to that kid while he was in the back of our car, well where would that leave us?

If we transport a person to a place of safety, and they leave while they are still intoxicated and therefore at risk, and something happens to that person — will we be held accountable?

We are always thinking about risks and consequences of our actions, the powers mean that we are vulnerable to civil liability in a lot of circumstances.

Non-public places

Police queried the use of the powers in non-public places. This was particularly pertinent for officers in Townsville and Mount Isa who drew attention to the existence of 'sniffing houses'.

If we are called to a disturbance at a private property and find a group of children sniffing paint, are we able to form the view that the place is not safe and detain and transport these children to a place of safety?

Forming the view of what is appropriate

In exercising the new powers, the onus is on police officers to form the view of what actions are appropriate for a person. Police indicated that there were a number of stages and elements that they must consider. Police must:

- make a judgment about the health of a person and determine if an ambulance should be called or if the person should be taken by police to hospital
- assess whether the person wants to be taken to a place of safety
- determine which place of safety is appropriate, including the person's home, or the home of a relative or friend (i.e. no likelihood of domestic violence)
- arrange to take the person to a place of safety at the earliest convenience.

Police said there were a number of assumptions made about the officers' knowledge and capabilities. These were:

- that the police officer is sufficiently trained to recognise when a person may be in need of ambulance assessment and be able to estimate the urgency of such an assessment (determining the seriousness of the intoxication, presence of any injuries or other medical condition)
- that, without an ambulance officer's assessment, a police officer can make a decision about the need to transport a person in a police vehicle
- that the police officer has knowledge of or is able to obtain information about a person's circumstances regarding the most appropriate place of safety
- that a responsible adult willing to care for the person can be located.

Police in all trial sites expressed reservations about the expectations and responsibility on them to make the most appropriate decisions, first about a person's health and second about a person's welfare.

We are chasing around for information and making these decisions but at the end of the day these are difficult issues where often there is no black and white.

If we do something we're doing it for the sake of the person's health and welfare. It's an issue of duty of care for us — it shouldn't be something that can come back and bite us.

Polydrug use

Police very commonly noted that, because of the high rate of polydrug use among people using volatile substances, they would often be detaining and transporting people who were under the influence of a number of substances. This fact inclined some police to the view that the trial powers should be extended to include all forms of intoxication, regardless of substance (including alcohol).

Can public drunkenness be changed to public intoxication? The parameters would be the same with regards to the standards applied, that if a person is also affected by alcohol, a drug or a volatile substance they are a danger to themselves or others and they may be arrested and taken to a place of safety or a watch-house.

Like the offence of 'drunk' it could require that a place of safety be considered first but if one was not available or the person's behaviour warrants, a watch-house could also be utilised to hold the person until the effects of the paint have worn off.

We don't really want to end up with one response for VSM, another for adult drunks and another for illicit drugs. Public intoxication and the behaviour that goes with it is the real issue.

Interactions with other government agencies

Police were asked by the evaluators about the nature of the police interactions with other stakeholder agencies involved in the trial (Queensland Ambulance Service, Queensland Health and the places of safety).

Ambulance

Police commented that their working relationship with the QAS was a good one.

We'll always support the Ambulance and they'll always support us, but they have the same limits on their resources [comparatively] as we do on ours.

The police pointed out that there had only been a handful of occasions where they had attended a VSM incident and needed to call an ambulance, and in only one instance had ambulance officers called police to help them restrain and transport an aggressive VSM-affected person to hospital.

Hospitals

The police who were interviewed reported mixed interactions with hospital (emergency room) staff in regard to patients with VSM-related problems. While some hospital staff were reported to be especially cooperative and supportive of the new trial response, others were much less inclined to view the trial as an appropriate use of hospital resources. In their view, these resources were subject to considerable pressure from higher-order health issues.

The places of safety

Police in the trial areas provided comments about the places of safety operating in their areas. Police in all trial areas, except Brisbane, commented that they had had limited opportunities to use the places of safety.

This was said to be due to police:

- not coming into contact with many people using volatile substances
- coming across VSM-affected people with warrants
- coming across VSM-affected people who were violent or who were otherwise ineligible (age) to take to a place of safety
- electing to use only the search and seizure power
- opting to take a VSM-affected person home (using the place of safety as a last resort)
- being unable to access the place of safety when required (operating days and times)
- not knowing where to take the affected person.

The majority of criticisms about places of safety came from Brisbane police, who experienced the highest level of contact with VSM and consequently had the most frequent contact with the service.

Police were critical or concerned about:

- the voluntary nature of the stays at the designated places of safety
- the volume of self-referrals to designated places of safety
- the apparent lack of comprehensive intake procedures, such as using a questionnaire to thoroughly assess the person's health
- the level of 'safety' provided by the place of safety
- the ability of staff to handle violent incidents
- the limited number of positions available

- the lack of medically trained staff
- little or no obvious prevention work being done
- seemingly limited levels of intervention and case management
- the place of safety concept sending the wrong message about VSM and other drug use

The trial rewards the behaviour. They see a police car and hail us down for a lift. They get taken to the place of safety intoxicated and get to hang-out with their friends doing fun stuff. They can get a feed, a shower and play pool or watch TV and when they are ready to leave they get given a train fare to get home.
- particular practices of some designated places of safety, such as allowing young people to come and go to 'top up', and staff providing children with cigarettes
- the lack of consistency in service ideology characterising the different designated places of safety (regarding drug use, child safety issues).

Designated places of safety staff perceptions

Referrals to a designated place of safety operated by a non-government organisation are a key element of the government's broader response to VSM, and the new police powers were intended to be the basis of these referrals. In considering the question of whether or not the trial police powers should be extended, it is therefore essential that the perspectives of the bodies responsible for accepting police referrals under the trial powers are understood and taken into account.

Three rounds of consultations with staff at each designated place of safety were conducted during the evaluation period. In addition, one meeting was held with all the place of safety coordinators (except one of the Brisbane places of safety) in April 2005. These sessions focused on staff's perceptions and thinking about VSM generally.

General concerns about referrals to places of safety

With the exception of one of the Brisbane places of safety, all sites reported relatively low numbers of QPS and QAS referrals across the trial period. Some providers responded to this by sending staff onto the streets to speak with potential clients, and providing information to relevant stakeholders, community groups and retailers.

Workers in all sites raised concerns about the voluntary nature of stays at the places of safety. Across all sites, instances of clients leaving the places of safety to 'top up' on drugs were reported.

They are not staying overnight, normally just a few hours. They know the routine — shower, food, help clean up, good manners, then go out for another hit.

Workers also frequently expressed concern about the policy that the facilities be provided specifically for the use of intoxicated young people. They were commonly of the view that this focus might be perceived to condone or reward VSM, and in some cases might actually encourage the practice. It was also argued that providing any service specifically targeting intoxicated clients did little to discourage the behaviour.

To address these concerns, a number of the sites extended their policies to accept young people when they were not actually affected by volatile substances, but were experiencing problems associated with VSM. It was recognised, however, that

this policy change meant bringing non-users into direct contact with users, and this potentially heightened rather than reduced the likelihood of future VSM.

Workers across all sites also raised concerns about the health and safety of both clients and staff involved in the place of safety trial. They noted that, in addition to the health risks to the individual engaging in VSM, there were associated risks of injury to the individuals as a consequence of drug-affected behaviour, and risks of aggressive behaviour towards others.

Case management

Across all sites, places of safety staff highlighted the value of responsible case management of their clients. However, most found that, as client numbers increased, they simply did not have the time or resources to perform this function effectively. All sites recognised that collaboration with key government agencies and local support groups was essential for managing the cases of young clients.

The Townsville provider had great difficulty securing an appropriate facility for running their place of safety, a fact that had significant case management implications. To address the local VSM needs before locating a site, the coordinator met with a number of key stakeholders within the area. They developed a faxback service that was to operate in the interim. Police and ambulance officers agreed that, after releasing a young person into the care of another person (other than the place of safety workers), they would fax the young person's details to the place of safety coordinator. The coordinator would then respond with a follow-up visit to the young person's 'family or carers' at the earliest appropriate time to provide education and support in relation to the VSM. During this visit, the coordinator would also make assessments about the family's need for additional services. Referrals were then made, based on these assessments. Because this process was deemed to be so effective, it continued in the Townsville area after a place of safety was secured.

Across all sites, where Indigenous young people were involved, staff had attempted to make contact with appropriate local Indigenous groups and/or Elders. This was seen to be an essential element in rehabilitation. It was generally recognised by places of safety staff that there was a need for Indigenous clients to feel a sense of 'cultural safety' — that is, Indigenous people should not be made to feel that they were being judged or negatively stereotyped by those offering a service response to VSM.

In many cases, staff reported that young people either needed the assistance of the Department of Child Safety, or were already clients of this agency. Staff indicated that, where possible, they tried to reinforce and make contact with the department to address protection issues. However, workers in all sites expressed concern about the lack of coordination of services available to young people involved in VSM, and the overall lack of services specifically targeting their needs.

Queensland Ambulance Service staff perceptions

At the start of the trial period for the new police powers and the operation of designated places of safety, it was expected that the QAS might provide a crucial link between the first (police) contact with people engaging in VSM and any subsequent transfer to a designated place of safety.

However, it became apparent that the role of the QAS was actually less than initially anticipated. QAS staff had relatively little involvement in the trial as a direct consequence of any exercises by police of the trial powers. Nevertheless, the QAS staff spoken to by the evaluators had useful comments about the new police powers and the broader strategy being trialled by the government.

Lack of medical training for places of safety staff

From the beginning of the trial, QAS staff across all trial sites expressed concern about the lack of medical training of place of safety staff, and their limited ability to distinguish the effects of VSM from other serious medical conditions, such as head injury. However, they were generally supportive of both the place of safety initiative and the new police powers. QAS staff were firmly of the view that their role in dealing with VSM was limited to that of assessing the medical risks associated with individual intoxication and, where necessary, transporting affected young people to the hospital.

Like other stakeholders involved in the trial, QAS officers noted that VSM was a symptom of broader aspects of social dysfunction within the young people's lives.

Our focus is medical but it is a social concern. Parents know where their kids are but don't seem to care. Parents put their [own] needs above their children's, the kids walk past here asking for fruit. Educated parents support schooling; others don't. The kids need role modelling about getting up and going to school. Instead, their parents model alcohol use, domestic violence and poor diet. The kid is a product of that environment. They use volatile substances to get away in the same way their parents use alcohol. The peer group becomes the dominant force and it is 'cool to be a fool'.

I believe these are larger problems and they are too deep for us to deal with, especially in the case of low socioeconomic groups and Indigenous kids whose parents don't seem to care what they do. Their parents seem indifferent. It is the last resort, they turn to volatile substances because they are cheap and accessible.

Hospital staff perceptions

Like QAS officers, staff at hospital emergency departments generally felt that they did not play a key role in the trial. Hence, they assigned a low priority to attending meetings with the evaluators. However, at least one session was held in each site with staff from accident and emergency departments. In many cases, these meetings were between the evaluators and the department's director.

Lack of awareness about the trial

Generally, hospital staff in the trial sites demonstrated a very marked lack of awareness of the trial and/or the new police powers relating to VSM. In a number of cases, hospital administration staff members expressed confusion about the nature of the intervention and were unclear about who in their organisation should be responsible for liaison with other community stakeholders. In some hospitals, both administration and medical staff indicated that, given the low number of patients presenting with VSM-related issues, they did not believe that any additional time or resources should be diverted towards addressing these issues. They had not attempted to actively engage with other stakeholders or familiarise themselves with the processes involved.

VSM is not hugely visible in the hospital; there have been maybe six cases this year.

Staff are very committed and work very hard indeed, so a meeting which won't actually achieve much does not seem a good way to spend taxpayers' money or very skilled clinicians' time. If there is a safe place in Townsville for the clients we don't know where it is. The police may have additional powers, but my staff report little if any change to their day to day reality.

Hospital response to VSM

Hospital staff stated that there was nothing they could do to reduce the physical effects of VSM. The usual procedure was simply to keep the patient under observation until the level of intoxication had sufficiently declined. In many cases, by the time the patient arrived at the hospital they had already largely recovered. It was also noted that the young people who engaged in VSM were prone to spontaneously discharging themselves from hospital care. Although concerned that the erratic behaviour demonstrated by these individuals during their attempts to leave a hospital facility might place patients at risk, medical staff commented that they could not hold them against their will.

Minors are brought in, but when they recover there is no-one here to deliver them to. We feel responsible for them but have no powers to detain them. This results in unsafe discharges. We can call Crisis Care if we can't find a carer but some children repeatedly abscond before someone can be found, putting themselves in danger. If police sign over responsibility for children with us we then have duty of care but they are free to run off whenever they want to. It just ends up being a revolving door.

Non-government sector perceptions

In addition to the staff of the designated places of safety, a wide range of other non-government youth workers saw themselves drawn into the government's new response to VSM. This was because it was generally recognised by all key stakeholders that clients of the designated places of safety (and other young people affected by the new police powers) were likely to already be clients of other welfare services, many of which are delivered by the non-government sector. For this reason, many representatives of non-government youth work organisations saw relatively little difference between themselves and non-government staff at designated places of safety. All agencies were dealing with the same client group and seeking to fulfil similar roles, the only difference being that youth workers at the designated places of safety were the only ones able to formally accept police referrals.

The non-government sector was generally very concerned that the real problem of VSM involved polydrug use. Volatile substances were seen to be readily accessible and inexpensive in comparison with more attractive alternatives such as alcohol, cannabis, heroin and speed. It was frequently noted that, finances permitting, most volatile substance users would seek out one of these alternative drugs.

Pills and speed are more of an issue here. Previously a lot of speed users we see have had chroming issues. Current drug users had chroming issues when they were 13, 14 ... as they turned 18 it changed. They still use drugs — it's just the difference of what they can access. (Youth worker, Townsville)

A lot of the crew that started a couple of years ago are now into morphine and opiates. Paint was just a stopgap because it was cheap and they didn't have to do any crime to get it. (Drug and alcohol worker, Brisbane)

VSM was frequently cited as an early warning sign for future, more problematic drug use. Several youth workers noted that activities and programs that focused specifically on VSM risked isolating other young people, and encouraging rather than discouraging use.

Youth workers in all sites reported that VSM was cyclical in nature, with use increasing in school holidays. Patterns of VSM use were also noted to be influenced by geographical location, with Brisbane workers noting that users moved along the train line into the city to use on weekends.

Perceived problems associated with the trial model

Across the non-government sector there were a number of concerns raised about a perceived lack of coordination and consultation in the development of the places of safety model. It was felt that implementation of the trial had been unduly rushed. Stakeholders felt that this had resulted in a lack of valuable information feeding into the model.

Workers consistently voiced concern about what they perceived to be the limited capacity of the model to address the complex issues involved in VSM.

The problem is it's not just a chroming issue. If it was all just about chroming, that would be simple. But it's not. But there is fifteen other things happening in their lives and chroming is just the offshoot of it. Creating a place that is specific to chroming doesn't address all the other issues. It's like putting a bandaid on after a car crash when they are bleeding from fifteen different places. You have one bandaid to use and that's all you've got, chroming is just one part of it. (Youth worker, Cairns)

It's certainly a more enlightened response than making it illegal. That would be a bad solution. But where we need to invest solutions is something that tries to deal with the underlying issues. When you look at all the psychiatric issues, infectious diseases and social issues, they are significant. Young people need something with some dignity and permanency that addresses these serious underlying issues. They are so traumatised by past and current abuse and that is overlooked. They are so traumatised by experiences of violence. (Youth organisation, Brisbane)

Chroming is not the problem, it is a symptom of many problems. But the biggest risk, the long-term risk, is that they are at that age in which they need to be held in the community. They need to be held by their family, education, their neighbourhood. They start experiencing exclusion from various social systems at a very young age. I think we still haven't understood what that actually means and what will happen in their future. (Outreach service, Brisbane)

This safety place all sounds good in theory but you've got to deal with whatever made people want to go down that path in the first place before this can be worked out. Why did they go down that road? What depressed them? What's happening for them? I remember being there and I didn't know anything about depression and peer pressure. All of a sudden one day it was surrounding you. It doesn't just go away, you change your lifestyle and you become accustomed to that way of living. When you do it for so many years with the same people, all your lives go in the one way ... something dramatic has to happen to change it. It's all good you got this place, but really what's it doing, if you are still in that frame of mind next day when you wake up? You can talk, give them money, but it's in one ear out the other. (Townsville, young male, 20)

Perceptions in remote Indigenous communities

In addition to consultations with stakeholders in each trial site, the evaluators consulted with community representatives from outside the trial areas, in particular at Aurukun and on Thursday Island in the Torres Strait. These out-of-area consultations were made for two related reasons. First, the characteristics of VSM in Queensland are very different in some of the areas outside the trial sites, and second, if the police powers and places of safety model are to be extended, they would need to be capable of operating effectively in these very different contexts.

Aurukun

Community representatives (and police) from Aurukun cited a range of factors contributing to VSM. These included boredom, peer influence and a desire to 'escape from family issues, community and education issues'. These issues

were said to include a high rate of sexual abuse, neglect, overcrowding, health problems, welfare dependence and parental gambling problems. Rates of educational achievement were reported to be low in the community, while rates of suicide and self-harm were reported to be very high.

Community representatives from Aurukun described a number of strategies that had been introduced to manage or reduce VSM. These included restrictions prohibiting the sale of petrol to individuals aged under 18 years. In the case of chronic users, this initiative was perceived to have contributed to increased levels of petrol theft as well as recorded incidents of young girls performing sexual favours for older users in return for access to petrol.

Another strategy reported by members of both the Aurukun and Old Mapoon communities was removing individuals involved in VSM from the local area. In the case of adult users, this strategy was considered effective in limiting the supply of petrol to young people. Similarly, removing young people identified as chronic users was considered effective in reducing social involvement in VSM. However, it was acknowledged that these effects were generally limited by the period of time that users could be detained outside the community. Furthermore, in some cases, removing individual volatile substance misusers was perceived to have contributed to the displacement of the problem to other Cape York communities.

Torres Strait Islands

Community representatives from the Torres Strait Islands (meeting on Thursday Island) reported that VSM had 'always been around' but had become more prevalent and more visible in recent years. Specifically, they commented that VSM was sporadic and that young people tended to move between marijuana, prescription drugs, aerosols and petrol, depending on levels of availability.

Torres Strait Island community representatives attributed recent increases in the prevalence and visibility of VSM to a 'breakdown in society' and a perceived lack of parental involvement in the upbringing of children. The introduction of government bureaucracies and restrictive legislation into the islands was claimed to have eroded and undermined traditional mechanisms of social control, including the responsibilities that parents, aunties and uncles traditionally held in managing children's behaviour, education and development. Torres Strait Island community representatives emphasised that associated problems were most pronounced in the outer islands. In these locations, a lack of government service providers, to replace the traditional social structures that government legislation was perceived to have undermined, was believed to contribute to an increased incidence of social problems. In turn, the incidence of these problems, together with a lack of alternative activities for youth, was said to result in increased VSM.

In response to observed misuse of volatile substances among schoolchildren on Thursday Island, the local high school began searching children's belongings for spray cans and confiscating any products containing volatile substances found on school premises. However, community representatives employed at the school stated that the initiative had not stopped students from coming to school intoxicated. Indeed, one representative commented that many young people felt that they gained welcome attention from their peers by coming to school intoxicated.

Conclusion

There are a number of useful insights into the operations of the trial police powers that can be gleaned from a consideration of the stakeholder perceptions reported in this chapter. In particular, there are four central messages that emerge, as follows.

- Police made relatively little use of the powers because they were concerned about exercising them, and concerned about the perceived lack of effectiveness of the powers.
- Even those responsible for accepting police referrals were hesitant about attributing any success to their response to such referrals.
- Both police and the operators of the designated places of safety had real concerns that the broader strategy supported by the new police powers condoned and even encouraged VSM, rather than containing and reducing such activities.
- The consultations with stakeholders from the Torres Strait Islands and at Aurukun call into question the applicability of the current model outside major urban centres, especially in situations where cultural considerations suggest the need for uniquely local responses to VSM.

If there is anything that brings together the essential substance of these four very significant reservations about the new police powers and the associated places of safety, it is the view that an alternative response to VSM is required. In particular, the stakeholders all draw attention (albeit articulated in different ways) to the tension between providing an immediate health-oriented response to VSM intoxication, and providing an effective longer-term response to the diverse welfare needs that underpin the engagement in VSM. The dissatisfaction with the current model on the part of almost all stakeholders derives in large part from the inability of the current model to respond effectively to either immediate or longer-term welfare needs.

Police are understandably concerned at what appears to them to be an expectation that they will act in the capacity of health and welfare professionals. The youth workers are equally concerned at their inability to provide needed welfare services to client groups free to 'take or leave' the services as they choose, without any requirement to curtail their use of volatile substances — and arguably with some real incentives to continue to misuse substances.

The Commission regards the issues highlighted by the stakeholder consultation process as matters of great seriousness. Accordingly, it has been especially mindful of these issues when considering the options for an enhanced response to VSM in Queensland.

5

Enhancing the police response to VSM

This chapter concludes the review by outlining the successes of the trial legislation and examining any shortcomings. In general, the trialled powers worked well, but there is scope for some enhancements. These centre on ensuring that the police have two key powers:

- **to hold a person affected by VSM for a limited period, for the person's own wellbeing and for the safety of others**
- **to require a person affected by VSM to supply their name and address.**

The Commission makes 26 recommendations to enhance police powers to deal with volatile substance abuse, the first of which includes a proviso that the new powers be subject to a time limit. This is because it is important that agencies accept that the enhanced powers are not the solution to the problem of volatile substance misuse — they are designed to support a broader multi-agency response to VSM. A sunset clause will allow an opportunity to evaluate whether this has occurred. The CMC, which will be monitoring and reporting on the exercise of the powers, will be well placed to advise whether the sunset clause should be invoked or, alternatively, the life of the powers extended.

General findings

Over a nine-month period, the CMC evaluated the use by police of new powers embodied in subsections 371B–D of the *Police Powers and Responsibilities Act 2000*. These 'trial' powers were used in five specified areas, and were intended to allow police to provide an enhanced response to VSM as part of a broader government strategy.

The CMC evaluators arrived at the following general conclusions:

- Police sought to use the trial powers on only 255 occasions during the nine-month period, and only 157 people were the subject of the powers in the trial sites.
- Despite some confusion about the trial's geographic limits, police generally exercised the powers on appropriate occasions and in a manner consistent with the intent.
- Operational police had some difficulties exercising the trial powers, because of limitations to the powers and a certain lack of clarity about how the powers were to be given effect.
- There were no persuasive indications that exercising the trial powers had any net-widening consequences.
- At times, police were reluctant to transfer intoxicated young people to the designated places of safety, as they felt that such a transfer would not be in the subject's best interests. Not all police were satisfied that the places of safety were in fact safe. In the Commission's view, there are some grounds for this perception.

Overall, these general conclusions led the Commission to believe that there are compelling arguments for extending the trialled police powers statewide and beyond their current lifespan — subject, however, to the following:

- that the powers themselves be amended and some new ancillary powers be implemented to take account of a number of operational issues that became apparent during the evaluation
- that modifications be made to the places of safety service delivery model based on the use of non-governmental organisations.

Concerns about the trial powers

It was obvious to evaluators early in the review that there were a number of problems with the operation of the trial police powers. These problems were predominantly caused not through the way police used the powers, but by the limitations and resource demands that the powers placed on police. They can be summarised as follows:

- concerns over limits of current powers
- concerns over operation of current powers
- concerns over duty of care and liability in exercise of current powers
- concerns with the broader VSM approach

Concerns over limits of current powers

There are limits to the police use of the current powers, and the scope and nature of the powers require clarification. For instance, under the current powers, police:

- have no ability to require a person's correct name, address or date of birth
 - Custody Index may be inaccurate and police are unable to determine if a person has parents, or is a child.
- have no ability to take further action where place of safety is not an option
 - Affected people are simply released back into the community and may remain a potential risk to themselves and others.
- have to transport potentially harmful things (confiscated volatile substances)
 - There is potential risk to the health of people in police vehicles.

Concerns over operation of current powers

Police are confused about using the current powers in certain circumstances and:

- uncertain of the interaction of the powers with questioning powers, issuing warrants and traditional arrest powers
 - Where a person is wanted on warrants, can they be served? Can they be arrested for an offence? Can they be questioned for an offence?
- unclear of the scope of the search powers
 - Can a person be searched in public sufficiently; and, if not, can they be taken to station for a further search? How do traditional search powers interact with section 371A?
- not convinced about the practical use of the specific Form 92 when releasing an affected person to a place of safety
 - Why do details have to be recorded on the Form 92 instead of an official notebook?

Concerns over duty of care and liability in exercise of current powers

The current powers do not empower police to respond effectively to protect affected people and the community. Issues raised include the following:

- Some places of safety are not safe and do not uphold a sufficient duty of care:
 - Some transfers to places of safety were not in the young person's best interests.
- Risks of injuries or deaths in custody:
 - How can this risk be minimised?

Concerns with the broader VSM approach

A recurrent issue was the need for increased coordination between police and other government agencies. It was felt that this would enable the development of an appropriate immediate, medium-term and long-term response to people engaging in VSM. Other concerns included:

- police being viewed as a taxi service
 - Police do not like being seen as a taxi service by people engaging in VSM and want power to take more decisive action.
- police being expected to act as health and social workers
 - Police are not health workers or social workers and want other agencies more actively involved to take the burden off them.
- police being uncertain about the role of Queensland Health
 - There are concerns over lack of engagement by Queensland Health with the VSM issue.
- little interaction between government services
 - There are concerns over lack of interaction and coordination between government services in addressing VSM.
- lack of conviction on the part of the police that the model provided any disincentives to engage in VSM
 - There seems no incentive in the current places of safety model to stop VSM; on the contrary, there are some unintended incentives to continue or even commence use.

There was also a perception among a diverse group of stakeholders that the responsibility for addressing the problem of VSM fell primarily with police. Police expressed concern: both that they had been given insufficient authority and operational guidelines to effectively manage initial contact with VSM-affected people, and that they were only the first level of response to the issue and should not be expected to provide the critical follow-up health or social-work response.

Effectively addressing these issues provides the basis for developing a significantly enhanced police response to VSM.

Development of an enhanced approach

The CMC therefore proposes making a number of changes that will result in a better police approach to dealing with VSM. These are based on some general defining features, as described below.

Therapeutic, rather than criminal

The most significant feature of the proposed approach is that it is a therapeutic rather than criminal justice system response. VSM is currently not illegal in

Queensland, and the Commission is not at this point persuaded that criminalising VSM is either practical or in the best interests of people engaging in it.

Recognition that VSM is a sign of other problems

The Commission is strongly of the view that VSM should in most cases be understood not only as a specific behaviour requiring remedial attention, but also (and more usually) as a marker or sign of other problems that need to be addressed by a broader range of social services.

Recognition that VSM is part of polydrug use

VSM almost always needs to be recognised as just one aspect of polydrug use. There are very few individuals for whom VSM is their only substance of abuse; in fact, there are very few individuals for whom VSM constitutes their ‘drug of choice’. One of the distinguishing features of VSM is the low regard in which the behaviour/drug is held, even by those regularly engaging in the practice. Taking account of this aspect of VSM is central to the proposed new model.

A broader welfare response

The Commission recognises that, although the police have a significant role to play in responding to VSM, they are not providers of the sorts of social services needed by those engaging in it. An effective response to VSM will require a broader welfare response if the needs of a difficult client group are to be met.

Modifying the role of non-government organisations

Although the non-governmental sector can effectively deliver services for the broader longer-term needs of those engaging in VSM, it is much less well equipped to offer immediate responses to those intoxicated by VSM. This means that some changes to the current role of non-government organisations in VSM-related service delivery are required.

Increasing the role of the Commission for Children, Young People and Child Guardian

The Commission is of the view that the Commission for Children, Young People and Child Guardian has a significant role to play in monitoring and evaluating the nature and effectiveness of the proposed response to VSM because of its statutory responsibilities to oversee the Department of Child Safety.

Recognition that police should not have primary responsibility for responding to VSM

It is critically important to recognise that the Commission is in no way advocating that police assume primary responsibility for responding to VSM. While police should be given lawful authority for an enhanced response to VSM, this does not mean that other agencies can shift responsibility for VSM matters to police. This is particularly important in areas that have elevated levels of VSM and a limited capacity to respond with client assistance services. An increased capacity for police to respond to VSM should be met with other agencies improving their own service delivery capacities to an equivalent degree.

In situations where the VSM problem is serious and welfare services limited (such as may occur in remote centres), the Commission stresses that VSM is a marker for a more diverse set of problems. Police powers should not be seen as an acceptable or appropriate alternative to whatever more general welfare services are required.

If police are the only agency capable of responding to VSM in certain communities, the Commission argues that the problems facing the community are clearly far greater than just VSM. This fact should be acknowledged and not avoided; otherwise a broad welfare responsibility would be transferred to police under the guise of a much narrower VSM-related responsibility.

If the Commission's recommendations are accepted, the Commission will monitor the use by police of the new powers and publicly report on the extent to which the powers have fulfilled the intended purpose as a support for a broader multi-agency response to VSM.

RECOMMENDATION 1

That the trial police powers relating to VSM be retained and extended statewide, subject to modifications to the operation of the designated places of safety and some amendments and augmentation of the trial police powers. These powers should be subject to a sunset clause, whereby after a period of three years of operation a decision would need to be made as to their retention or expiration.

Modification to the designated places of safety model

The CMC's suggested new service delivery model is diagrammatically presented in Figure 5.1 on page 50. As the figure shows, the CMC has aimed to advance a practical and fiscally responsible service delivery model capable of being implemented throughout Queensland, despite the considerable diversity of the VSM problem and the local resources available.

The proposed model aims at a better 'fit' between agency capacities (whether government or non-government) and the expectations on the various agencies that contribute to the larger government strategic response to VSM. Each element of the model is intended as a component of a broader therapeutic response to VSM, which better protects the immediate safety of those intoxicated as a result of VSM while also providing a basis for a longer-term response to the more deep-seated problems behind VSM.

The enhanced approach does not make misuse of volatile substances illegal. Nor does the model shift the focus of the existing legislation from the therapeutic needs of substance-affected individuals. On the contrary, the primary focus of the suggested developments is the health, safety and welfare both of substance-affected individuals and of the community. At its core, the proposal gives police expanded options for a therapeutic response to VSM.

The Commission proposes that diverse general welfare-oriented **client assistance services**, such as those already provided by the non-government sector, continue to be made available to people who engage in VSM but are not affected by a volatile substance at the time they access the service. This should, however, be made quite separate from an **intoxication-recovery service** for inhalant-intoxicated people. Such a service could be offered by an existing provider of client assistance services as an adjunct to other services.

In many respects, the enhanced approach proposed by the Commission draws on the model of the Mental Health Act. Powers under the Act include apprehending and detaining people to prevent the commission of offences (s. 44) and diverting the person into therapeutic care alternatives (similar to the drug diversion scheme) without criminalising the person's behaviour. Thus, police may apprehend a person who has committed no offence, for the purpose of taking them to a place where they may receive appropriate services, including medical assistance. Table 5.1

compares the approach proposed by the Commission with the relevant operational sections of the Mental Health Act and the approach taken to public drunkenness under the PPRA.

The Commission reiterates that the development of the proposed model should be only a part of the overall government response to VSM within Queensland. In many respects, it is unfortunate that a law enforcement response is most often the first point of contact at scenes where volatile substances are misused, when it may often be a health response or social services response that is more urgently needed. The reality is, however, that police officers are the most likely to witness or be called to attend such scenes in the course of their duties, and this is why an effective, responsive and responsible set of powers and operational guidelines should be made available to operational police.

Figure 5.1: Enhanced response — the proposed new model

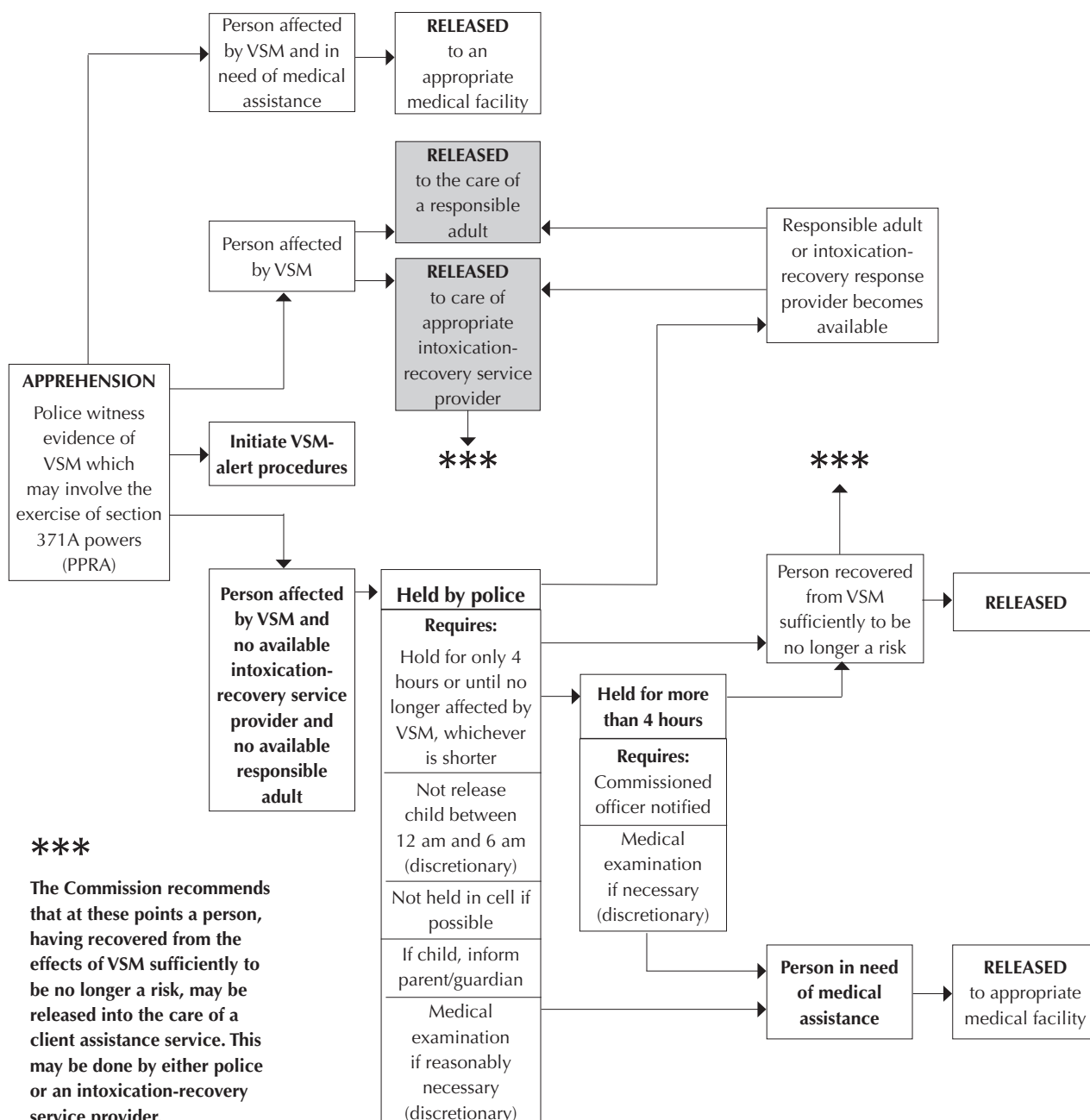


Table 5.1: Comparison between Mental Health Act, proposed VSM model and public drunkenness legislation

	Mental Health Act	Proposed VSM model	Public drunkenness legislation
Has the person committed an offence?	No	No	Yes
Can the person be arrested?	No	No	Yes
Person may be apprehended where police reasonably believe:	<ul style="list-style-type: none"> • Person has a mental illness. • Due to the illness there is an imminent risk of significant physical harm to the person or other people. • It would be dangerous to delay. 	<ul style="list-style-type: none"> • Person is affected by VSM. • Due to VSM there is a risk to the health or safety of the person or other persons. 	<ul style="list-style-type: none"> • Person is drunk in a public place.
Place where person must be taken:	<ul style="list-style-type: none"> • Must be taken to an authorised mental health service for examination. 	<ul style="list-style-type: none"> • Must be taken to a parent/guardian, responsible adult or intoxication-recovery service provider, where possible and appropriate. 	<ul style="list-style-type: none"> • Can be taken to police establishment. • Arrest should be discontinued where appropriate, and person should be released to place of safety, or appropriate adult.
Where no such service is available:	<ul style="list-style-type: none"> • Assumption that no interim arrangement would be necessary due to the high number of service providers and high level of treatable risk to patient. 	<ul style="list-style-type: none"> • Person posing such a risk may be held by police until such service becomes available, or the person has recovered such that they no longer pose a risk. 	<ul style="list-style-type: none"> • Person, including a child, may be held in police custody under the arrest.
Length of time held:	<ul style="list-style-type: none"> • Up to 6 hours for the purpose of initial examination at authorised mental health service. 	<ul style="list-style-type: none"> • Up to 4 hours, though can be extended in limited circumstances, by police. 	<ul style="list-style-type: none"> • As per normal arrest procedures by police.

The enhanced response explained

The details of the enhanced police response to VSM are explained throughout the rest of this chapter in three categories:

- general police responsibility and related power within the broader VSM approach
- specific police powers and a better response to VSM
- clarification of other issues raised during the review.

Recommendations are included within each category.

General police responsibility and related power within the broader VSM approach

The central focus of the Commission's approach to VSM is a desire to ensure that children who are misusing volatile substances are given effective and ongoing case management that provides for their welfare and safety. Strengthening links between a range of government agencies, including Police, Child Safety, Communities and Health, is pivotal to this goal.

To achieve this, and ensure that police can initiate an effective response, the Commission proposes two broad changes to the government's VSM strategy.

First, police must be able to take an affected person to a safe environment that will provide for the person's immediate care and protection from a health as well as a social welfare perspective. The Commission has found that, when such an environment is not available, police can be unwilling to use their apprehension powers, or feel dissatisfied with their role in addressing VSM. An intoxication recovery service, physically separate from other client assistance services offered by an organisation, would address this concern and other concerns with the current places of safety model.

Second, because police are usually the first point of contact for young people engaging in VSM, this opportunity must be taken to initiate medium- and long-term care options. Police should therefore have a responsibility to alert the Department of Child Safety about children engaging in VSM so that preventative strategies can be implemented.

Unfortunately, the existing places of safety operated by non-government organisations have to fulfil two roles which, although not incompatible, cannot easily be reconciled under the current contractual arrangements. These places try to offer, simultaneously, a sort of 'sobering up' facility and a way of connecting people engaging in VSM with welfare services that might help them stop the practice.

As previously mentioned, the Commission therefore believes that the function of the existing places of safety needs to be separated to offer:

- an intoxication-recovery service
- a client assistance service.

The police 'VSM-alert' responsibility is integral to the success of this new model.

Intoxication-recovery service

The Commission recognises the need for a facility with a monitored environment in which a person can safely recover from the effects of VSM, and have access

to first aid services for any resulting ‘cuts and scrapes’. This would not replace the services of the QAS or a hospital emergency department, where a person has more acute needs requiring professional treatment. Instead, it is somewhere for a person to be monitored for the hour or two that is usually enough for the level of intoxication to subside to the point where the affected person is no longer a risk to themselves or to others.

Such a service was, in fact, one of the primary aims of the original places of safety. Over time the places of safety evolved into an emergency accommodation service used by a much wider group than just those referred by police. The size of the extended group meant that the nature of the places of safety changed — to the extent that some police were unwilling to make referrals because of concern for the safety of the people they referred.

Despite reservations about the operations of the current places of safety, the CMC readily accepts that a tightly focused intoxication recovery service, more consistent with the early conceptions of how the facilities might operate, could easily be provided by non-government organisations. Agencies would accept referrals from police or the QAS, and could provide the service in addition to the general welfare services they typically provide.

The intoxication recovery service would need to be very clearly separated from any client assistance facilities. However, once the person was no longer intoxicated they could then ‘graduate’ to the other facilities available, although this would be absolutely contingent on the cessation of VSM (i.e. no leaving the facility for 20 minutes in order to ‘top up’ before returning to enjoy the available amenities while freshly intoxicated).

In funding terms, a non-government organisation providing welfare services to the client group on behalf of the government (i.e. a client assistance service of some type) could receive additional funds to support an accompanying intoxication-recovery service — on condition that the need for such a service could be satisfactorily demonstrated.

Because access to such a service would depend on a referral from either the police or the QAS, and because such a service is not inherently attractive in the way the current designated place of safety facilities are, it is likely that it would manage a small number of people at any one time (and, even then, only in areas of high population density or areas with especially high levels of VSM).

Without a more rigorous needs-assessment exercise, it is difficult to predict accurately how many locations would have the need for an intoxication recovery service. However, during the evaluation period, it appeared that only the Brisbane site demonstrated the need for such a service.

Even when access to an intoxication-recovery service is carefully calibrated to real levels of need, the Commission recognises that there may be occasions when demand outstrips supply, or when access to the service is restricted for some other reason (e.g. staff unavailability). In such circumstances, the amendments to the trial police powers advocated by the Commission then become critical.

Client assistance service

Once a person has made the transition from being a client of an intoxication recovery service to being the recipient of the more general client assistance service offered by the agency, the government policy objective of more effectively responding to the broader welfare needs of those engaging in VSM can be addressed.

At the heart of the VSM-related client assistance service is the VSM-alert scheme involving police and designated non-government organisations. This scheme was developed in Townsville by a non-government organisation that was unable to establish an actual 'place of safety' at the start of the trial. While waiting for premises to become available, this organisation (together with police) developed what was envisaged as a short-term interim measure, which then proved to be effective in responding to the longer-term welfare needs of the client group engaging in VSM.

The Commission believes that this is a model of considerable promise, which, if implemented appropriately, could be used statewide. The success of the scheme would depend on which body was made responsible for receiving the alerts from police and assessing what response was required (by which agency, and with what degree of urgency). In the Commission's view, the most appropriate agency for this role is the Department of Child Safety — although it is recognised that in many, if not most, instances it would be the Department of Communities that would need to take responsibility for case management to meet the longer-term needs of individuals.

Police VSM-alert responsibility

The Commission recommends that police must report the apprehension and release of any volatile substance-affected child to the Department of Child Safety. Police would record on a form a number of relevant details, such as the child's name and address, if known; the reason for apprehending the child; and the subsequent police response (i.e. if the child was released to an intoxication recovery service provider, or to a parent, guardian or other suitable adult, or was held by police until their release).

This form would be given to Child Safety, where it would normally constitute an 'alert' rather than a notification of harm under the *Child Protection Act 1999*. Repeated alerts for a single individual or particularly serious alerts could, however, be upgraded by Child Safety to the status of a formal notification.

On receiving an alert from the police, Child Safety would have to institute their standard process of intake screening and then, where necessary, start case management. The department would in many (if not most) instances need to forward the details of the alert to a more relevant department than themselves. This would usually be the Department of Communities.

The Commission stresses that VSM alerts must be immediately subject to the risk-assessment screening processes of the Department of Child Safety, even though the longer-term follow-up response to VSM will generally fall within the responsibility of Communities rather than Child Safety. Child protection screening has to be carried out before the matter is forwarded to another agency for their attention.

RECOMMENDATION 2

That it be mandatory for police to initiate a VSM-alert process to the Department of Child Safety whenever an affected child is apprehended under the VSM powers.

The VSM-alert process should take place as soon as reasonably possible after a child is apprehended and should include the child's name, address and condition at time of apprehension, and the police response.

Power to require person to state name and address

Given the importance of police being able to accurately report the identity of affected children to the Department of Child Safety, the Commission is concerned about the current inability of police to require a person's name, age and address.

The Commission believes that this has a detrimental effect on the capacity of all agencies to give long-term care and support.

Under the Commission's proposed changes to the VSM-response strategy, police must be able to give accurate names and addresses to the Department of Child Safety, which must in turn be able to supply correct information to other necessary agencies.

The power to require a person to supply their name and address is generally contained in sections 32 and 33 of the PPRA, in circumstances where a person is found committing an offence, or is reasonably suspected of having committed an offence, where a person is being or has been given a direction, and where a person may reasonably be able to assist police with an investigation into an offence. Police are similarly empowered under the *Transport Operations (Passenger Transport) Act 1994* and associated regulations.

Given that the misuse of a volatile substance is not an offence (and the Commission is not arguing that it should be made an offence), police therefore have no power to require an affected person's name and address. This has proven problematic for police, especially when trying to select the most suitable referral for the person.

Police are also required by the current policy to complete the custody index every time they exercise the power to detain. If police are unable to verify a person's details it is likely that inaccurate information will be recorded on the custody index, reducing the accountability of the process.

Police are currently forced to make decisions about a person based on incorrect information. This may increase the risk of harm to the affected person, or to other people (including places of safety staff) or to property. For example, police may be unable to determine the existence of a domestic violence order or another court-imposed order or condition relating to an affected person, or the presence of a mental illness or other health condition which may be recorded on a relevant police index.

The Commission is, however, aware that authorising police to require a person's name and address might create other problems. Most notably, if a power were to be implemented with an associated penalty not dissimilar to the current section 33 power, affected people who did not give their name and address would be subject to criminal penalty. As the basis for this power is intended to be therapeutic, such an outcome is potentially unsatisfactory.

In order to best balance these concerns, the Commission suggests that police should be given a power to require an affected person's name, with a penalty for non-compliance — but this criminal sanction should only be enforced in exceptional circumstances.

The Commission recommends that section 33 of the PPRA be amended to include circumstances in which a person is apprehended under the proposed VSM powers. Where an affected person is not apprehended, despite the fact that they may be searched and potentially harmful things may be seized, police will not have the power to require them to state their name and address.

RECOMMENDATION 3

That, in support of the VSM-alert process, police be given the power to require a person's correct name and address when apprehending a person under the proposed powers. Criminal sanction for non-compliance should only be enforced in exceptional circumstances.

Specific police powers and a better response to VSM

As well as increasing police responsibility, the Commission considers that significant changes are needed to the powers of police so that they can more effectively respond to VSM. In addition to the power to require an affected person's name and address, the proposed changes include amending the existing powers to remove the obligation of police to release an affected person and give police the authority to hold an affected person as a last resort, outlining the related police duties, and clarifying the scope of the proposed powers.

Amendments to the existing police powers

Queensland police are currently authorised to apprehend and detain people who are affected by a potentially harmful substance. The apprehension and detention, however, can only be for the purpose of taking the person to a place of safety, where they can receive necessary care and protection. Where this is not possible, the officer must release the person.

The Commission is concerned that this limits police capacity to further prevent self-harming behaviour or allow opportunities for treatment. While the Commission is satisfied with the rationale behind the adoption of the detention power (namely that it is 'in the interests of the welfare of the affected person'), it is difficult to reconcile this rationale with the reality that police may be forced to simply release an affected person, in particular a child. It is unsatisfactory that police are legally incapable of providing opportunities for further care or protection which may otherwise be available.

The Commission's proposed amendments would enable police to continue to hold affected individuals in certain circumstances for a limited period, thereby reducing the instances of affected individuals being released back into the public while they still pose a risk to themselves or others. This extension of the existing power builds on the power to apprehend and detain in the interests of the affected person, and depends on no other reasonable option being available to police.

The proposed amendments also make two significant changes to the current apprehension and detention provisions. First, the basis upon which police can apprehend a person is limited by requiring them to be satisfied not only that the person is affected by a volatile substance but also that they pose a risk to themselves or any other person. Second, a person may be apprehended and detained for any of two purposes — release to a medical facility or service, or release to an intoxication-recovery service provider or suitable adult — but that person may be held by police until such an option is available, or, where no such option is available, until the level of intoxication has subsided to the point where the person is no longer a risk to themselves or others.

In addition to a series of clarifications of existing and proposed powers and duties, there are two key amendments that should be noted. The first is that a person may only be apprehended if they are affected by a potentially harmful substance and they are also likely to be a risk to the health or safety of themselves or others. The second is that police may continue to hold a person as a last resort and are not compelled to immediately release if they still pose a risk to the health or safety of themselves or others.

Other Australian jurisdictions

In the course of describing the proposed model, the Commission has made reference to the models adopted in all other Australian jurisdictions. While not all of the legislative schemes the Commission has considered relate to volatile substance misuse, each scheme does demonstrate the scope of police powers in other jurisdictions to deal with intoxication, however described.

It is important to note that 'intoxication' is defined variously in the legislation, though in all jurisdictions is used to encompass more than drunkenness by alcohol consumption. Excluding the Northern Territory and Victoria, where VSM-specific legislation has been enacted, intoxication more generally has been the subject of police action. The scope of the term 'intoxication' does, however, vary.

In all other jurisdictions, at a minimum 'intoxication' includes the effects of alcohol or other drugs. The South Australian, New South Wales and Tasmanian legislation does not expand upon this definition to include volatile substances as being specifically within the definition of a drug or intoxicant, though the South Australian legislation does include petrol and other volatile liquids containing hydrocarbons within the definition of 'drug'. The Western Australian and Australian Capital Territory legislation both expand the definition of intoxication to include 'volatile substances' and 'other substances' respectively.

It is important to note, however, that the behaviour resulting from all forms of intoxication is often likely to be similar, and therefore legislative responses to such behaviour in public places are instructive in situating the Queensland police powers within the broader Australian context.

The Commission has provided excerpts and descriptions of relevant legislative schemes in order to better illustrate the range of responses currently in force in Australia and to allow comparison with both the existing Queensland powers and the proposed model.

The relevant Acts are listed below. The section number relevant to the definition of 'intoxication' is listed where appropriate.

- *Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003* (Vic.)
- *Volatile Substance Abuse Prevention Act 2005* (NT)
- *Protective Custody Act 2000* (WA), s. 3
- *Intoxicated Persons (Care and Protection) Act 1994* (ACT), s. 3
- *Public Intoxication Act 1984* (SA), ss. 4 & 7
- *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW), s. 205
- *Police Offences Act 1935* (Tas.), s. 4A

The proposed amendments to the existing police powers are described in greater detail as follows.

Person is both behaving in an intoxicated manner and likely to be a risk to themselves or others

While it is not the intention of either the current legislative scheme or that proposed by the Commission to bring people, in particular young people, into contact with the criminal justice system unless absolutely necessary, this does not mean that contact and interaction with police should be similarly avoided.

As the Commission has sought to provide a therapeutic response to affected people, this response must enable police to apprehend affected people in order for them to access treatment alternatives. So that this cannot be viewed as a heavy-handed power open to misuse, the Commission has added a question of risk to the factors that must be satisfied before an officer can apprehend an individual. An officer apprehending an individual must be satisfied both that the person is affected by the inhalation or ingestion of a potentially harmful substance, and that the person is likely to be a risk to themselves or others.

It is the Commission's view that this twin test will provide police with an operational framework to assist them in determining which individuals should be subject to apprehension and assist in ensuring that the power to apprehend and detain affected persons is used proportionately and appropriately.

RECOMMENDATION 4

That the police authority to exercise the apprehension powers require officers to be reasonably satisfied not only that a person is affected by the inhalation or ingestion of a potentially harmful thing, but also that the apprehension is necessary to protect the health or safety of the affected person or other persons.

Current Queensland legislation

Section 10 of the *Summary Offences Act 2005* makes an offence of public intoxication. A person may therefore be arrested simply because they are intoxicated. The current police powers with respect to VSM authorise police to apprehend and detain a person simply because they are affected by the ingestion or inhalation of a potentially harmful thing. Neither provision requires the twin-test of condition and risk. The Commission would note first that VSM is not a criminal offence, therefore the simple act of misusing a volatile substance cannot trigger a simple arrest provision. More importantly, while the Commission believes that an affected person may always be a risk to themselves, the possibility that the police may be required to hold the affected person in police custody until other arrangements can be made favours an apprehension test more rigorous than simple intoxication or an altered state of mind.

Other Australian jurisdictions

The legislation in all other Australian jurisdictions relating to apprehension of intoxicated people, through VSM or alcohol or other drugs, includes a similar twin-test which governs police capacity to apprehend and detain. In short, the police must be satisfied that a person is intoxicated and poses some manner of risk to themselves or others. The relevant language used in each is replicated below:

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60L:

reasonable grounds for believing that the person ... (b) is inhaling a volatile substance or has recently inhaled a volatile substance; and (c) is likely by act or neglect to cause immediate serious bodily harm to himself or herself or to some other person

Volatile Substance Abuse Prevention Act 2005 (NT), s. 19:

reasonable grounds to believe the person – (a) is inhaling or has recently inhaled a volatile substance; and (b) should be apprehended to protect the health or safety of the person or other persons

Protective Custody Act 2000 (WA), s. 6:

reasonably suspects that a person ... (a) is intoxicated; and (b) needs to be apprehended – (i) to protect the health or safety of the person or any other person; or (ii) to prevent the person causing serious damage to property

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

believes on reasonable grounds that a person ... is intoxicated and is, because of that intoxication —

- (a) behaving in a disorderly manner; or
- (b) behaving in a manner likely to cause injury to himself, herself or another person, or damage to any property; or
- (c) incapable of protecting himself or herself from physical harm

Public Intoxication Act 1984 (SA), s. 7:

reasonable grounds to believe —

- (a) that a person ... is under the influence of a drug or alcohol; and
- (b) that by reason of that fact the person is unable to take proper care of himself

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 206:
an intoxicated person...who is:

- (a) behaving in a disorderly manner or in a manner likely to cause injury to the person or another person or damage property, or
- (b) in need of physical protection because the person is intoxicated

Police Offences Act 1935 (Tas.), s. 4A:

believes on reasonable grounds that a person ... is intoxicated and —

- (a) is behaving in a manner likely to cause injury to himself, herself or another person, or damage to any property; or
- (b) is incapable of protecting himself or herself from physical harm.

New duty to inform apprehended persons

It is important that police inform affected people that they are not being arrested and charged with an offence. The Commission recommends that police have a duty to tell an affected person that they have been apprehended with the intention of preventing the person causing harm to themselves or others.

RECOMMENDATION 5

That, in the course of exercising the power to apprehend and detain affected persons, police should be obliged to inform the affected person that they are not under arrest and that they have been apprehended to prevent them causing harm to themselves or others.

Duty to release affected person

When apprehending an affected person, police have a primary duty to release that person into the care of an appropriate facility or person. The emphasis is on the welfare of the affected person — ensuring that they get necessary medical attention and an appropriate and adequate environment in which to recover from the effects of VSM.

The Commission recommends that the first responsibility of police when releasing an affected person is to take account of any medical need. In the event that a police officer attends a scene where a person is apparently affected by volatile substance misuse and the officer is concerned that a medical emergency is developing or is at hand, the police officer may apprehend and detain the person for the purpose of releasing them to an appropriate medical facility.

The proposed responsibility to release an affected person to a medical facility does not deviate substantially from the powers and responsibilities currently undertaken by police. Section 371B(2) specifically notes that a hospital is a place of safety for a person in need of medical attention, while both sections 371B(2) and 371C(1) note that a place of safety may be a vehicle under the control of someone other than a police officer that is used to transport persons to another place of safety.

In the absence of a medical emergency, the person should be released to an appropriate person or facility. Where the affected person is a child, a parent or guardian will most often be the most appropriate person; where the person is an adult, an appropriate person may be a relative or spouse. Where no such person is available, an intoxication-recovery service provider is a suitable place for release.

In determining who is a 'suitable' adult, police should have regard for a number of factors. In particular, where police have a reasonable suspicion that the affected person may be at risk of violence, or may place the adult at risk of violence due to the affected person's condition, police should consider the adult not to be suitable in the circumstances and should therefore not release the affected person into their care. Further, the Commission recommends that police should have regard to the objections raised by an affected person concerning their release to an adult. Where the affected person is an adult and objects to being released into the care of another person, police should not so release the affected person. Where the

affected person is a child, police should not release them into the care of an adult where the child objects to being so released and the police officer is reasonably satisfied that the child is of sufficient age and understanding to make such a decision. In both situations, this person is not a 'suitable' adult.

It is only in the absence of any appropriate person or facility that the police may continue to hold a person, either until a facility or person becomes available, or until the person is no longer sufficiently affected by VSM so as to be a risk to themselves or others.

RECOMMENDATION 6

That it be made explicit that, where an affected person requires medical attention, police must release the affected person to an appropriate medical facility, or cause the person to be released to an appropriate medical facility.

RECOMMENDATION 7

That it be made explicit that, where no medical emergency exists, police have a duty to release an apprehended person into the care of:

- a parent or guardian
- an intoxication-recovery service provider, or
- another suitable adult who is willing and able to provide the affected person with care and protection.

Further, that an adult not be considered suitable where, for example:

- there is a reasonable suspicion that the person will be at risk of or expose others to risk of violence at that place
- the affected person is an adult and objects to being released to the suitable adult, or
- the affected person is a child and objects to being released to the suitable adult and the officer is satisfied that the child is of sufficient age and understanding to make such a decision.

Other Australian jurisdictions

In all other Australian jurisdictions, with the exception of South Australia, the primary responsibility of police officers to people apprehended for intoxication, VSM or otherwise, is to release them as soon as practicable to a suitable person or place or safety, or an equivalent. In South Australia this is an option, but a broader discretion is left to the attending police officer.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

- (3) ... as soon as practicable after apprehending and detaining ... a person who is under 18 years of age, a member of the police force must release the person into the care of a suitable person who —
- (a) the member reasonably believes is capable of taking care of the detained person; and
 - (b) consents to taking care of the detained person. Depending on the circumstances of each case, a suitable person may include the detained person's parent, guardian or another adult family member or employee of an appropriate health or welfare agency.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 21:

as soon as practicable after apprehending a person, the police officer ... must take the apprehended person —

- (a) to a place of safety, where the person may be released into the care of a person at that place; or
- (b) to a responsible adult and, if the responsible adult consents, release the apprehended person into the adult's care.

Protective Custody Act 2000 (WA), s. 11:

- (1) As soon as practicable after a child is apprehended, an authorized officer must release the child —
 - (a) into the care of a person who is the child's parent or legal guardian;
 - (b) into the care of a person —
 - (i) whom the officer reasonably believes is a responsible person capable of taking care of the child; and
 - (ii) who consents to taking charge of the child; or
 - (c) if the officer is unable to comply with paragraph (a) or (b), into the care of the person in charge of an appropriate facility.

Protective Custody Act 2000, s. 12:

- (1) As soon as practicable after an adult is apprehended, an authorized officer must release the adult —
 - (a) into the care of another person ...; or
 - (b) into the care of a person in charge of an appropriate facility.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

- (2) The police officer may take the person into custody only if the officer is satisfied that there is no other reasonable alternative for the person's care and protection.

Public Intoxication Act 1984 (SA), s. 7:

- (3) Where a member of the police force ... has apprehended a person ... he shall take that person as soon as practicable —
 - (a) to the place of residence, if any, at which the apprehended person is permanently or temporarily residing and there release him from custody;
 - (b) to a place for the time being approved by the Minister for the purposes of this paragraph and there release him from custody;
 - (c) to a police station; or
 - (d) to a sobering-up centre for admission as a patient.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 206:

- (3) An intoxicated person detained by a police officer under this Part is to be taken to, and released into the care of, a responsible person willing immediately to undertake the care of the intoxicated person.

Police Offences Act 1935 (Tas.), s. 4A:

- (3) A police officer may —
 - (a) at any time ... release a person taken into custody ... or cause that person to be released ... to a place of safety, or into the care of a responsible person, willing to take that person into care; ...
- (4) A person may only be held [in police custody] if a police officer has made reasonable inquiries to find a place of safety or a responsible person and has been unable to find a place of safety, or a responsible person, willing to take the person into care.

(See also other Australian jurisdictions attached to Recommendation 12)

New authority to hold affected person as a last resort

Under the current powers police are not able to take further preventative or protective action if an affected person cannot be released to a place of safety. Instead, the affected person must be released. Police officers have raised concerns that this leaves them no alternative but to release affected people, in particular affected youths, back onto the streets. In the Commission's view, this does little to address either the issues of public safety and amenity, or the welfare and safety of the affected person.

The Commission has heard anecdotal reports of police holding VSM-affected people at police facilities until other arrangements can be made, or until the person is no longer affected by a volatile substance. While data received from the

Custody Index may support this finding, it should not occur under the authority of sections 371B–C.

The Commission recommends giving police a limited power to hold affected people, including at a police station as a last resort, where no other alternative can be arranged and where the person poses a risk to themselves or others. This may occur where there is no suitable adult to take care of the affected person and no intoxication-recovery service providers can be located or exist. While this eventuality is not a goal of the response to VSM, it resolves the problem of simply releasing affected people back into the community, where they may present a danger to themselves and the community in general.

Expanding the safe environments to include police stations has several advantages. It enables police to ensure that an affected person remains at the premises until they are no longer VSM intoxicated and no longer a risk to themselves or others. It also allows affected people, in particular children, to be monitored for any signs of adverse physical or mental developments, until a more appropriate therapeutic alternative can be found or the child's parents or guardian can be contacted. Importantly, police gain the flexibility to work within their local infrastructure. Therefore, even in more remote, potentially resource-poor areas of the state, police can still initiate and implement a first response to VSM that takes account of the longer-term therapeutic needs of affected people and the community that will be addressed after the VSM-alert process is initiated.

RECOMMENDATION 8

That police no longer be required to release an affected person and may continue to hold an affected person as a last resort where:

- **there is no intoxication-recovery service provider, parent, guardian or suitable adult available and willing to take care of the affected person**
- **the affected person's condition is such that they would be a risk to themselves or others if released to an intoxication-recovery service provider, parent, guardian or suitable adult, and**
- **the affected person would be a risk to themselves or others if they were simply released.**

Current Queensland legislation

There is already an understanding in Queensland law that a child may be kept in custody for their own protection, even in circumstances where they would otherwise be released. This can be seen in section 48(7) of the *Juvenile Justice Act 1992* which states that:

The court or officer must not release the child if the court or officer is satisfied — (a) the child's safety would be endangered if the child were released; and (b) in the circumstances, there is no reasonably practicable way of ensuring the child's safety other than by keeping the child in custody. Examples of paragraph (a) — The child is heavily intoxicated.

While it is recognised that this section deals with children who have been held in custody in connection with an offence, the Commission notes that it reflects a primary interest in the welfare of the child at all times, even in circumstances where it may curtail their liberty.

Further, the power to hold children for a further period has, as far as possible, been designed to ensure that the fundamental principles of juvenile justice are upheld, as listed in Schedule 1 of the *Juvenile Justice Act* and reflected in the Memorandum of Understanding Regarding the Detention of Children in Watch-houses. Despite the fact that principle 17 deals with children detained in custody for an offence, the principle of custody being as a last resort and for the least time justified may be extended to apply to custody for any purpose. The Commission notes the fundamental difference between holding a child in custody on suspicion of an offence and detaining a child for their own

protection, but would advocate that, where a decision is made to ensure children at risk are provided with care and no other appropriate alternative is available, holding a child for a temporary period where no other reasonable option is available is consistent with the aims of child welfare and juvenile justice in Queensland.

The Commission also notes that section 18 of the Child Protection Act authorises police to take a child at immediate risk of harm into custody. Once again, this reflects an underlying concern for the welfare of children and providing police with the operational powers to intervene and take effective action where the circumstances demand it.

Other Australian jurisdictions

All other Australian jurisdictions empower police to take an intoxicated individual, however so defined, into police custody. With the exception of the South Australian legislation, police custody is an option of last resort when other alternatives for an individual's care have been exhausted.

In no jurisdiction is the exercise of this specific power associated with the commission of an offence. Public drunkenness is an offence in only two jurisdictions outside Queensland — in Victoria (s. 13 of *Summary Offences Act 1966*) and Tasmania (s. 25 of *Police Offences Act 1935*). In neither of these jurisdictions is the apprehension and detention of individuals for intoxication generally linked to a related offence provision. In Victoria, the *Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003* is specifically aimed at volatile substance misuse within juveniles. The Tasmanian Police Offences Act does not make mention of VSM.

Despite the absence of any offences related to public intoxication in other jurisdictions, police are empowered to detain people intoxicated in a public place for a period of time for their welfare. The Commission recommends the adoption of a similar approach.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

- (4) If a member of the police force, after taking all reasonable steps, has been unable to release the detained person into the care of a suitable person in accordance with subsection 3, the member of the police force —
 - (a) must release the detained person; or
 - (b) subject to subsection 2 may continue to detain that person.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 22:

- (1) This section applies if, after making all reasonable efforts, the police officer or authorised person is unable —
 - (a) to take the apprehended person to a place of safety or responsible adult; or
 - (b) to find a responsible adult who will consent to take care of the apprehended person. ...
- (3) If the police officer or authorised person considers the apprehended person continues to pose a risk, he or she may take the apprehended person to a police station to be held in protective custody in accordance with Division 4.

Protective Custody Act 2000 (WA), s. 7:

- (1) An authorised officer may detain an apprehended person but any detention must be in accordance with subsections 2, 3 and 4.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

- (1) ... the [police] officer may take the person into custody and detain him or her.

Public Intoxication Act 1984 (SA), s. 7:

- (3) Where a member of the police force ... has apprehended a person ... he shall take that person as soon as practicable —
 - (a) to the place of residence, if any, at which the apprehended person is permanently or temporarily residing and there release him from custody;

- (b) to a place for the time being approved by the Minister for the purposes of this paragraph and there release him from custody;
- (c) to a police station; or
- (d) to a sobering-up centre for admission as a patient.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 206:

- (4) An intoxicated person detained by a police officer under this Part may be taken to and detained in an authorised place of detention if
 - (a) it is necessary to do so temporarily for the purpose of finding a responsible person willing to undertake the care of the intoxicated person, or
 - (b) a responsible person cannot be found to take care of the intoxicated person or the intoxicated person is not willing to be released into the care of a responsible person and it is impracticable to take the intoxicated person home, or
 - (c) the intoxicated person is behaving or is likely to behave so violently that a responsible person would not be capable of taking care of and controlling the intoxicated person.

Police Offences Act 1935 (Tas.), s. 4A:

- (2) ... the police officer may take the [intoxicated] person into custody.

Young people in custody

A major issue needing clarification concerns holding people, in particular Aboriginal and Torres Strait Islander youths, in police custody. In developing the last resort detention power, the Commission was keenly aware of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody in 1991.

The Royal Commission made 339 recommendations reflecting its major findings, designed to reduce Aboriginal deaths in custody by improving the standard of care within custody and, more importantly, by reducing the number of Aboriginal people in custody. Of particular note are the following recommendations (critical text bold):

Young Aboriginal people and the juvenile justice system

Recommendation 62

That governments and Aboriginal organisations recognise that the problems affecting Aboriginal juveniles are so widespread and have such potentially disastrous repercussions for the future that there is an urgent need for governments and Aboriginal organisations to negotiate together to devise strategies designed **to reduce the rate at which Aboriginal juveniles are involved in the welfare and criminal justice systems and, in particular, to reduce the rate at which Aboriginal juveniles are separated from their families and communities, whether by being declared to be in need of care, detained, imprisoned or otherwise.**

Diversion from police custody

Recommendation 79:

That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to **abolish the offence of public drunkenness.**

Recommendation 80:

That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to **establish and maintain non-custodial facilities for the care and treatment of intoxicated persons.**

Recommendation 81:

That legislation decriminalising drunkenness should **place a statutory duty on police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons.**

Imprisonment as a last resort

Recommendation 92:

That governments which have not already done so should legislate to enforce the principle that **imprisonment should be utilised only as a sanction of last resort**.

While the Commission notes that the proposed power to hold affected people must be distinguished from imprisonment for a criminal offence, it acknowledges that any removal of people to police facilities may be viewed with the same concern, regardless of the proposed therapeutic basis for such detention.

While the Commission's proposed model does empower police to hold affected individuals in certain circumstances, it does so within the context of a series of limitations and a broader therapeutic framework. It is intended as a last alternative, and may be exercised only in concert with a series of police responsibilities aimed at protecting the rights and welfare of the apprehended person. These responsibilities ensure that the power does not run contrary either to the spirit of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody, or to the rights and duties of care owed by police to all citizens.

Duties where a person is held by police as a last resort

The Commission proposes that the power for police to hold an affected person should be used as a last resort where the care and protection of an affected person and potentially the safety or health of others may be at risk. It is important, therefore, to ensure that the exercise of this power provides a balance between the care and protection of an affected person, and the rights of people who have committed no criminal offence to be free from unnecessary police interference.

To this end, there are a number of duties attached to this power. They are:

- Duty to inform appropriate people
- Duty to arrange medical examination
- Duty to release as soon as possible
- Duty to act in the best interests of the child
- Duty to not hold in a cell or lock-up
- Duty to segregate affected persons from persons in custody
- No authority to charge or question while held as a last resort
- Duty to keep appropriate records

Duty to inform appropriate people

When using the power to hold an affected person as a last resort, police must make all reasonable efforts to inform an appropriate person. This is designed to ensure a continuing effort by police to find suitable alternatives to police detention. In many cases, these efforts may have already been made in the course of the apprehension and detention in accordance with earlier recommendations. Where the affected person is a child, police should contact the child's parents, guardian or other relative; where the affected person is an adult, police should allow the affected person to make contact with an appropriate person.

This duty is in addition to the VSM-alert requirement that notification be made by police officers to the Department of Child Safety.

RECOMMENDATION 9

That, where police hold an affected child as a last resort, police take all reasonable steps to contact the child's parents, guardian or other relative. Where police hold an affected person who is an adult, police should ensure that the affected person is given reasonable opportunity to contact an appropriate person. This responsibility is distinct from the police responsibility to initiate the VSM-alert procedure to the Department of Child Safety.

Current Queensland legislation

A similar responsibility to inform a child's parents is in sections 20 and 21 of the *Child Protection Act 1999*. Further, informing a child's parents is in keeping with principle 10 of the charter of juvenile justice principles in the *Juvenile Justice Act 1992* which states:

A parent of a child should be encouraged to fulfil the parent's responsibility for the care and supervision of the child.

Finally, section 223 of the PPRA requires that police inform the parents of an arrested child of the child's arrest and whereabouts. While this relates to an arrest, the principle of ensuring that a parent is duly informed of a child's situation is important to uphold.

Other Australian jurisdictions

Three jurisdictions include express legislative provisions that require police officers to take steps to contact or allow an affected person to contact a suitable person when detained by police.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 22:

- (4) If a child is taken to a police station to be held in protective custody, the police officer or authorised person must, if practicable, **inform** a parent or guardian of the child of that action.

Public Intoxication Act 1984 (SA), s. 7:

- (7) Where a child is detained under this section, the person by whom he is detained shall, as soon as practicable after the commencement of the detention, **notify** a parent or other guardian of the child that the child has been so detained, unless —
 - (a) the whereabouts of every such parent or guardian is, after reasonable enquiries, unknown; or
 - (b) it is not, in the circumstances of the case, reasonably practicable to give such a notification.
- (8) Where a person (including a child) is detained pursuant to this section, the person by whom he is detained shall allow him **a reasonable opportunity** to communicate with a solicitor, relative or friend.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 207:

- (2) An intoxicated person who is detained in an authorised place of detention under this Part: (a) must be given **a reasonable opportunity** by the person in charge of that place to contact a responsible person; ...

Duty to arrange medical examination

Police have a duty to arrange for a medical examination for any person being held, where warranted. While police officers may be competent to make an initial assessment, the Commission is keen to ensure that police are not expected to provide medical care themselves. Close links with officers from Queensland Health and medical professionals are vital for affected people to receive appropriate medical care.

The police officer in charge should have regard to an affected person's medical condition on a minimum of three occasions: when the affected person is first apprehended by police; when the affected person is held by police; and where an

affected person is held for more than four hours. At all other times, however, the welfare of the affected person should be considered paramount.

When a medical examination takes place and the affected person is cleared of any immediate medical need, they may be held by police in accordance with the previously discussed limitations. Where a medical officer advises that an affected person requires further medical treatment, the affected person must be released to an appropriate medical facility. As in the case of any release to a third party, police should receive a signed undertaking from the medical facility or officer.

RECOMMENDATION 10

That, whenever necessary, police arrange a medical examination of an affected person held by police as a last resort. Where necessary, police must release an affected person to an appropriate medical facility.

Other Australian jurisdictions

Volatile Substance Abuse Prevention Act 2005 (NT), s. 28:

- (2)(d) if instructed to hold the apprehended person in [continued] protective custody – arrange for a health practitioner to examine the person as soon as practicable.

Protective Custody Act 2000 (WA), s. 10:

- (1) If an apprehended person needs a medical examination, an authorized officer, as soon as practicable, is to arrange for the person to be medically examined by a suitably qualified person.
- (2) The authorized officer is to continue detaining the apprehended person subject to section 7 unless —
 - (a) under section 29 of the *Mental Health Act 1996* the apprehended person is referred for examination by a psychiatrist; or
 - (b) the person who medically examines the apprehended person directs that the person be left in his or her charge.
- (3) If an authorized officer arranges for a person to be medically examined the officer must record the fact, the name of the person conducting the examination, and the date and time when the person was examined.

Public Intoxication Act 1984 (SA), s. 7:

- (11) Nothing in this section prevents an officer in charge of a police station or a person in charge of a sobering-up centre from discharging at any time a person detained pursuant to this section for the purpose of receiving medical attention or treatment.

Duty to release affected person as soon as possible

The power to hold VSM-affected people aims to provide for their care and welfare, not to simply detain them. Police should therefore hold people for the shortest amount of time possible.

Release where person no longer intoxicated

When a detained person being held by police has recovered from the effects of VSM sufficiently so as to no longer pose a risk to themselves or others, they must be released. While it is desirable that police release children into the custody of parents, a guardian or some other suitable adult, the Commission recognises that this may not always be possible.

In these circumstances, the Commission recommends that, where possible and appropriate to do so, a person should be released to a client assistance service. This is in keeping with both the long-term therapeutic goals of the new approach to VSM and the welfare needs of volatile substance abusers.

RECOMMENDATION 11

That an apprehended person held by police as a last resort be held for the shortest reasonable time, and be released when they have recovered from the effects of VSM sufficiently that they no longer pose a risk to themselves or others.

Other Australian jurisdictions

All other Australian jurisdictions require that a person being detained by police for intoxication, howsoever described, must be released when they have recovered from the effects of intoxication sufficiently that they no longer pose a risk to themselves or others.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

- (2) A person who has been apprehended and detained under section 60L and who is under 18 years of age **may only be detained** for as long as a member of the police force has reasonable grounds for believing that the person —
 - (a) has recently inhaled a volatile substance; and
 - (b) is likely by act or neglect to cause immediate serious bodily harm to himself or herself or to some other person.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 26:

- (1) Subject to this Division, an apprehended person **may be held only until** it reasonably appears to a responsible officer the person no longer poses a risk.
- (2) Subject to this Division, if it reasonably appears to a responsible officer that an apprehended person no longer poses a risk, the officer **must release** the person or cause the person to be released from protective custody.

Protective Custody Act 2000 (WA), s. 7:

- (2) An authorized officer **must not detain** an apprehended person who is not, or who is no longer, intoxicated.
- (3) An authorized officer must not detain an apprehended person who is intoxicated for any longer than is necessary —
 - (a) to protect the health or safety of the person or any other person; or
 - (b) to prevent the person causing serious damage to property.

Public Intoxication Act 1984 (SA), s. 7:

- (4) Where a person apprehended under this section is taken to a police station pursuant to this section, the officer in charge of that station may detain the person and may give such directions to that person as are reasonably necessary for that purpose, but shall, before the expiration of the period of ten hours from the time of apprehension—
 - (a) **discharge** the person if the person has, in the opinion of the officer in charge, so recovered from the effects of the drug of alcohol as to be able to take care of himself; ...

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 207:

- (2) An intoxicated person who is detained in an authorised place of detention under this Part: ...
 - (f) **must be released** as soon as the person ceases to be an intoxicated person.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

- (3) A person detained under subsection (1) shall be released—
 - (a) when he or she ceases to be intoxicated; or
 - (b) at the expiration of the period of 8 hours after he or she is so detained; whichever is earlier.

Police Offences Act 1935 (TAS), s. 4A:

- (6) A person taken into custody under subsection (2) **is to be released** —
 - (a) at the expiration of the period of 8 hours after he or she was taken into custody; or
 - (b) when a police officer is of the opinion that it is reasonable to do so — whichever is earlier.

Release to intoxication-recovery service provider or suitable adult

Police also have a limited power to release a person while they are still affected by VSM and a risk to themselves or others, if a more suitable option becomes available. For instance, during the period in which an affected person is being held by police, an intoxication-recovery service provider or suitable adult may be located. If such a service or person is willing and able to provide care and protection for the affected person, and the affected person's condition is such that release to the service or person is appropriate, then the affected person may be released into their care.

RECOMMENDATION 12

That an apprehended person held by police as a last resort be held for the shortest reasonable time, and at any time after apprehension be released into the care of an intoxication-recovery service provider or suitable adult even if the affected person has not recovered from the effects of VSM sufficiently that they no longer pose a risk to themselves or others.

Other Australian jurisdictions

All other jurisdictions authorise police to release an apprehended person into the care of a responsible facility or adult from being detained by police. This authority is perhaps most succinctly expressed in the Western Australian legislation which holds that the power to detain does not affect the duty to release as soon as possible.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

'as soon as practicable after apprehending and detaining under section 60L person who is under 18 years of age, a member of the police force must release the person into the care of a suitable person who —

- (a) the member reasonably believes is capable of taking care of the detained person; and
- (b) consents to taking care of the detained person.

Note: Depending on the circumstances of each case, a suitable person may include the detained person's parent, guardian or another adult family member or an employee of an appropriate health or welfare agency.'

Volatile Substance Abuse Prevention Act 2005 (NT), s. 27:

- (1) A responsible officer **may at any time release** an apprehended person or cause an apprehended person to be released into the care of a person the officer reasonably believes is capable of taking care of the apprehended person.
- (2) Subsection (1) does not apply in the following circumstances:
 - (a) if the apprehended person is an adult who objects to being released into the care of the other person;
 - (b) if the apprehended person is a child who objects to being released into the care of the other person and the responsible officer is satisfied the child is of sufficient age and understanding to form an informed opinion.

Protective Custody Act 2000 (WA), s. 7:

- (6) The power to detain an apprehended person does not affect the duty under section 11(1) and 12(1) to release a person as soon as practicable after he or she is apprehended.

Protective Custody Act 2000 (WA), s. 13:

- (1) An authorized officer **may at any time release** an apprehended adult into the care of another person who applies for the adult's release if — (a) the adult does not object to being released into the care of the applicant; and (b) the officer reasonably believes that the applicant is capable of taking care of the adult.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

- (5) Nothing in this section prevents a police officer from releasing a person detained under subsection (1) if, in the opinion of the police officer, it is reasonable to do so.
- (6) For subsection (5), a police officer shall be taken to have acted reasonably if the officer releases a person detained under subsection (1) into the care of the manager of a licensed place.

Public Intoxication Act 1984 (SA), s. 7:

- (4) Where a person ... is taken to a police station pursuant to this section, the officer in charge of that station ... shall, before the expiration of the period of ten hours from the time of apprehension—
 - (a) discharge the person if the person has, in the opinion of the officer in charge, so recovered from the effects of the drug or alcohol as to be able to take care of himself; or
 - (b) if not, cause the person to be **transferred** to a sobering-up centre for admission as a patient.
- (9) Notwithstanding any other provision of this section, if—
 - (a) a solicitor acting on behalf of a person detained in a police station pursuant to this section, or a relative or friend of a person so detained, requests that he be discharged into the care of the solicitor, relative or friend; and
 - (b) the officer in charge of the police station is satisfied that the solicitor, relative or friend is able and willing to care properly for that person, that person shall be discharged into the care of the solicitor, relative or friend.

Note: When reading these sections as a whole, it is apparent that an affected person should be released when they have recovered from the effects of the drug or alcohol, or where they are released to a sobering-up centre, or where they are released to a solicitor, relative or friend.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 206:

- (4) An intoxicated person detained by a police officer under this Part may be taken to and detained in an authorised place of detention if: (a) it is necessary to do so temporarily for the purpose of finding a responsible person willing to undertake the care of the intoxicated person ...

Note: The necessary implication of this section is that a person may be released from protective custody once a responsible person is found, although the affected person may still be intoxicated.

Police Offences Act 1935 (Tas.), s. 4A:

- (3) A police officer may —
 - (a) **at any time**, without any further or other authority than this subsection, release a person taken into custody under subsection (2), or cause that person to be released, without that person entering into a recognisance or bail, to a place of safety, or into the care of a responsible person, willing to take that person into care

Where person held for more than four hours

The Commission recommends that apprehended people should not be held for more than four hours, which is usually enough time for a person to recover from the effects of VSM. This time should only be extended where the police officer is reasonably satisfied that the person is still intoxicated and still poses a risk to the health or safety of themselves or others.

When an affected person is held for more than four hours, the police officer making the decision to continue custody must inform a commissioned officer of the decision and the commissioned officer must affirm that decision. Further, a record must be kept of the reasons for continuing to hold the person beyond four hours and a second assessment of the apprehended person's medical condition must be made if necessary.

RECOMMENDATION 13

That an apprehended person held by police as a last resort be held for no longer than four hours, unless exceptional circumstances indicate that a person is still affected by VSM and still poses a risk to themselves or others. Where a person is held for more than four hours, the attending officer must inform a commissioned officer of the decision and that decision must be affirmed. A record of the reasons for holding the affected person for more than four hours must be made and a medical examination arranged if necessary.

Other Australian jurisdictions

Four jurisdictions place a limit within the legislation on the length of time a person may be held in custody for intoxication. The shortest time legislated is six hours under the Northern Territory legislation, though a longer period of custody is available where necessary. One reason for the shorter time proposed in the Queensland model is that the nature of a volatile substance most often results in a shorter immediate recovery time than for alcohol or some other drugs.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 28(1):

A person held in protective custody for more than six hours will then be considered to be held in continued protective custody, which entails a series of further police responsibilities.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4(3) & (4):

A person in custody shall be released at the expiration of 8 hours after they were so detained, and a police officer shall not allow a person detained to remain at a police station for more than 12 hours after being first detained.

Public Intoxication Act 1984 (SA), s. 7(4):

Person apprehended and held in a police station shall be discharged or sent to a sobering-up centre “before the expiration of the period of 10 hours from the time of apprehension”.

Police Offences Act 1935 (Tas.), s. 4A(6):

A person in custody is to be released at the expiration of eight hours after being taken into custody, though may be detained for a further four hours if likely to still cause injury to self, others or property, or are incapable of protecting self from physical harm.

Duty to act in the best interests of the child

While the Commission’s proposed power to allow a VSM-affected child to be held by police as a last resort is intended as a welfare response, there is a related concern about how and when police should release the child. The Commission stresses that the time of day or the place of release should always be in the best interests of the child and therefore recommends that police have discretion to delay the release of a child until outside the hours of midnight and 6 am, even if the child is no longer VSM-affected. This power does not prevent the release of a child during those hours to an appropriate facility, particularly a client assistance service, or to a suitable person if one becomes available.

It also does not affect the duty to inform a commissioned officer where a person is held for more than four hours, duties to inform a parent, guardian or other suitable adult, or the duty to order a medical examination.

RECOMMENDATION 14

That the duty to release a person is at all times subject to the overriding principle of protecting the best interests of the child. Where it is in the best interests of a child to do so, a police officer may elect not to release a child between the hours of midnight and 6 am where they are being held by police as a last resort. This applies only where a child is no longer affected by VSM and would otherwise be released. This discretion does not affect the police responsibility to release a child to an appropriate facility or person during the hours of midnight to 6 am.

Other Australian jurisdictions

Both the Northern Territory and Western Australia include provision for holding people in police custody during the hours of midnight to 7:30 am, even if they no longer pose a risk. In both cases the continued apprehension is discretionary and operates for both apprehended adults and children.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 26:

- (3) An apprehended person who is in protective custody after midnight and before 7.30 am on a particular day may be held in custody until 7.30 am of that day even if the person no longer poses a risk during that period.

Protective Custody Act 2000 (WA), s. 7:

- (4) If an apprehended person is detained in a police station or lock-up, then, despite subsections (2) and (3), a police officer may decide not to release the person between the hours of midnight and 7.30 am if release during those hours is not in the best interests of the person.

Duty to not hold in a cell or lock-up

An affected person may be held in a police establishment only if absolutely necessary. Such an option is not intended as a sanction for criminal behaviour, nor as a default form of imprisonment. As such, an affected person should, as far as practicable, be kept in conditions separate from those of a police lock-up or cell.

The Commission recognises that there may be situations in which the facilities available to a police officer are limited and a cell or lock-up facility is the most convenient option. However, the Commission rejects mere convenience as an acceptable basis for using a lock-up or cell, and suggests adopting a standard similar to that in Western Australia, where a child can be held in a cell or lock-up only where exceptional circumstances arise, while an adult can only be held in a cell or lock-up where it is impractical to do otherwise.

RECOMMENDATION 15

That an apprehended child held by police as a last resort be held in a place other than a police cell or lock-up unless exceptional circumstances arise. An apprehended adult held by police in the same circumstances must be held in a place other than a police cell or lock-up unless it is impractical to do otherwise.

Children in watch-houses

As a result of the proposed new powers, there is a potential that children could be held in watch-houses. In response to this concern, the Commission makes two points. First, the number of people likely to be held by police under these powers is extremely small. The vast majority of those who are apprehended for VSM are likely to be released either to parents or to other suitable adults, or be released to an intoxication-recovery service provider. Only in exceptional circumstances — where no other person or facility exists to take appropriate care of an affected person and where there is a risk of the affected child harming themselves or others if they were to be released — should police continue to hold them. Second, police are not compelled to hold affected people in a holding-cell or watch-house. The power gives police the authority to do so, though even this authority is tempered by responsibilities. **Holding a child in a watch-house is the last option of a last option, to be exercised only where no other appropriate response is available, and no other more appropriate mechanism for holding the child is available.** While the Commission is adamant that holding children in a watch-house should, where possible, be avoided, it does not retreat from the position that where it is absolutely necessary, for the welfare of the child, the safety of others and the protection of police, it is an option that police must have.

The Commission has sought to ensure that, where a child may be held in a watch-house, that detention complies with existing standards of care and relevant guidelines. In particular, the Commission makes reference to the 'Memorandum of Understanding between the Queensland Police Service and Department of Communities Regarding the Detention of Children in Watch-houses' (notably section 4 'Preamble', section 5.7 'Detention of a child in a watch-house' and section 6 'Standards for the care of children held in watch-houses').

Other Australian jurisdictions

Four jurisdictions limit the holding of apprehended people in police cells or lock-up facilities to differing degrees. It should be noted that the section of the NT legislation applies only to apprehended children and that it is currently unclear what any regulations may declare. The Victorian legislation also applies only to people under 18 years of age.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

- (6) A member of the police force must not detain a person under section 60L in —
 - (a) a police gaol within the meaning of the *Corrections Act 1986*; or
 - (b) a police cell or lock-up.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 24:

An apprehended person who is a child must not be held inside a cell at a police station except in accordance with the Regulations.

Protective Custody Act 2000 (WA), ss. 11(5) & 12(4):

- 11(5) Any detention under section 7(1) of a child by a police officer must not be in a police station or lock-up unless —
 - (a) in the time needed to comply with subsection (1) exceptional circumstances arise that justify detaining the child in a police station or lock-up; or
 - (b) exceptional circumstances make it impracticable to comply with subsection (1).
- 12 (4) Any detention under section 7(1) of an adult by a police officer must not be in a police station or lock-up unless —
 - (a) in the time needed to comply with subsection (1) exceptional circumstances arise that justify detaining the adult in a police station or lock-up; or
 - (b) it is impracticable to comply with subsection (1) by taking reasonable measures.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 207:

- (2) An intoxicated person who is detained in an authorised place of detention under this Part:
 - (d) must not be detained in a cell at that place unless it is necessary to do so or unless it is impracticable to detain the person elsewhere at that place, and
 - (e) must be provided with necessary food, drink, bedding and blankets appropriate to the person's needs.

Duty to segregate affected persons from persons in custody

Regardless of where a child is detained, they should be segregated from contact with any adult who is being held in custody, regardless of whether that adult is being held under the VSM powers or for the commission or alleged commission of an offence. Any adult who is being held by police under the VSM powers should also not be placed in contact with any other person being held in custody for the commission or alleged commission of an offence. Further, children and adults held by police must be given adequate food, water and bedding as appropriate in the circumstances.

RECOMMENDATION 16

That a child held by police as a last resort be segregated from contact with any adult in custody, and that any person held by police in the same circumstances should be segregated from any other person held in custody for the commission, or alleged commission, of an offence.

No authority to charge or question an affected person

The Commission seeks to ensure that the power to hold affected people is not broadened to become part of more general police law-enforcement activities. The power is intended to be used as a last resort and in circumstances where it supports the overall therapeutic goal of the government's VSM policy approach. It is not a criminal-law enforcement power and should not be used as such.

The Commission recommends that people apprehended and held under the VSM power cannot be questioned about any offence or alleged offence, or charged with any offence. Further, police cannot collect any forensic information, such as photographs, fingerprints or DNA samples.

The proposed VSM powers to apprehend and detain an affected person do not prejudice any existing police powers to stop, detain and arrest people for the commission or suspected commission of an offence. In the event that a person is suspected of having committed an offence, but an officer elects to apprehend the individual under the VSM powers and not the current arrest provisions of the PPRA, the apprehended person cannot be questioned about or charged with the suspected offence while they are being held by police under those powers. On release, police may then arrest the individual if the prerequisites for arrest still apply.

RECOMMENDATION 17

That a person held by police as a last resort cannot be:

- questioned about any offence
- charged with any offence, or
- fingerprinted, photographed or otherwise subjected to a forensic procedure

while being held under the VSM powers.

Current Queensland legislation

Section 254 of the Police Powers and Responsibilities Act currently requires police to delay the questioning of a person in custody where that person is apparently under the influence of liquor or a drug. The Commission recommends that this same requirement be applied to affected people who are held by police as a last resort. This proposal is based on the fact that an affected person may have a reduced capacity to understand questions and their rights and decide accordingly, and also because the affected person has not been apprehended for a criminal offence and should not, therefore, be subject to questioning about unrelated criminal matters.

Other Australian jurisdictions

Of the three prohibitions suggested — charging a person, questioning a person and taking forensic information from a person — two jurisdictions prohibit all three in the specific legislation (NT and WA). Tasmania prohibits questioning and the taking of forensic information from an apprehended person, while Victoria prohibits interviewing or questioning an apprehended person. The Victorian Act does require police to inform an apprehended person that they are not under arrest for any offence, but includes no mention of whether a person may, at a later stage, be charged with an offence while in police custody.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60M:

- (7) A member of the police force must not **interview** or **question** a person who is apprehended and detained under section 60L in relation to any offence or alleged offence.

The Victorian legislation also includes a duty to inform an apprehended person that they are 'not under arrest in relation to any alleged offence' [s. 60L(3)a].

Volatile Substance Abuse Prevention Act 2005 (NT), s. 17(3):

- (3) An apprehended person —
- (a) must not be **charged with** an offence;
 - (b) must not be **questioned** by a police officer in relation to an offence; and
 - (c) must not be **photographed** or have his or her **fingerprints** taken.

Protective Custody Act 2000 (WA), s. 24:

- (1) An apprehended person who has not been released —
- (a) is not to be **questioned** in relation to any offence that he or she is suspected of committing;
 - (b) is not to be subjected to any procedure the purpose of which is to obtain information that can be used for **forensic purposes**; and
 - (c) is not to be **charged** with an offence.

Police Offences Act 1935 (Tas.), s. 4B:

A person held in custody under section 4A —

- (a) is not to be questioned by a police officer in relation to an offence; and
- (b) is not to be photographed or to have his or her fingerprints taken.

Duty to keep appropriate records

The Commission has previously noted the importance of police maintaining accurate and up-to-date records of people apprehended and detained under the proposed model. Importantly, police have both an external and an internal record-keeping responsibility. The internal record-keeping responsibility requires that at a bare minimum police record where and when affected people are held by police as a last resort; steps taken to contact an affected child's parent, guardian or suitable adult; the reasons for holding an affected person, including if necessary any reasons for holding the person beyond four hours; and the manner, place and time of an apprehended person's release.

These records should be augmented by police custodial records and job indexes as currently used; records of signed undertakings received from people released to an intoxication-recovery service provider, parent, guardian or other suitable adult; records of medical treatment provided; and the circumstances of a person's release to a medical facility. Records of things seized from individuals being held by police should also be kept. The external record-keeping responsibility requires that police initiate the VSM-alert system to the Department of Child Safety and any other contacts with Child Safety that may occur as a result of police responses to an affected child, including the child's release.

RECOMMENDATION 18

That, where an affected person is held as a last resort, police record:

- **where and when affected persons are held by police**
- **steps taken to contact an affected child's parent, guardian or suitable adult**
- **the reasons for detaining a person, including any reasons for detaining the person beyond four hours, and**
- **the manner, place and time of a person's release.**

Police duties upon release

The Commission makes clear that police, on apprehending an affected person, even if only briefly in order to transport them to an intoxication-recovery service provider or suitable adult, must assume a duty of care for that person. While police have a duty to release an affected person as soon as reasonable, they must exercise this duty in the best interests of the affected person. Police must therefore ensure that an apprehended person is released to an appropriate place and that, where that place is under the control of another person, the other person agrees to undertake the care and protection of the apprehended person.

Where an affected person is released into the care of another person (i.e. an intoxication-recovery service provider, parent, guardian or other suitable adult), the other person should acknowledge in writing that they have taken into their care the affected person and any items seized by police from the affected person that can be returned. Such an acknowledgment should, if possible, note the affected person's name and apparent condition, the name and badge number of the police officer attending, and the time and date of the release.

Where a person has been held by police and has recovered from the effects of VSM sufficiently that they no longer pose a risk to themselves or others, they should be released. In such a circumstance, the Commission makes two points. First, a police officer should release a person in an appropriate place for the person's age, condition and the time of day. The Commission notes that police may release such a person at a client assistance service provider, though they cannot compel them to remain there. Second, if possible the apprehended person should acknowledge in writing the time, date and place of their release. Where a person is unwilling or unable to acknowledge in writing their release, police should ensure that a record is made, recording the appropriate information in an official notebook.

RECOMMENDATION 19

That, when a person is released, a police officer take responsibility for:

- releasing the person in an appropriate place
- ensuring that the released person acknowledges in writing the time, date and place of their release where practicable
- ensuring that any person or facility into whose care a person is released acknowledges in writing the time, date and place of the release, as well as the name of the released person, their apparent condition and the name and registered number of the officer attending, and
- returning to the released person or to another person to whom an affected person is released any items that have not been destroyed or forfeited to the state or that would be inappropriate to be returned at the time of their release to an intoxication-recovery service provider or medical facility.

Clarification of the scope of police powers

Where police can exercise the VSM powers

Currently, police powers do not specify whether they can only be exercised in a public place or if they are able to operate on private premises as well. The general entry provisions in the PPRA restrict police entry to a dwelling without the consent of the occupier to the part of the place that is not a dwelling (s. 17(5)). Other provisions allow only for a general power to enter premises for the purpose of arrest (s. 19). Police currently complain that they are unsure about the scope of their powers and that they feel unable to act in situations where VSM is occurring on private premises. The Commissioner's Circular, OPM and SOPs provide little clarification of the scope of the powers. As noted in Chapter 4, the existence of

‘sniffing houses’ has concerned police in Townsville and Mount Isa, most notably because they are unsure about whether or not they have the power to act.

To prevent any confusion, the Commission recommends that the proposed police powers clearly authorise police to act in three circumstances: first, where the affected person is in a public place; second, where the affected person is trespassing on private premises; or, third, where the affected person is on private premises and a police officer is given consent to enter those premises by either the occupier or the owner.

RECOMMENDATION 20

That police exercise the proposed apprehension powers where a person is:

- **in a public place**
- **trespassing on private property, or**
- **on private property and where the police are invited onto the property by the occupier or owner of the property.**

Other Australian jurisdictions

Three jurisdictions expand the operation of powers beyond that of a public place (Victoria, NT and WA). It is important to note that the two jurisdictions that are broadest in scope — Victoria and the Northern Territory — are the only two legislative schemes aimed specifically at VSM.

Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.), s. 60C:

- (a) in a public place; or (b) on a private premises, if consent to enter the premises is given to a member — (i) by the occupier of those premises or (ii) where there is no occupier of those premises, the owner of the premises

Volatile Substance Abuse Prevention Act 2005 (NT), s. 8:

- (a) in a public place;
- (b) trespassing on private property; or
- (c) on private premises, if consent to enter the premises is given to the police officer or authorised person —
 - (i) by the occupier of the premises; or
 - (ii) if there is no occupier — by the owner of the premises.

Protective Custody Act 2000 (WA), s. 6:

a person who is in a public place or who is trespassing on private property

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 4:

a person in a public place [which includes a school]

Public Intoxication Act 1984 (SA), s. 7:

a person who is in a public place

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 206(2):

person found in a public place [which includes a school]

Police Offences Act 1935 (Tas.), s. 4A:

a person is in a public place

Avoid charging apprehended persons with offences

The prohibition against charging an apprehended person with an offence while they are being held by police under the VSM powers does not prevent a person being charged at any other time.

There is also a possibility that a person may commit offences in the course of being apprehended or while being held. The Commission has considered the position that a person cannot be charged at all with such offences, but finds the potential result unsatisfactory. A complete prohibition against charging people in such circumstances may do little to dissuade people from causing police

further difficulties. Similarly, increasing the chance of affected people being brought within the criminal justice system by virtue only of the exercise of the apprehension powers strikes the Commission as unwanted. It is difficult, however, to enshrine in legislation a middle ground which does not equally disadvantage both the interests of the affected person and those of police.

The Commission therefore reiterates the underlying principle of the proposed model — that the power to apprehend and detain should at all times be exercised in the interests of the affected person. While police are not prevented from charging a person with offences they committed while being apprehended or held under the proposed powers, officers should strongly resist doing so, particularly where the offences are for relatively minor matters such as offensive language. Police should have particular regard to the nature of the offence, the circumstance of the person's apprehension and the condition of the apprehended person at the time of committing the offence. If police were to find it necessary to bring charges, they can only do so when the affected person is no longer held for VSM.

RECOMMENDATION 21

That, where reasonable, police avoid charging a person with offences committed during the course of their apprehension or detention under the proposed powers.

Persons not in lawful custody

People who have been apprehended under the proposed police powers and are subsequently detained by police should not, in the Commission's view, be considered in 'lawful custody' for the purposes of the law relating to escape from lawful custody. An affected person has committed no criminal offence to trigger their apprehension; rather, the person is apprehended to provide for their own protection and the protection of others. Their behaviour should not, therefore, be a cause for subsequent criminalisation, even if they escape from police detention. Criminalising such behaviour could also prevent other people giving assistance to an 'escaped' affected person, as harbouring an escaped person is an offence.

The Commission notes that, while police have power to compel a person to remain in their care while being held temporarily, no such power is proposed for other facilities or people, including the people staffing an intoxication-recovery service. An affected person may voluntarily leave such a place without legislative penalty.

RECOMMENDATION 22

That an apprehended person not be considered to be in lawful custody for the purposes of any law relating to escape from lawful custody.

Current Queensland legislation

Section 142 of the Criminal Code creates an offence of escape from lawful custody, punishable by up to seven years imprisonment. Section 144 of the Criminal Code creates an offence of harbouring a person who has escaped from lawful custody. The Commission would recommend that neither of these provisions apply to people held by police where no other appropriate facility or person is available, and that, to ensure this, section 145A of the Criminal Code be amended to include people held by police under the proposed model.

Section 145A of the Code currently excludes people held under the Mental Health Act and the Child Protection Act from the operation of the escape offence provisions of sections 141–144. Both of these Acts provide for holding people in custody for their own protection and the protection of others, and as such reflect similar goals to the proposed power to hold an affected person where no other appropriate person or facility is available. The Commission

would view as entirely consistent the addition to section 145A of the proposed power to hold affected people.

Other Australian jurisdictions

Both Western Australia and South Australia make specific mention in the apprehension legislation of the status of apprehended people in relation to lawful custody and escape. The WA legislation declares people in protective custody not to be in lawful custody for the purposes of escape, while SA declares people detained under the Act to be deemed in lawful custody.

Protective Custody Act 2000 (WA), s. 25:

For the purposes of any law relating to escape from lawful custody, an apprehended person who has not been released is not to be taken as being in lawful custody.

Public Intoxication Act 1984 (SA), s. 10:

10(1) A person who has been detained shall, until he is discharged in accordance with this Act, be deemed to be in lawful custody—

- (a) while he is kept in the police station or sobering-up centre pursuant to this Act; or
 - (b) while he is in the custody of a person in whose charge he is placed by the officer in charge of the police station, or by the person in charge of the sobering-up centre, as the case may be.
- (2) Where a member of the police force or an authorized officer has reasonable cause to believe that a person detained pursuant to this Act has escaped from lawful custody, he may apprehend that person at any time without warrant and return him to the place in which he was being detained.

Executing warrants while a person is held by police

The only exception to the rule against questioning and charging an affected person held by police (see Recommendation 17) is where an individual is named in an outstanding warrant. The Commission is aware that police have a responsibility to execute warrants in a timely fashion and, to this end, advocates that police be empowered to serve warrants on an individual before they are released from police care.

Where an individual is apprehended and detained under the VSM powers, and it subsequently comes to light that the person is named in an outstanding warrant, that individual can be taken into custody under the terms of the warrant at the point that they would otherwise be released from police care under the VSM powers. Importantly, all responsibilities to contact a parent, guardian or suitable adult, provide medical care and allow an apprehended person to recover from the effects of VSM must be complied with regardless.

Where the affected person would otherwise be released to an intoxication recovery centre or responsible person, the police may continue to hold the affected person under authority of the warrant. Where an affected person has outstanding warrants and the police are aware of this at the time the person comes to the attention of the police for VSM, the person should be taken into custody under the terms of the warrant, though necessary account should be taken of the person's state of intoxication. The Commission again stresses that police should always have regard for the welfare of the affected person.

RECOMMENDATION 23

That the proposed apprehension and detention powers not be exercised in a way that would unduly impede the ability of police to execute warrants. Any warrants should be executed at the point at which an apprehended person would otherwise be released.

Searching apprehended persons

The new model proposes that an affected person may be apprehended and detained regardless of whether or not they have been searched. A person held by police may be searched by a police officer and any potentially harmful thing or article that could be used to endanger the health or safety of the affected person or any other person may be seized.

The search powers should also be read in concert with existing police powers under the PPRA — to search a person without a warrant (section 27), and the safeguards with respect to searches (sections 382 to 390).

The Commission recommends that any potentially harmful thing seized may be dealt with by police in the same manner as any potentially harmful thing seized under section 371A of the PPRA (see also Recommendation 25). Any thing that is seized and not destroyed or forfeited to the state must be returned to the person on their release from police care. Items seized that are not potentially harmful things should be dealt with according to existing police procedure, including the keeping of appropriate records and returning seized items where appropriate.

RECOMMENDATION 24

That police holding a person as a last resort be given the power to search an apprehended person, including any items seized from them. Any potentially harmful thing seized from a person may be dealt with in the same manner as under section 371A of the Police Powers and Responsibilities Act. Items that are seized and not destroyed or forfeited to the state must be returned to the person when they are released.

Other Australian jurisdictions

All other jurisdictions, with the exception of Victoria, provide specifically for the searching of apprehended people in the apprehension legislation. The Victorian legislation does provide for police to search a person and seize volatile substances, though this power is ostensibly operative before apprehension.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 25:

- (1) A responsible officer may —
 - (a) search an apprehended person or cause an apprehended person to be searched; and
 - (b) remove or cause to be removed from the apprehended person, for safe keeping until the person is released from protective custody —
 - (i) money and valuables found on or about the apprehended person; and
 - (ii) items on or about the apprehended person that are likely to cause harm, or could be used by any person to cause harm, to the apprehended person or any other person.
- (2) All money and valuables taken from an apprehended person must be recorded in a register kept for that purpose and must be returned to the apprehended person on receipt of a signature or other mark made in the register by the apprehended person.

Protective Custody Act 2000 (WA), ss. 8 & 9:

- 8(1) An authorized officer may search an apprehended person, and any thing found on or with the person, for any thing that can be seized under section 9.
- 9(1) An authorized officer may seize from an apprehended person —
 - (a) any intoxicant;
 - (b) any article (including any drug prescribed for the person) that could endanger the health or safety of the person or any other person.
- 9(2) If alcohol or any substance containing alcohol, is seized from an apprehended person, an authorized officer may destroy it.

- 9(3) If an intoxicant other than alcohol is seized from an apprehended person, an authorized officer may destroy it if the officer reasonably suspects that if it were returned to the person, the person is likely to use it to become intoxicated.
- 9(4) Anything seized under subsection (1) that is not destroyed under subsection (2) or (3), must be dealt with under section 14.
- 9(5) An authorized officer who seizes any thing under this section must record the fact and must record how the thing is dealt with.

Intoxicated Persons (Care and Protection) Act 1994 (ACT), s. 5:

- (1) A police officer may search a person who is taken into custody under section 4 (1) and may take possession of any articles found in his or her possession.
- (2) A person is entitled to the return of any articles taken from him or her under subsection (1) when he or she ceases to be detained under section 4.

Public Intoxication Act 1984 (SA), s. 7:

- (2) The member of the police force or authorized officer— ...
 - (b) may search the person apprehended for the purpose of removing any object that may be a danger to that person or to others and remove and take custody of any such object and any valuable object found on that person.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 208:

- (1) A police officer or other detention officer by whom an intoxicated person is detained under this Part may search the intoxicated person and may take possession of any personal belongings found in the person's possession.
- (2) A person is entitled to the return of the personal belongings taken from the person under subsection (1) when the person ceases to be detained under this Part.

Police Offences Act 1935 (Tas.), s. 4A:

- (7) A police officer may —
 - (a) search or cause to be searched a person who has been taken into custody under subsection (2); and
 - (b) remove or cause to be removed from that person for safe keeping, until the person is released from custody, any money or valuables that are found on or about that person and any item on or about that person that is likely to cause harm to that person or any other person or that could be used by that person or any other person to cause harm to that person or any other person.

New power to dispose of seized things

The terms of this review are limited to sections 371B–371D of the PPRA and therefore exclude review of the operation of the search and seizure power (under section 371A). However, officers have raised the issue of the disposal of seized potentially harmful things as a key concern.

Under the current law, officers must bring seized items back to the station. Officers feel that this could affect the health of individuals using police vehicles for extended periods.

To reduce this risk, the Commission recommends the introduction of a discretionary power to dispose of or make safe seized property. Given the nature of the materials, it is important that neither police nor members of the public are placed at risk when transporting or storing volatile substances. The Commission believes that police officers are best placed to make decisions about the best practice of transporting, storing, disposing of or destroying potentially hazardous materials of this description.

The Commission also recommends the introduction of a responsibility on police, when exercising both the current seizure power under section 371A(4) and the proposed disposal power, to maintain written records of the particulars of the item

seized, the circumstances in which it was seized and the person from whom it was seized.

RECOMMENDATION 25

That police be given the power to dispose of or otherwise make safe potentially harmful things that they are given or have seized from persons in exercise of section 371A of the Police Powers and Responsibilities Act.

Other Australian jurisdictions

A similar power to dispose of seized things can be found in the *Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003* (Vic.), section 600, in the *Protective Custody Act 2000* (WA), section 5(3), and in the *Volatile Substance Abuse Prevention Act 2005* (NT), section 15.

The need for appropriate operational guidelines

As previously noted, the existing operational guidelines for police are insufficient. The current guidelines are drawn from the Commissioner's Circular 08/2004, the Operational Procedures Manual, the Standard Operating Procedures for each District and the computer-based training package. These lack any specifics of how the VSM powers in the PPRA interact with existing police powers, notably the powers to arrest, question or search a person. Further, the guidelines offer police little to no assistance in discharging their duty of care for those affected by VSM, in particular where those persons must be released while still intoxicated.

The Commission recommends that the QPS provide a more detailed set of operational guidelines to police officers to more fully explain both the current powers and any new powers. These guidelines should cover the matters that are the subject of Commission recommendations, including:

- clarification of the interaction of existing police powers with the current or proposed VSM-related powers to search and seize potentially harmful things and to apprehend affected people
- best practice guidelines for the release of affected people
- clarification of the role of QPS officers with other government services in the broader VSM-response plan
- clarification of the duty of care owed by police officers to affected people and the limits of this duty
- clarification of the duties owed by police officers to affected people.

RECOMMENDATION 26

That the Queensland Police Service develop detailed operational guidelines for police officers about existing police powers and any proposed new police powers. These guidelines should cover the matters that are the subject of Commission recommendations, including:

- clarification of the interaction of existing police powers with the current or proposed VSM-related powers to search and seize potentially harmful things and to apprehend affected persons, including a direction to use apprehension and detention powers as opposed to move-on powers
- best practice guidelines for releasing affected persons
- clarification of the role of QPS officers with other government services in the broader VSM-response plan
- clarification of the duty of care owed by police officers to affected persons and the limits of this duty, and
- clarification of the duties owed by police officers to affected persons.

Clarification of other issues raised during the review

While reviewing the existing police powers, the Commission noted a number of other issues that needed clarification. Some of these relate to the impact that the police powers will have on existing legislation to hold individuals in custody. While the Commission notes that these are appropriate and necessary concerns to raise, it is satisfied that the recommendations it has made do not compromise existing standards of care, responsibilities or policies currently in place, and will have minimal impact on all other legislative schemes.

The key issues for clarification are as follows:

- liability immunity
- the operation of the proposed model within existing Queensland laws.

There are related matters to some of these key issues, which will also be explained.

Liability immunity

Police have raised queries about their duty of care for people affected by volatile substances. Due to the nature of the intoxicants used and the resulting unpredictable effects, police are concerned that there is potential for an affected person to suffer injury through no fault of a police officer while detained by police.

The Commission accepts that the unpredictable nature of volatile substances and the reports of ‘sudden sniffing deaths’ are legitimate concerns for police when exercising a power over an individual. However, the Commission notes that police officers and people acting under the authority of the VSM apprehension provisions should already be protected from civil liability. Sufficient protection is given under the *Police Service Administration Act 1990*.

Current Queensland legislation

Section 5 of the *Police Powers and Responsibilities Act 2000* provides that:

- (1) It is Parliament’s intention that police officers should comply with this Act in exercising powers and performing responsibilities under it.
- (2) For ensuring compliance with Parliament’s intention, a police officer who contravenes this Act may be dealt with as provided by law.

In recommending civil liability immunity for officers, the Commission does not seek to derogate from section 5.

Currently, police liability for acts and omissions done in the course of employment are covered in section 10.5 of the *Police Service Administration Act 1990*, which states:

- (1) The Crown is liable for a tort committed by any officer, staff member, recruit or volunteer, acting, or purporting to act, in the execution of duty as an officer, a staff member, recruit or volunteer, in like manner as an employer is liable for tort committed by the employer’s servant in the course of employment.
- (1A) The Crown is to be treated for all purposes as a joint tortfeasor with the officer, staff member, recruit or volunteer who committed the tort.

An officer would still be liable, therefore, as a joint tortfeasor.

An exception is provided, however, in subsection (5), which can indemnify an officer against liability where the liability occurred in circumstances where the officer was providing assistance to a person suffering illness or injury.

- (5) If an officer, staff member, recruit or volunteer incurs liability in law for a tort committed by the officer, staff member, recruit or volunteer in the course of rendering assistance, directly or indirectly, to a person suffering, or apparently suffering, from illness or injury in circumstances that the officer, staff member, recruit or volunteer reasonably considers to constitute an emergency, and if the officer, staff member, recruit or volunteer acted therein in good faith and without gross negligence, the Crown is

to indemnify and keep indemnified the officer, staff member, recruit or volunteer in respect of that liability.

The Commission notes that the operation of section 10.5(5) of the Police Service Administration Act would apply appropriately to circumstances involving volatile substance misuse, and that individual police officers can be afforded the protections therein for actions taken in the course of their duties under the proposed model.

Other Australian jurisdictions

Four Australian jurisdictions include a specific immunity from liability in the legislation authorising police to take action against intoxicated people, howsoever described. Each of these jurisdictions provides protection from civil liability, while only the Northern Territory and New South Wales provide protection for criminal liability.

Volatile Substance Abuse Prevention Act 2005 (NT), s. 68:

A person is not civilly or criminally liable for an act done or omitted to be done by a person in good faith in the exercise of a power or in performance of a function under the Act. This does not affect the liability the Territory may have.

Protective Custody Act 2000 (WA), s. 28:

No action in tort against a person for an act done or omitted to be done by a person in good faith in the exercise of a power or in performance of a function under the Act. This does not relieve the Crown of any liability.

Public Intoxication Act 1984 (SA), s. 13:

No civil liability for a person for act of omission in good faith in the exercise of powers or discharge of duties under the Act. This does not relieve the Crown of any liability.

Law Enforcement (Powers and Responsibilities) Act 2002 (NSW), s. 8:

No action against person for act of omission done in good faith in the execution of the Act.

The operation of the proposed model within existing Queensland laws

The Commission has proposed an enhanced model to address VSM that would work largely within Queensland's existing legal framework. While substantial changes to the PPRA are needed to enact the new police powers, these powers are intended to function within the current legal framework.

The proposed model would also operate in concert with and subject to existing provisions of other Acts. The proposed powers are not intended to derogate from other powers a police officer may have under the PPRA or any other Act.

The Commission has noted five other legislative regimes that might operate with the proposed model:

- Police Powers and Responsibilities Act
- Criminal Code Act, Summary Offences Act and other criminal offence legislation
- Child Protection Act
- Juvenile Justice Act
- Mental Health Act.

Police Powers and Responsibilities Act

While some Australian jurisdictions have enacted entirely new legislation to deal with the issue of VSM, others have incorporated the apprehension and detention powers within existing legislation. The Commission supports the inclusion of these powers as amendments to the Police Powers and Responsibilities Act.

As noted previously, the proposed police powers do not erode the current powers officers have under the PPRA. Thus, where warranted in the circumstances, police may still, for example, arrest an affected person without warrant under section 198, arrest an affected person under a warrant under section 202, or move a person on under section 39.

Arrest without warrant

In the case of arrest without a warrant, a police officer may elect to exercise either this power or the proposed power to apprehend in response to VSM. The Commission would recommend that, in making a decision as to which power to exercise, a police officer should have regard to such factors as the severity of the offence or alleged offence.

Where a person is apprehended under the VSM powers, a police officer may not question or charge the affected person, or subject them to any forensic process such as fingerprinting, photographing or the taking of DNA. If, at the point that the apprehended person is released, there is sufficient evidence and cause to execute an arrest without warrant under the PPRA, police may then proceed to exercise the appropriate arrest response.

Where a person is arrested under existing police arrest powers, and that person is affected by VSM, the Commission recommends that section 254 of the PPRA should apply. Under this section, a person so arrested should not be questioned until the officer is reasonably satisfied that the influence of a volatile substance no longer affected the person's ability to understand their rights and decide whether or not to answer questions.

Arrest under warrant

In the case where a police officer is aware, before the proposed VSM apprehension powers have been exercised, that an affected person is named in a warrant for arrest, the officer should arrest the affected person under the terms of the warrant. However, the Commission would recommend that section 254 would still apply as above.

Where an affected person is apprehended under the proposed VSM apprehension powers and it subsequently becomes known to an officer that the person is named in a warrant for arrest, the police officer should hold the affected person until they are no longer affected by a volatile substance. All responsibilities owed to an apprehended person who is held by police, as a last resort, still apply — namely the duty to inform a parent, guardian or suitable adult, the duty to provide appropriate conditions of detention and the duty to provide medical assessment and treatment as needed. However, at the point where an apprehended person has sufficiently recovered from the effects of VSM such that they no longer pose a risk to the health or safety of themselves or others and would therefore otherwise be released, the Commission would recommend that the police could then arrest the person under the terms of the warrant. In effect, the proposed VSM-related powers must be allowed to run their course and provide an affected person with care and protection, before the warrant can be executed.

Move-on powers

The proposed police powers could operate in areas in which police are also authorised to exercise move-on powers under section 39 of the PPRA. The police move-on powers operate at or near a prescribed place, including shops, child-care centres, licensed premises, ATMs, war memorials and railway stations.

As with the proposed police powers to apprehend and detain an affected person, the move-on powers are an alternative to arrest. The Commission sees no inconsistency with both options being available to officers in the course of their duties. The Commission would recommend, however, that the proposed VSM powers be used in preference to the move-on powers if VSM is a factor. The Commission's primary concern is to ensure that people engaging in VSM are provided with care at the earliest possible opportunity and not simply moved to another location. The Commission is reluctant, however, to recommend that such a provision be enshrined in legislation as it may unduly hamper the activities and effectiveness of operational policing.

The Commission sees no difficulty in police exercising the power to search an individual and seize potentially harmful things, under section 371A, and then subsequently exercising the move-on powers.

Search and seizure power

As discussed previously, the power to search and seize (section 371A) is separate from that of both sections 371B and 371C, and of the Commission's proposed police powers. Police officers exercising the power to search an individual and seize potentially harmful things are not compelled to then exercise the power to apprehend an individual. Similarly, a person may be apprehended without first having been searched or without potentially harmful things being seized.

Further, the operation of section 27 search powers is not affected by the operation of either subsection 371A or a person being apprehended. Where circumstances warrant the exercise of section 27 in the interests of the affected person, the police officer or other people, the Commission suggests that such powers be applied according to current police operating practices. Further, these powers do not derogate from the existing search powers and responsibilities in sections 27 and 382–390 of the PPRA.

Finally, the Commission notes that a police officer may execute a search of an individual and then take any other action available to them under the current police powers, including arrest. The option of apprehending an individual for VSM-related matters does not preclude such an alternative.

Use of reasonably necessary force

The Commission recommends that police continue to have the authority to use reasonably necessary force in exercising the proposed apprehension powers. Currently, police have authority under section 376 of the PPRA to use reasonably necessary force in the exercise of a power under the Act or another Act. The Commission would not seek to deny police this capacity.

The Commission is aware, however, of the potential for harm to an affected person in circumstances where their stress levels or heart-rate are drastically increased. At all times while exercising or considering exercising the Commission's proposed police powers, police should have paramount concern for the health and welfare of the affected person, as noted in the Commissioner's Circular 08/2004.

Criminal Code Act, Summary Offences Act and offence legislation

People who commit offences while affected by VSM are not immune from the operation of the relevant offence provision in the *Criminal Code Act 1899*, the *Summary Offences Act 2005* or any other Act creating an offence. Police may, however, elect not to arrest an individual who is committing an offence, but instead to apprehend them under the proposed powers. The Commission recommends that police officers have regard to such matters as the seriousness of the offence and the effect of apprehension or arrest on evidence or witnesses. The

Commission makes no comment on the manner in which the criminal courts may deal with people who committed or are alleged to have committed an offence while affected by VSM.

Child Protection Act

The Commission reiterates the importance of protecting children at risk of harm. A number of sections of the *Child Protection Act 1999* provide for the protection of children at immediate risk of harm and the Commission does not seek to interfere with this. Thus, all elements of the proposed police power model should be read in addition to and not affecting the operation of the Child Protection Act. The Commission advocates that the execution of powers and duties under the Child Protection Act take precedence over the operation of the proposed VSM-related powers.

The Commission makes particular mention of the situation where police may fulfil their responsibility to release an affected child into the care of a parent or guardian. The Commission can foresee circumstances in which the police may form a reasonable suspicion that the parent or guardian to whom an affected child is being released is incapable of caring for the child, or where releasing the child to that person may place the child at further risk of harm. In such a circumstance, the Commission would recommend that police exercise their responsibilities and powers under the Child Protection Act and take whatever action is both authorised and necessary to safeguard the child's welfare. Such action should take place in addition to the VSM-alert requirement.

Juvenile Justice Act

The *Juvenile Justice Act 1992* deals with police powers over juveniles who are arrested in connection with an offence. Sections 11 and 13 are of particular note in this regard. These provisions would not be affected by the proposed police powers except that the use of the proposed police powers offers police an alternative to arrest in some circumstances.

Mental Health Act

Police currently have powers under the *Mental Health Act 2000* to apprehend and detain a person for the purpose of taking them to a mental health service.

The Commission states that these powers should take precedence over the proposed VSM powers. Where a person affected by VSM comes to the attention of a police officer and the police officer reasonably believes that sections of the Mental Health Act apply, the police officer should execute their responsibility under this Act and not the VSM powers. At all times while exercising or considering exercising the Commission's proposed police powers, police should have paramount concern for the health and welfare of the affected person.

An important condition

The Commission makes 26 recommendations to enhance police powers to deal with volatile substance misuse, the first of which includes a proviso that the new powers be subject to a time limit. This is because it is important that agencies accept that the enhanced powers are not the solution to the problem of volatile substance misuse — they are designed to support a broader multi-agency response to VSM. A sunset clause will allow an opportunity to evaluate whether this acceptance has occurred. The CMC, which will be monitoring and reporting on the exercise of the powers, will be well placed to advise whether the sunset clause should be invoked or, alternatively, the life of the powers extended.

In advocating a sunset clause, the CMC is not calling into question the capacity of the police to use the powers appropriately when responding to VSM. Rather, it seeks to highlight the importance of stakeholders understanding that, although police are a critical contributor to the multi-agency response to VSM, they cannot be expected to assume primary responsibility for what is a welfare rather than law enforcement function. A failure to appreciate the significance of this point opens the way for the one major potential risk to effective implementation of the enhanced response to VSM favoured by the CMC. This risk is that the suggested changes to police powers come to be seen as an 'end' in themselves, rather than a 'means to an end'.

The role of police when exercising new VSM-related powers is essentially to trigger the welfare-oriented therapeutic response. In most instances, primary responsibility for this response will be carried either by the Department of Communities directly or indirectly by the non-government organisations funded by the department.

Conclusion

The CMC has proposed an enhanced approach to police powers to address the core issues that emerged during the review of the trial powers.

Central to the improvements are three core ideals:

- 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 retributive
- the model should be part of a much broader government response to the issue of VSM.

There are two main additions to the enhanced powers that form the basis for the Commission's 26 recommendations. First, police would have the power to hold affected people as a last resort, where to release a person would pose a risk to the health and safety of that person or others. This power is to be used only under a limited set of circumstances, and in effect would be exercised where an officer would currently be forced to release an affected person in the absence of a parent, guardian or place of safety. Second, police gain the power to require a person's correct name and address.

Linked to these key powers are a series of related powers and responsibilities. The most important of these is the police duty to initiate a VSM-alert procedure to the Department of Child Safety for all apprehended children. The Commission is critically concerned that accurate information about children engaging in VSM is received and acted on by the appropriate agencies. Giving the Department of Child Safety immediate and accurate information about affected children would ensure medium- and long-term management of cases. This would operate in close conjunction with the proposed changes to the places of safety model, incorporating a twin-service model of an intoxication-recovery service and a client assistance service.

Other new police responsibilities include 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 people.

In considering the evaluation data, the Commission assesses that police have exercised their new trial powers cautiously and responsibly, and have consistently given very serious attention to their duty of care to people engaging in the practice of inhalant misuse, which, although not illegal, is similar in its effects to illicit drug use.

The Commission recognises that VSM, even more than the use of illegal drugs such as cannabis and amphetamines, needs to be recognised as a marker of underlying issues requiring the attention of welfare services. The Commission is persuaded that police also recognise this fact, and that they have endeavoured to use the trial powers as an aspect of a therapeutic rather than criminal justice system response to inhalant misuse. Partly because of this fact, the Commission recognises that some police (and others) may have reservations about the enhancements to the powers advocated in this report.

There is likely to be concern in some quarters that providing police with the authority to detain an intoxicated person despite no offence having been committed constitutes a potentially problematic quasi-criminalisation of VSM. The Commission stresses that the enhanced powers it is advocating are in no way intended to reduce the government's therapeutic orientation towards VSM. On the contrary, the Commission seeks to give police a lawful authority to more effectively respond to VSM, guided by an overarching commitment to prevention, harm minimisation, and diversion from any unnecessary contact with the criminal justice system. The Commission also draws attention to the fact that the enhanced police powers fall somewhere between the powers police already have, in terms of responding to people with mental disorders and to those who are intoxicated as a result of the use of alcohol.

Finally, the Commission stresses that its recommendations to support and give effect to enhancing the police powers are conditional: it will withdraw its support of these recommendations if its future monitoring of the new powers reveals that agencies have not understood that the enhanced powers are designed to support a broader multi-agency response to VSM — they are not the solution in themselves to the problem of volatile substance misuse.

The Commission recognises the complexity of the issues involved. It accepts that there are no easy answers to VSM-related problems, and emphasises its view that, for enhanced police powers to work as intended, it is critical that there is a matching commitment by government to reconfigure the function of the designated places of safety operated by non-government organisations.

Appendix A: Relevant legislation

Police Powers and Responsibilities and Other Legislation Amendment Act 2003 No. 92, 2003

13 Replacement of s. 371A (Power to seize potentially harmful things)

Section 371A—

omit, insert—

‘371A Power to seize potentially harmful things

‘(1) This section applies if a police officer—

(a) finds a person in circumstances in which the police officer reasonably suspects the person is in possession of a potentially harmful thing the person has ingested or inhaled, is ingesting or inhaling, or is about to ingest or inhale; or

(b) finds a person in possession of a potentially harmful thing in circumstances in which the police officer reasonably suspects the person has ingested or inhaled, is ingesting or inhaling, or is about to ingest or inhale, the thing.

Example for paragraph (a)—

A police officer finds a person with paint on the person’s lips.

‘(2) The police officer may search the person and anything in the person’s possession to find out whether the person is in possession of a potentially harmful thing.

‘(3) If the person is in possession of a potentially harmful thing, the police officer may ask the person to explain why the person is in possession of the thing.

‘(4) If the person does not give a reasonable explanation, the police officer may seize the potentially harmful thing.

‘(5) It is not a reasonable explanation for subsection (4) that the person is in possession of the potentially harmful thing to inhale it or ingest it.

‘(6) On the seizure of the potentially harmful thing, the thing is forfeited to the State.

‘(7) Section 38013 does not apply to a thing seized under this section.

‘371B Dealing with persons affected by potentially harmful things

‘(1) This section applies to a person at a declared locality if, because of the way the person is behaving and other relevant indicators, a police officer is satisfied the person is affected by the ingestion or inhalation of a potentially harmful thing.

Example of a relevant indicator—

The presence of spray paint cans near the person.

‘(2) However, this section applies to the person only if it is appropriate for the person to be taken to a place, other than a police establishment or police station, and the police officer considers the place is a place at which the person can receive the treatment or care necessary to enable the person to recover safely from the effects of the potentially harmful thing (a “place of safety”).

Examples of a place of safety—

1. A hospital may be a place of safety for a person who needs medical attention.
2. A vehicle used to transport persons to a place of safety and under the control of someone other than a police officer may be a place of safety.
3. The person’s home, or the home of a relative or friend, may be a place of safety if

there is no likelihood of domestic violence or associated domestic violence happening at the place because of the person's condition or the person is not subject to a domestic violence order preventing the person from entering or remaining at the place.

'(3) It is lawful for the police officer to detain the person for the purpose of taking the person to a place of safety.

'(4) In this section—

"declared locality" means a locality declared under a regulation for this section.

'371C Duties in relation to person detained under s. 371B

'(1) It is the duty of the police officer who detains a person under section 371B, at the earliest reasonable opportunity—

(a) to take the person to a place of safety; and

(b) to release the person at the place of safety.

Example—

The place of safety may be a vehicle under the control of someone other than a police officer that is used to transport persons to another place of safety.

'(2) Subsection (1) does not apply if the police officer is satisfied—

(a) a person at a place of safety refuses, or is unable, to provide care for the relevant person; or

(b) the relevant person's behaviour may pose a risk of harm, including, but not limited to, an act of domestic violence or associated domestic violence, to other persons at a place of safety; or

(c) the police officer is unable to find a place of safety that is willing to provide care for the relevant person.

'(3) If this section does not apply because of subsection (2), the person must be released.

'(4) Before the police officer releases the person, the police officer must ensure the person apparently in possession or in charge of the relevant place of safety gives a police officer a signed undertaking in the approved form to provide care for the relevant person.

'(5) If the place of safety is not the person's home, the person apparently in possession or in charge of the place of safety may lawfully provide care for the person until the person voluntarily leaves the place.

'(6) As soon as practicable after a person is released under subsection (1) or (3), the police officer must enter in a register kept for this section the particulars prescribed under a regulation for this section.

'371D No compulsion to stay at place of safety

'A person taken to a place of safety can not be compelled to stay there, unless another Act otherwise requires.

'371E Review of operation of ss. 371B–371D

'(1) The CMC must keep the operation of sections 371B to 371D under review for 9 months after the sections commence.

'(2) The conduct of the review and the preparation of the report is a function of the CMC for the *Crime and Misconduct Act 2001*.

'(3) In the course of preparing the report, the CMC must consult with the Minister.

'(4) The CMC must give a copy of the report to the Speaker for tabling in the Legislative Assembly.

‘371F Expiry of ss. 371B–371E

‘(1) Sections 371B to 371E and this section expire 1 year after they commence.

‘(2) However, a regulation may extend the operation of the provisions and this section for periods of up to 1 year.’

53 Insertion of new s. 37D

Part 4, after section 37C—

insert—

‘37D Sale of potentially harmful things

‘(1) A person (the **“seller”**) must not sell a potentially harmful thing to another person if the seller knows or believes, on reasonable grounds, that the other person—

- (a) intends to inhale or ingest the thing; or
- (b) intends to sell the thing to another person for inhalation or ingestion whether by that person or someone else.

Maximum penalty—

- (a) for a first offence—25 penalty units or 3 months imprisonment; or
- (b) for a second or later offence—50 penalty units or 1 year imprisonment.

‘(2) For the purposes of the *Anti-Discrimination Act 1991*, section 46, a seller is not to be taken to discriminate against a person only because the seller refuses to sell a potentially harmful thing to the person because of subsection (1).

‘(3) In this section—

“potentially harmful thing”—

(a) means a thing a person may lawfully possess that is or contains a substance that may be harmful to a person if ingested or inhaled; and

Example—

- 1. Glue.
- 2. Paint.
- 3. A solvent.

(b) includes methylated spirits; and

(c) does not include a thing intended by its manufacturer to be inhaled or ingested by a person using it.

“sell” includes—

- (a) sell by wholesale, retail or auction; and
- (b) supply in trade or commerce or under an arrangement; and
- (c) agree, attempt or offer to sell; and
- (d) keep or expose for sale; and
- (e) cause or permit to be sold.’

Appendix B: Police online survey and analysis of results

OFFICER SURVEY

CMC PLACE OF SAFETY EVALUATION



INTRODUCTION

The Research and Prevention unit of the CMC is conducting an evaluation of the Volatile Substance Misuse (VSM) Place of Safety trial. The trial is operating for 12 months from 1 July 2004 in five designated trial zones (Brisbane Central, Logan, Cairns, Townsville and Mt Isa).

This survey is seeking information about your views and experiences of dealing with individuals affected by volatile substances, the amendments to the Police Powers and Responsibilities Act 2000 (s. 371A-E) and the Place of Safety trial. Police currently in a trial zone, as well as police outside the trial zones, are encouraged to complete the survey.

For officers outside a trial zone, this survey is your opportunity to highlight issues specific to your area that may impact on the effectiveness and or appropriateness of state-wide implementation of the VSM Police Powers. Participation in this process is voluntary and confidential. Your feedback is important to get a comprehensive picture of VSM in Queensland and to understand the impact of police powers.

You have been randomly sampled to participate in this survey. A total of 900 Police Officers throughout Queensland have been selected. It is important that you complete the survey only once. Survey responses must be submitted within three weeks of receipt of the email.

When you have completed the survey, your responses are automatically sent to a secure location on the bulletin board. This location is only accessible by the QPS system administrator. No additional information other than your survey responses is recorded. It is not possible to identify any individual who completes the survey. At the end of the three weeks, the data will be forwarded to researchers at the CMC for analysis.

For more information about this survey or the review of the trial Police Powers, please contact Julianne Webster, a/Senior Research Officer, on phone: 07 3360 6812 or email: julianne.webster@cmc.qld.gov.au.

BACKGROUND INFORMATION

1. Rank

- ☐ a) Constable ☐ c) Sergeant
☐ b) Senior Constable ☐ d) Other (*Please specify:* _____)

2. Sex

- ☐ a) Male ☐ b) Female

3. Age group

- ☐ a) 19-23 ☐ d) 34-38
☐ b) 24-28 ☐ e) 39+
☐ c) 29-33

4. Years of service (to the nearest year)

_____ years

5. QPS Region/Command

- ☐ a) Central ☐ g) Metro North
☐ b) Far Northern ☐ h) Metro South
☐ c) Operations Support Command ☐ i) South Eastern
☐ d) Northern ☐ j) State Crime Operations
☐ e) Southern Command
☐ f) North Coast ☐ k) Other (*Please specify:* _____)

6. Which of the following best describes your principal responsibilities?

- ☐ a) General duties ☐ e) Juvenile Aid Bureau
☐ b) Specialist duties ☐ f) Traffic
☐ c) Criminal investigation ☐ g) Other (*Please specify:* _____)
☐ d) School-based police officer

VOLATILE SUBSTANCE MISUSE (VSM)

7. In the previous 12 months, while on duty, how often have you come across people misusing volatile substances?

- ☐ a) Daily or almost every shift ☐ d) A few times a year
☐ b) Weekly ☐ e) Never
☐ c) Monthly

8. Over the past 12 months, how much of a problem would you say VSM is in your area?

- ☐ a) not a problem: *(Please skip to question 11.)*
☐ b) minor — involves 5 or less regular users
☐ c) medium — involves more than 5 but less than 20 regular users
☐ d) major — involves 20 or more regular users
☐ e) other *(Please specify approximate number of regular users: _____)*

9. In the past 12 months, compared with previous years, has the amount of VSM in your area:

- ☐ a) increased (situation has worsened)
☐ b) not changed
☐ c) decreased (situation has improved)

10. How much would you say VSM is associated with the following types of problems in your area?

	Not associated	Moderately associated	Highly associated
a) Disorderly behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Offences against the person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Property offences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Conflicts with retailers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Suicide and mental health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRIAL AREAS AND PLACES OF SAFETY

11. Please rate your understanding of the place of safety trial, operating in the five trial zones?

- ☐ a) Very Poor ☐ d) Good
☐ b) Poor ☐ e) Excellent
☐ c) Moderate

12. What VSM training have you received?

- ☐ a) Academy (i.e. pre-service)
☐ b) Online — web-based
☐ c) None (*Please skip to question 14.*)
☐ d) Other (*Please specify:* _____)

13. Please rate the training in terms of its realism/preparation for real life on the street.

- ☐ a) Very poor ☐ d) Good
☐ b) Poor ☐ e) Excellent
☐ c) Moderate

14. Are you working in a trial zone?

- ☐ a) Yes
☐ b) No (*Please skip to question 17.*)
☐ c) Unsure (*Please skip to question 17.*)

15. Have you experienced any difficulties in relation to the designated trial site boundaries, and using the new powers?

- ☐ a) Yes (*Please specify:* _____

_____)
☐ b) No

16. Overall, how effective do you believe the new powers have been in reducing the level of visible volatile substance misuse in your area?

- ☐ a) Very effective ☐ d) Ineffective
☐ b) Effective ☐ e) Very ineffective
☐ c) Neutral

POLICE POWERS AND RESPONSIBILITIES

In the next four questions, we want to assess your general attitudes to VSM, and your views about whether the legislation will help police officers address VSM-related problems in their areas. Please mark one response for each statement.

17. VSM is something that police should have assistance in dealing with in your town/suburb/district.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

If agreed, what type of assistance? *Please specify:* _____

18. The new Police Powers to address VSM provide police officers with effective mechanisms to detain and transport users to a safe place.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

19. The new Police Powers to address VSM will create opportunities for police officers to intervene with at-risk youth (eg child protection issue).

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

20. The new Police Powers to address VSM will help police officers reduce the number of young people misusing volatile substances in public places.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

In the next three questions, we want to assess your general attitudes about what changes need to be made to help you better respond to volatile substance misuse. Please circle one response for each statement.

21. The present police powers are sufficient to enable you to manage people misusing volatile substances.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

If you disagreed, why? *Please specify:* _____

22. Police need more training to know how to deal with people who misuse volatile substances.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

23. VSM is an issue that requires a multi agency response.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree

If you agreed, what type of response? *Please specify:* _____

OTHER COMMENTS

24. Are there any other comments you would like to make?

Police survey analysis

In order to gauge the experiences and opinions of trial police powers and place of safety strategy a survey was developed by the CMC research team and administered to a target sample of operational police. In mid-March 2005, 900 randomly sampled operational police officers were sent the survey electronically, and were given three weeks to complete it. The survey was made available online to be completed anonymously.

Sixty officers responded (of whom 28 were in trial zones), yielding a response rate of 7 per cent. These officers were divided approximately equally between the three target ranks (18 constables, 20 senior constables and 22 sergeants). Responses were obtained from all QPS Regions and Commands, and from officers from a range of functional units, including 28 general duties officers.

With such a low response rate, it is possible that the survey under-represents officers who have little or no experience with volatile substance misusers. It is possible that the officers who did respond to the survey had the most experience with VSM.

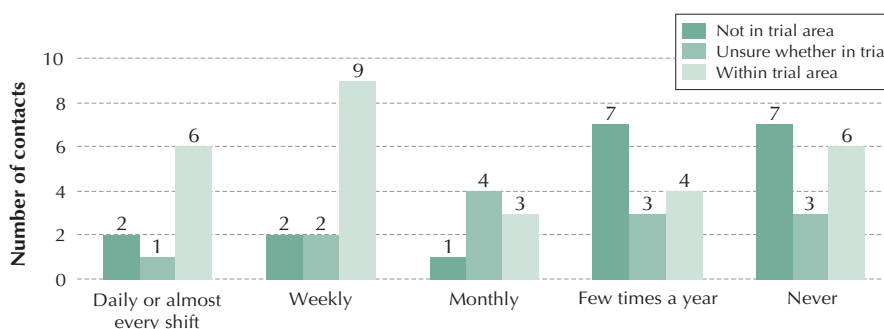
The following sections outline key findings from the survey.

Officer experience and perceptions of VSM

Early in the survey, officers were asked about the volume of VSM-related jobs they experienced. Figure B1 shows their responses in relation to frequency of VSM experiences. Responses have been categorised according to whether or not officers were in one of the trial sites.

Over half of the officers within the trial zones (15, or 54%) experienced weekly or daily encounters with people misusing volatile substances. Of the 16 officers who stated they never encountered VSM, only four could be considered to be in an area where encounters with volatile substance misusers would be expected. (For instance, communication room operators and intelligence analysts would be unlikely to be called to such incidents.) As discussed above, officers who had more experience of VSM may have been more likely to respond to the survey than officers with less or no experience.

Figure B1. Number of on-duty VSM contacts in the last 12 months



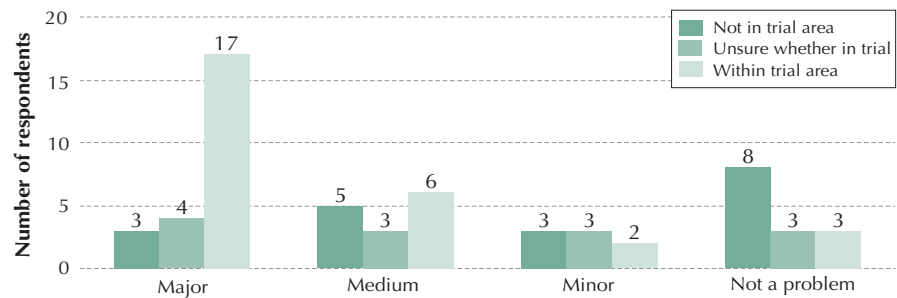
Officers were then asked to comment on how much of a problem VSM was in their area. Results show that officers within a trial area were much more likely to perceive VSM as a major problem in their area (see Figure B2 on next page).

When asked to comment on changes in the amount of VSM in their area (compared with previous years), 38 per cent of officers (23) thought there was no change, while 33 per cent (20) thought the problem was increasing. Only 10 per cent of respondents (6) believed the amount of VSM was decreasing.

Officers were asked their opinion on how VSM was associated with other behaviour, including disorderly behaviour, offences against the person, offences against property, conflicts with retailers, suicide and mental health issues, and truancy. While most officers thought that a range of these problems were at least moderately associated with VSM, they

tended to believe that VSM was more frequently associated with disorderly behaviour and property offences than with issues such as truancy and mental health.

Figure B2. Extent of VSM problem in area of operation over past 12 months



Trial areas and places of safety

Officers were asked whether they had experienced any difficulties in relation to the new powers. In the few cases where the response was 'yes' (7 officers), they had an opportunity to explain. In most of these cases, the difficulty related to accessing a place of safety when needed (5). One comment related to the fact that the volatile substance misuser was able to return to the area where they had originally been detained, and there was no power for further action. The final comment related to the time taken to fill in the custody index when a user had been detained.

In order to operate effectively, it is important that officers within the trial sites have a reasonable level of understanding of the place of safety trial. When asked to comment on this, all but two officers believed they had at least a moderate level of understanding of the trial (two officers stated they had a poor level of understanding).

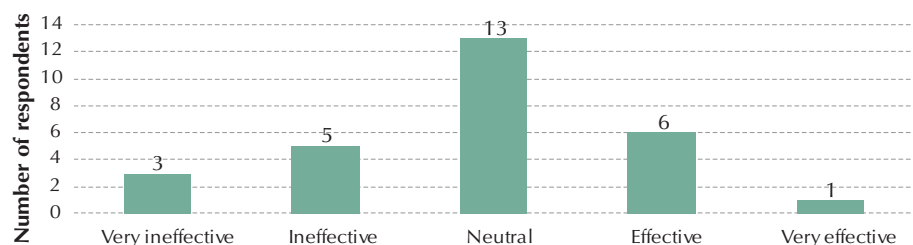
When asked about the training they had received, all but one of the 28 officers within the trial zones stated that they had received training. These officers believed that the training provided at least a moderate level of realism and preparation for real life on the street. Thirty-two per cent of respondents (9) thought the training was 'good' or 'excellent' in this respect.

The final training-related question asked officers about any need for additional training to assist them when dealing with people who misuse volatile substances. Most respondents agreed that more training was required in this regard.

Police powers and responsibilities

When asked to comment on the general effectiveness of the new powers in reducing the level of visible VSM, the majority of officers were neutral (see Figure B3).

Figure B3. Overall effectiveness of new powers in reducing visible level of VSM



Officers were then asked about the need for assistance when dealing with VSM. Generally police within the trial sites strongly agreed that assistance was needed from other agencies. Overall, there was a strong affirmative response to: 'VSM is an issue that requires a multi-agency response'. None of the officers disagreed with this statement, and the degree of

agreement did not depend on whether or not the officers were in a trial area. The comment below is illustrative:

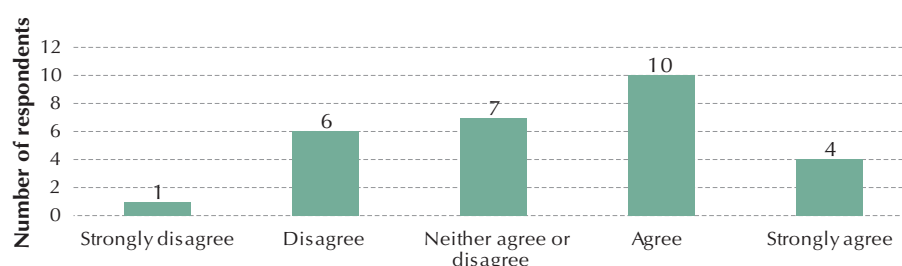
Obviously, police and members of the public are the first to interact with those people associated with VSM. Having dealt with the first response, police should be able to rely on other agencies e.g. Queensland Ambulance Service, Mental Health, Community Health, Department of Family Services etc. to conduct follow-ups to assist these people with the problem.

An officer from outside the trial expressed the view that a place of safety other than a watch-house was required in the area. The officer concluded:

A place of safety and the active support of the community are the two most important things police need.

When asked a series of more specific questions in relation to the new powers, 50 per cent of respondents (14) within the trial sites agreed that the new powers would help them intervene with at-risk youth. Twenty-five per cent (7) provided a neutral response, and the other 25 per cent disagreed (see Figure B4).

Figure B4. Extent to which new police powers create opportunities for intervention with at-risk youth (e.g. child protection issues)



When asked to comment on the effectiveness of the new powers to detain and transport volatile substance users to a safe place, 68 per cent (19) believed the powers to be effective, and 18 per cent (5) disagreed that the powers were effective in this regard; four respondents were neutral.

Finally, officers were asked whether the new powers would help police reduce the number of young people misusing volatile substances in public places. Forty-six per cent of respondents within the trial sites (13) disagreed that the powers would achieve this, while seven agreed with the statement. Seven officers neither agreed or disagreed with this statement.

Some police officers expressed concern that, after being removed from a public place, the volatile substance users then receive no further support. The comment below is typical of these concerns:

The substance misuser gets no treatment for his/her problem. All that happens is that he/she is taken 'off the streets' for a short period of time. Further, when a misuser is placed in a place of safety, nothing prevents him/her leaving the facility immediately.

General comments

While the new legislation generally received a favourable response from officers, there was some concern that police could do little other than removing the volatile substance misusers from the streets. One officer stated:


Overall I feel positive about the trial. I believe it is a step in the right direction. As with most things though with young destitute users, they will not stop substance abusing just because we transport them to a place of safety. As with most things they will have to want to stop sniffing before they actually take steps to stop. They just don't seem to care that they are ruining their future health.

Another consistent theme was the amount of time and paperwork required when taking action under the new legislation.

The process should be kept simple with the view in mind that it is designed to benefit the juvenile by taking them to a place of safety and provide them an environment that is safe while they recover. If the process is not kept simple and straightforward, then people/police will not be inclined to use it.

Appendix C: Place of safety client information form

FAX COMPLETED FORM TO 07 3360 6333, ATTN: J. WEBSTER
OR MAKE A COPY AND POST THE ORIGINAL TO
J. WEBSTER, CRIME & MISCONDUCT COMMISSION, REPLY PAID 3123, BRISBANE QLD 4001.

July 2004
**CRIME AND
MISCONDUCT
COMMISSION**

QUEENSLAND

PLACE OF SAFETY CLIENT INFORMATION

FORM MUST BE COMPLETED FOR EACH NEW CONTACT WITH CLIENT.

PLACE OF SAFETY LOCATION: _____

CLIENT ARRIVAL

DATE: _____ TIME: _____ ☐ AM ☐ PM

How did the client come to the place of safety?

☐ REFERRED BY AMBULANCE ☐ REFERRED BY POLICE
☐ SELF-REFERRED ☐ OTHER – PLEASE SPECIFY: _____

CLIENT DETAILS

CLIENT NAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ ABORIGINAL OR TORRES STRAIT ISLANDER? ☐ NO ☐ YES: ☐ A ☐ TI ☐ BOTH
OR OTHER ETHNICITY: _____

AT THE PLACE OF SAFETY

Has the client had contact with this place of safety before? ☐ NO ☐ YES: How many times? _____

Did the client appear intoxicated when referred to/arrived at this place of safety? ☐ NO ☐ YES: What was the cause of intoxication? (e.g. chroming, alcohol, other illicit drugs) _____

Did the client receive crisis counselling? ☐ YES ☐ NO

Did the client stay overnight? ☐ YES ☐ NO

Did the client require medical treatment? ☐ NO ☐ YES: What was the treatment? _____

Was the client reconnected with family/responsible support environment?

☐ YES: What was the support environment? (please specify) _____

☐ NO: Was the client managed into other accommodation services? (please specify) _____

Was the client managed through other referral pathways? ☐ NO ☐ YES: Please specify _____

CASE MANAGEMENT OPTIONS

CONSIDERED: _____

IMPLEMENTED: _____

REASON(S) FOR DECISION: _____


ARRANGEMENTS TO FOLLOW UP PROGRESS OF CLIENT? ☐ NO ☐ YES: Please specify _____

TIME CLIENT LEFT PLACE OF SAFETY: _____ ☐ AM ☐ PM SIGNATURE: _____

Appendix D: Place of safety client survey form

THANK YOU FOR PARTICIPATING IN THIS SURVEY. ALL INFORMATION PROVIDED IS CONFIDENTIAL.
PLEASE GIVE YOUR COMPLETED SURVEY TO THE PLACE OF SAFETY COORDINATOR
POST TO J. WEBSTER, CRIME & MISCONDUCT COMMISSION, REPLY PAID 3123, BRISBANE QLD 4001.

July 2004
CRIME AND
MISCONDUCT
COMMISSION



CLIENT SURVEY
EVALUATION OF PLACES OF SAFETY

ALL THE INFORMATION YOU PROVIDE IS COMPLETELY PRIVATE AND ANONYMOUS AND WILL ONLY BE USED
FOR RESEARCH PURPOSES. DO YOU AGREE? ☐ YES ☐ NO: DO NOT FILL OUT THIS FORM.

PLACE OF SAFETY LOCATION: _____ DATE: _____

CLIENT INFORMATION

ARE YOU... ☐ MALE? ☐ FEMALE? ABORIGINAL OR TORRES STRAIT ISLANDER? ☐ NO ☐ YES: ☐ A ☐ TI ☐ BOTH
OR OTHER ETHNICITY: _____

How old are you? _____ Are you still at school? ☐ NO ☐ YES: WHAT YEAR ARE YOU IN? _____

What sort of place are you living in now? (TICK ONE BOX ONLY)

<input type="checkbox"/> FAMILY HOUSE	<input type="checkbox"/> BOARDING HOUSE, MOTEL OR HOSTEL
<input type="checkbox"/> RENTED HOUSE OR FLAT	<input type="checkbox"/> REFUGE OR SHELTER
<input type="checkbox"/> SQUAT/ON THE STREET	<input type="checkbox"/> MEDICAL FACILITY/RESIDENTIAL DRUG TREATMENT
<input type="checkbox"/> OTHER – PLEASE SPECIFY: _____	

What is your main source of income? (TICK ONE BOX ONLY)

<input type="checkbox"/> PAID JOB	<input type="checkbox"/> MONEY FROM FAMILY
<input type="checkbox"/> GOVERNMENT BENEFITS	<input type="checkbox"/> NONE
<input type="checkbox"/> OTHER – PLEASE SPECIFY: _____	

INHALANT USE

How old were you when you first started chroming? _____

In the last month, how many times would you say you have chromed? (TICK ONE BOX ONLY)

<input type="checkbox"/> EVERY DAY	<input type="checkbox"/> A FEW TIMES A WEEK
<input type="checkbox"/> ONCE A WEEK	<input type="checkbox"/> FIVE TIMES OR LESS

In the last week, how many times would you say you have chromed? (TICK ONE BOX ONLY)

<input type="checkbox"/> EVERY DAY	<input type="checkbox"/> A FEW TIMES
<input type="checkbox"/> ONCE	

How often do you chrome...? (TICK ONE BOX FOR EACH LINE)

	ALL THE TIME	SOMETIMES	NEVER
ALONE AT HOME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AT HOME OR AT A FRIEND'S HOME WITH A GROUP OF FRIENDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WITH A GROUP OF FRIENDS IN A PUBLIC PLACE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER PLACES: _____

Why did you start chroming? (TICK ALL THAT APPLY)

☐ MY FRIENDS WERE DOING IT ☐ I WANTED TO SEE WHAT IT WAS LIKE

☐ I WANTED TO FORGET MY PROBLEMS ☐ I HAD NOTHING ELSE TO DO (BOREDOM)

☐ OTHER – PLEASE SPECIFY: _____

Why are you still chroming? (TICK ALL THAT APPLY)

☐ MY FRIENDS ARE DOING IT ☐ I WANT TO FORGET MY PROBLEMS

☐ I HAVE NOTHING ELSE TO DO (BOREDOM) ☐ I CAN'T ALWAYS AFFORD THE DRUGS I WOULD PREFER TO USE

☐ OTHER – PLEASE SPECIFY: _____

Who knows about your chroming? (TICK ALL THAT APPLY)

☐ PARENTS ☐ OTHER FAMILY

☐ FRIENDS ☐ POLICE

☐ AMBULANCE/HOSPITAL/DOCTORS ☐ TEACHERS

☐ WORKMATES ☐ NO ONE

If you were to stop chroming, what would the reasons be? (TICK ALL THAT APPLY)

☐ TO HAVE BETTER HEALTH ☐ TO AVOID TROUBLE WITH THE POLICE

☐ TO BE MORE IN CONTROL OF MY LIFE ☐ I DON'T ENJOY THE AFFECTS OF CHROMING ANYMORE

☐ FRIENDS/FAMILY WANT ME TO STOP ☐ I WANT TO GET A JOB

☐ I WANT TO RETURN TO SCHOOL/STUDY ☐ OTHER – PLEASE SPECIFY: _____

Have you ever received medical treatment as a result of chroming? ☐ NO ☐ YES: WHAT WAS THE TREATMENT? _____

Has your chroming landed you in hospital? ☐ NO ☐ YES: WHAT WERE THE INJURIES? HOW WERE THEY RECEIVED? _____

What do you think needs to be done to help young people who are chroming? _____

OTHER DRUG USE

Do you use other drugs at the same time as chroming? ☐ NO ☐ YES: WHICH DRUGS DO YOU REGULARLY USE? (TICK ALL THAT APPLY)

☐ ALCOHOL ☐ CANNABIS

☐ PRESCRIPTION DRUGS ☐ OTHER – PLEASE SPECIFY: _____

What is your favourite drug (including inhalants, alcohol and prescription drugs)? _____

PLACE OF SAFETY

How many times have you been in contact with this Place of Safety? _____

Has the Place of Safety assisted you? ☐ NO ☐ YES: HOW? _____

☐ GAVE ME AWARENESS OF THE DANGERS OF CHROMING ☐ GAVE ME SOMEONE TO TALK TO

☐ KEPT ME OFF THE STREETS/KEPT ME SAFE ☐ IT REFERRED ME TO A REHABILITATION PROGRAM

☐ IT REFERRED ME TO A DETOXIFICATION PROGRAM ☐ HOW ELSE? (PLEASE SPECIFY) _____

How well do you think the people at the Place of Safety understand inhalant use?

☐ REALLY WELL ☐ NOT THAT WELL

☐ THEY HAVE NO IDEA ☐ I DON'T KNOW

Appendix E: QAS information form

FAX COMPLETED FORM TO 3247 8267 OR POST TO MEDICAL DIRECTOR'S OFFICE,
QUEENSLAND AMBULANCE SERVICE, GPO BOX 1425, BRISBANE QLD 4001.

July 2004
CRIME AND
MISCONDUCT
COMMISSION



QUEENSLAND

VOLATILE SUBSTANCE MISUSE INFORMATION FORM

SEE BACK OF FORM FOR COMPLETION GUIDELINES.

QUEENSLAND AMBULANCE SERVICE

RESPONSIBLE OFFICER: _____

DATE: _____ FIRST CONTACT TIME: _____ ☐ AM ☐ PM

LOCATION OF CONTACT: _____

SOURCE/ORIGIN OF CONTACT: _____

VSM INCIDENT

CLIENT DETAILS

CLIENT NAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ ABORIGINAL OR TORRES STRAIT ISLANDER? ☐ NO ☐ YES: ☐ A ☐ TI ☐ BOTH
OR OTHER ETHNICITY: _____

☐ UNDER INFLUENCE OF INHALANT AT TIME OF CONTACT

☐ UNDER INFLUENCE OF ALCOHOL OR OTHER DRUGS AT TIME OF CONTACT

☐ KNOWLEDGE OF PREVIOUS VSM

☐ NO OBVIOUS VSM-RELATED IMPAIRMENT

☐ OTHER DETAILS: _____

RESPONSE DETAILS

ACTIONS TAKEN: _____

REASONS FOR ACTIONS TAKEN: _____

EXPECTED RESULTS OF ACTIONS: _____

TIME AT END OF CONTACT: _____ ☐ AM ☐ PM SIGNATURE: _____

FORM COMPLETION GUIDELINES

RESPONSIBLE OFFICER — For example: title and name of officer making contact with client.

DATE — The date of contact with client.

FIRST CONTACT TIME — The time in which the 'event' commenced/when job despatched.

LOCATION OF CONTACT — street and suburb, any relevant descriptive information about the place of contact, for example: in park, shopping mall or home.

SOURCE/ORIGIN OF CONTACT — For example: police or ambulance despatch.

VSM INCIDENT

CLIENT DETAILS

CLIENT NAME — Given names and surname of the client.

DATE OF BIRTH — The client's date of birth — DD/MM/YYYY.

SEX — Tick either male or female.

ABORIGINAL OR TORRES STRAIT ISLANDER — Tick box for No or Yes and Aboriginal, Torres Strait Islander or both.

UNDER THE INFLUENCE OF INHALANT AT TIME OF CONTACT — Tick box if at the time of contact the client showed signs of being under the influence.

UNDER INFLUENCE OF ALCOHOL OR OTHER DRUGS AT TIME OF CONTACT — Tick box if at the time of contact the client showed signs of being under the influence of alcohol or other drugs.

KNOWLEDGE OF PREVIOUS VSM — Tick box if the client is someone who is known to have a history of VSM.

NO OBVIOUS VSM-RELATED IMPAIRMENT — Tick box if at the time of contact the client does not appear to show any signs of short term impairment resulting from VSM.

OTHER — Tick box and write in space any other circumstances relating to the client's contact with a responsible officer. For example: the call out does not relate to VSM but use of other drugs.

RESPONSE DETAILS

ACTIONS TAKEN — Includes: interviewed and transported to A&E or to a place of safety.

REASONS FOR ACTIONS — Includes: to get health assessment, to access a place of safety.


EXPECTED RESULTS OF ACTIONS — Includes: health assessment by qualified health professional or access to case management services by a place of safety.

TIME AT END OF CONTACT — The time in which the 'event' finished — when the job was closed off.

Appendix F: Queensland Health emergency department information form

FAX COMPLETED FORM TO 07 3360 6333, ATTN: J. WEBSTER, OR POST TO
J. WEBSTER, CRIME & MISCONDUCT COMMISSION, REPLY PAID 3123, BRISBANE QLD 4001.

August 2004
CRIME AND
MISCONDUCT
COMMISSION



QUEENSLAND

VOLATILE SUBSTANCE MISUSE INFORMATION FORM

SEE BACK OF FORM FOR COMPLETION GUIDELINES.

QUEENSLAND HEALTH – EMERGENCY DEPARTMENT

TO BE COMPLETED AT TRIAGE

RESPONSIBLE OFFICER: _____

DATE: _____ FIRST CONTACT TIME: _____ ☐ AM ☐ PM

HOSPITAL LOCATION: _____

HOW REFERRED?

☐ REFERRED BY AMBULANCE ☐ REFERRED BY POLICE

☐ SELF-REFERRED ☐ OTHER – PLEASE SPECIFY: _____

CLIENT DETAILS

CLIENT NAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ ABORIGINAL OR TORRES STRAIT ISLANDER? ☐ NO ☐ YES: ☐ A ☐ TI ☐ BOTH
OR OTHER ETHNICITY: _____

☐ UNDER INFLUENCE OF INHALANT AT TIME OF CONTACT

☐ UNDER INFLUENCE OF ALCOHOL OR OTHER DRUGS AT TIME OF CONTACT

☐ NO OBVIOUS VSM-RELATED IMPAIRMENT

☐ OTHER DETAILS: _____

SIGNATURE: _____

TO BE COMPLETED BY TREATMENT PROVIDER (DOCTOR/NURSE PRACTITIONER)

TREATMENT

RESPONSIBLE OFFICER: _____

☐ TREATMENT: _____

☐ NO TREATMENT PROVIDED

☐ DISCHARGED

☐ CLIENT LEFT BEFORE RECEIVING TREATMENT

EXIT

COLLECTED BY A PLACE OF SAFETY? ☐ YES ☐ DON'T KNOW ☐ NO: HOW WERE THEY TRANSFERRED TO A PLACE OF SAFETY? _____

TIME AT END OF CONTACT: _____ ☐ AM ☐ PM SIGNATURE: _____

FORM COMPLETION GUIDELINES

TRIAGE

RESPONSIBLE OFFICER – Person conducting triage assessment.

DATE – The date of contact with client.

FIRST CONTACT TIME – The time in which the 'event' commenced/when job despatched.

HOSPITAL LOCATION – Hospital name and suburb/town.

HOW REFERRED – How the person got to the emergency department.

CLIENT DETAILS

CLIENT NAME – Given names and surname of the client.

DATE OF BIRTH – The client's date of birth – DD/MM/YYYY.

SEX – Tick either male or female.

ABORIGINAL OR TORRES STRAIT ISLANDER – Tick box for No or Yes and Aboriginal, Torres Strait Islander or both, OR write client ethnicity.

UNDER THE INFLUENCE OF INHALANT AT TIME OF CONTACT – Tick box if at the time of contact the client showed signs of being under the influence.

UNDER INFLUENCE OF ALCOHOL OR OTHER DRUGS AT TIME OF CONTACT – Tick box if at the time of contact the client showed signs of being under the influence of alcohol or other drugs.

NO OBVIOUS VSM-RELATED IMPAIRMENT – Tick box if at the time of contact the client does not appear to show any signs of short term impairment resulting from VSM.

OTHER – Tick box and write in space any other circumstances relating to the client's contact with a responsible officer. For example: the call out does not relate to VSM but use of other drugs.

TREATMENT PROVIDER

TREATMENT

RESPONSIBLE OFFICER – Person assessing/delivering treatment needs (i.e. doctor/nurse practitioner)

TREATMENT PROVIDED – Tick box if treatment was provided and specify treatment administered.

NO TREATMENT PROVIDED – Tick box when no treatment was provided after assessment.

DISCHARGED – Tick box if patient was discharged.

CLIENT LEFT BEFORE RECEIVING TREATMENT – Tick box if client left hospital on own accord before receiving treatment.

EXIT

COLLECTED BY A PLACE OF SAFETY – Indicate if client was collected by P.O.S. If no, how were they transferred to a P.O.S. Indicate how the person was transported.

TIME AT END OF CONTACT – The time in which the 'event' finished – when the job was closed off.

Appendix G: Literature review

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' (Drugs and Crime Prevention Committee 2002a, p. 7). In Australia, about 250 products have been identified as containing potentially intoxicating inhalable substances. These are commonly divided into four main classes:

- **solvents**, such as glues, paint thinners and removers, dry-cleaning fluids, petrol, contact adhesives, correction fluids, felt pens
- **aerosols**, such as spray paints, insect spray, hair spray, deodorant spray, air fresheners, cooking oil spray, fabric protector spray, Ventolin
- **gases**, such as household gases (butane, bottled domestic gas, cylinder propane gas), medical anaesthetics (ether, chloroform, halothane, nitrous oxide), refrigerant gases
- **nitrites**, such as amyl nitrate, butyl nitrate. (QPS 2004c)

Many of these products are commonly used as part of everyday household maintenance and management. They are both legal to possess and readily available for purchase in mainstream retail outlets. At the same time, each contains chemical compounds of varying degrees of toxicity and many appear on Queensland Health's list of common poisons (Queensland Health 2003). The relative toxicity associated with the inhalation of volatile substances depends on the specific nature of the chemical compound(s) found in the product used, and each substance varies in terms of its pharmacological effects. However, all volatile substances have in common the short-term effect of depressing the central nervous system (Chick & Cantwell 1994; Drugs and Crime Prevention Committee 2002a).

The Drugs and Crime Prevention Committee (2002b) estimate the duration of the short-term effects of VSM at between about 5 and 45 minutes after inhalation. Users feel euphoric, exhilarated, relaxed, and high or intoxicated, in much the same way as they would if they had consumed alcohol. The subsequent effects are also similar to those of alcohol; the initial effects tend to be followed by sensations of dizziness, nausea, numbness, fatigue, confusion, perceptual distortions, impaired coordination and headaches (Benignus 1981a; Bingham, Cohnsen & Powell 2001; Ellenhorn et al. 1997; Stollery & Flindt 1988; Zenz 1988; Zenz, Dickerson & Horvath 1994). In some instances, prolonged use of volatile substances has been reported to result in hallucinations of significant duration and intensity (Drugs and Crime Prevention Committee 2002b; MacLean 2003).

VSM: prevalence and populations

International research indicates that VSM is most common in adolescence, with lifetime use peaking at between 13 and 15 years of age (Beauvais 1992; Beauvais & Oetting 1987, cited in Toumbourou, Dimsey & Rowland 2004; Indian and Inuit Health Committee, Canadian Paediatric Society 1998; Johnson, O'Malley & Bachman 2002; Liang 1997; Liu 2003; National Centre of Social Research/National Foundation of Educational Research 2004; World Health Organisation 1999b). Research also suggests that indigenous peoples, regardless of age, are more likely to demonstrate VSM involvement than non-indigenous peoples (Casswell 1992 & Gfellner 1994, both cited in World Health Organisation 1999b; Health Canada 1999). In terms of the prevalence of VSM within and across age and ethnic groupings, however, significant differences are noted between states and nations. Indeed, a United Nations overview of the use of drugs among youth in 50 member nations found that the 'percentage of youth who have tried an inhalant at least once in their life' ranged

between 0.4 per cent and 25.5 per cent (United Nations 1999, p. 14). Across all nations considered, the average lifetime prevalence of VSM in youth populations was estimated as 7.7 per cent.

Differences between the methods of data collection of each nation taking part in the UN research preclude direct comparison across international boundaries. However, it is noteworthy that, of the 50 countries involved, Australia was identified as having the highest 'lifetime prevalence rate' (25.5%) of 'inhalant abuse among youth populations'.

The prevalence rate quoted by the UN was obtained from the 1996 nationwide survey of Australian secondary students, and is consistent with the results of a similar survey undertaken in 1999. Of the 25 486 12- to 17-year-old students sampled as part of this research, 26 per cent reported having used volatile substances at least once during their lifetime, with 19.2 per cent having engaged in VSM in the year before they completed the survey (White 2001). Younger students were more likely to have used volatile substances within the past year than older students. Specifically, 12-year-olds were more than three times as likely as 17-year-olds (25.5% and 8.1% respectively) to report VSM involvement during the past year (White 2001). Similarly, a 1999 Queensland survey of alcohol and drug use among school students revealed that students in Years 7 and 8 were up to ten times more likely than those in Years 11 and 12 (10%, compared with less than 1%) to have misused volatile substances during the previous week (Stanton et al. 2000).

Despite the consistency between the results of the Australian school-based surveys and international literature on the peak age of VSM, the results obtained from the Australian school surveys should be viewed with caution. The methodology precluded involvement by students who were absent, truant or not attending school on the day of the survey, and by those whose parents did not consent to their participation. Furthermore, results obtained from school-based surveys tend to provide significantly higher estimates of VSM than household surveys of this practice. For instance, the 2004 Australian Institute of Health and Welfare National Household Drug Survey found that 2.5 per cent of 29 445 Australians aged 14 years and over had misused volatile substances at some time during their lifetime. In the case of individuals aged 12–19 years, 0.9 per cent reported that they had misused volatile substances (AIHW 2005). Indeed, in contrast to the results of the school-based surveys, males aged 20–29 years (5.4%) were identified as more likely than any other age group to have engaged in VSM.

As an explanation of the different results from the school-based and household drug surveys, it is suggested that the validity of household drug surveys might be limited by young people being reluctant to 'admit using drugs in the presence of their families' (United Nations 1999, p. 3). However, it is also possible that, in the school environment, peer pressure to engage in risk-taking behaviour may encourage young people to claim drug use that they do not actually engage in. Nevertheless, given research demonstrating that both current and previous users of volatile substances are commonly loath to admit to their involvement in VSM, because it is considered a 'dirty' drug and less socially desirable than other drug classes, this conclusion appears unwarranted (MacLean 2003, p. 5; Smart 1992). It is suggested, therefore, that the results of the school-based survey provide a more reliable estimate of actual VSM use than the results of the household surveys do, at least for young people who are attending school.

Patterns of VSM

In contrast to the dearth of accurate information on the prevalence of VSM in Australia, locally based research has provided significant insight into the way in which young people misuse volatile substances. This research differentiates between individuals who engage in VSM as a purely social activity, those who experiment with VSM once or twice but do not continue to make use of associated products over the longer term, and those who demonstrate chronic and/or intensive VSM involvement (May & Del Vicchio 1997, cited in Bellhouse, Johnston & Fuller 2001; Rose 2001). Although individuals involved in chronic VSM are commonly perceived to pose the greatest risk to themselves and others, they are also reported to comprise the smallest proportion of users of volatile substances (Carroll,

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

Longitudinal research suggests that, of the young people who become chronic misusers of volatile substances, significant proportions also become 'polydrug'¹ users (Garriott 1992; Joe, Garriott & Simpson 1991; May & Del Vicchio 1997, cited in Bellhouse, Johnston & Fuller 2001; Williams et al. 2000). Indeed, associated research shows that, as school students age, reported levels of recent volatile substance misuse decrease and reported levels of other drug use (such as tobacco, alcohol, marijuana, hallucinogens, heroin, amphetamines and cocaine) increase (Department of Human Services 1996; Makkai 1994). Given the generally negative perception of VSM, both among drug users and within the broader population (MacLean 2003), it has been suggested that volatile substances are seldom the chronic user's 'drug of choice', but rather the cheapest and most accessible alternative to other more desirable substances (Drugs and Crime Prevention Committee 2002b). Furthermore, according to Beauvais (1992), even when volatile substances are identified as a young person's preferred drug, ongoing exclusive use is rare and adolescent 'solvent' abusers are 'prone to use whatever is available'. Oetting and Webb (1992) suggest that this propensity may result from the social environment in which volatile substances are typically misused, and the desire for participants in these environments to share resources and identities.

Risks associated with VSM

The confusion, perceptual distortions and hallucinations experienced by some individuals after inhaling volatile substances have been shown to place them at considerable risk of causing harm to themselves or others (Drugs and Crime Prevention Committee 2002b, p. 11). In one of the few Australian studies on the issue, an examination of records held by the Victorian State Coroners Court and Institute of Forensic Medicine revealed 44 fatalities occurring between 1991 and 2000 that were in some way associated with the use of volatile substances (Drugs and Crime Prevention Committee, 2002b). Of these, 17 involved suspected suicides and eight were described as 'accidents related to intoxication' (pp. 35–36). These accidents included road fatalities, incidents in which VSM-affected individuals were killed after stepping in front of moving vehicles, one incident in which an individual fell from the rooftop location where he was inhaling a volatile substance, and one in which the deceased was found suffocated by the plastic bag that he was using to inhale a volatile substance. In a similar US investigation of all fatalities occurring between 1982 and 1988 in Bexar County, Texas, 39 were identified as being associated with the use of volatile substances (Garriott 1992). Of these, 28 were attributed to suicide, most commonly by hanging. Accidents were identified as the second most common cause of death associated with inhalant abuse (10), closely followed by homicides (9). According to Garriott, these fatalities 'tended to result from aberrant aggressiveness or bizarre accident-prone behaviours', such as 'challenging auto or train traffic' (p. 186); and, together with the fatalities attributed to suicide, these observations suggest a strong association between inhalant abuse and violent death.

Among the most comprehensive investigations of volatile substance mortality rates, Field-Smith et al. (2002) documented annual trends in UK fatalities from 1971 to 2000. Of the 1923 fatalities associated with volatile substance abuse, 16.2 per cent (312) were attributed to trauma (including accidents, hanging and drowning), 11.6 per cent (224) were caused by suffocation involving the plastic bag used to inhale the volatile substance, and 14.5 per cent (278) resulted from the inhalation of vomit. Suicide fatalities were included in the figures pertaining to trauma and represented 23 per cent (72) of this category, or 4.2 per cent of total VSA-related fatalities.

Toxicity of volatile substances

A comparison of Australian, American and British datasets reveals some notable differences in the patterns associated with VSM mortality. Although this comparison must be viewed

1 Users of more than one type of drug (e.g. volatile substances and marijuana).

with caution, in view of the different locality sizes, time periods, and methods used in each of these investigations, it is notable that suicide was the leading cause of death among the Australian and American cases reviewed (Drugs and Crime Prevention Committee 2002b; Garriott 1992), while the cause of death of more than half of the 1024 British fatalities (53.3%) was attributed to the toxicity of the substance inhaled (Field-Smith et al. 2002). In the Australian sample, toxicity accounted for only 13 of the 44 fatalities reviewed (29.5%) and in the American sample it accounted for 7 of the 39 fatalities reviewed (18%).

These differences may be partly explained by cultural differences between the three geographic areas. Certainly, location-specific differences in firearm possession may account for at least some of the VSM-associated homicides identified in the Texan sample. Also, the UK does not have an indigenous population in the same sense as those of Australia and the United States, and both Australian and international evidence suggests a significant correlation between being indigenous and increased suicide risk (Australian Bureau of Statistics 2002; Department of Health and Ageing 1999). Nevertheless, the differences in the nature of these fatalities may also be directly attributed to the types of substances most commonly misused in each country.

In the US sample, toluene-based solvents were the substances most commonly associated with VSM fatalities (32 fatalities or 82% of all fatalities sampled). However, fatalities specifically associated with the toxicity of the substance inhaled most commonly involved the use of trichloroethylene-based solvents (two of four toxicity-related fatalities compared with one of 32 other fatalities). In contrast, 'gases' (and specifically butane gases) were the most commonly identified substances of abuse recorded in the British sample (886 fatalities or 43.73% of all fatalities sampled), followed by aerosols (368 fatalities or 18.16% of all fatalities sampled), many of which also contained butane. In the Australian sample, butane and/or propane were also implicated as the volatile substances most commonly associated with fatalities attributed to toxicity.

Research into the effects of heavy or chronic exposure to butane, propane, trichloroethylene and trichlorofluoromethane (also known as CFC or freon) has revealed an association with the development of potentially fatal cardiac arrhythmias (Bingham, Cochrane & Powell 2001; Doring et al. 2002; El-Menyar, El-Tawil & Al Suwaidi 2005; Gosselin, Smith & Hodge 1984; Gray & Lazarus 1993; Groppi et al. 1994; Lewis 1996; Siegel & Wason 1992; Watson, Gibler & Hassan 1986; Williams & Cole 1998; World Health Organisation 1990; Zenz 1988). Of particular note are a number of clinical cases reporting sudden fatalities resulting from purposeful misuse of substances containing butane and trichlorofluoromethane, and one study which investigated the fatalities of 110 individuals who misused various volatile substances (American Conference of Governmental Industrial Hygienists 1991; Bland et al. 1998; Ellenhorn & Barceloux 1988; Fuke et al. 2002; Goodman & Gilman 1975; Haddad 1990; Rohrig 1997). This investigation revealed that at least 18 fatalities occurred after heavy exercise or stress (Ellenhorn & Barceloux 1988; Zenz, Dickerson & Horvath 1994). The results of autopsies undertaken as part of this and other research into what has come to be referred to as 'sudden sniffing death' revealed that 'recreational' inhalation of either trichlorofluoromethane or butane may contribute to a condition in which the heart becomes overly sensitive to adrenaline, so that exertion at the time of exposure may lead to a heart attack (American Conference of Governmental Industrial Hygienists 1991; Haddad 1990).

The research and clinical findings on toluene differ from those on butane. Garriott (1992) states that, while toluene 'has been implicated in a few fatalities, those cases reported ... may not [actually] be attributed to toluene as authors often fail to critically rule out other substances' (p. 185). Nevertheless, chronic and high levels of exposure to both toluene and other volatile substances commonly found in solvents (such as xylene) have been clinically associated with adverse central nervous system effects contributing to decreased accuracy in visual perception, decreased colour discrimination, memory loss, muscular weakness, decreased manual dexterity, convulsions, narcosis, brain damage and unconsciousness (ATSDR 1993, 1995, 2000; American Conference of Governmental Industrial Hygienists 1991; Benignus 1981b; Chalmers 1991, cited in HealthInfoNet 2001; Cleland & Kingsbury 1977; Echeverria et al. 1991; Ellenhorn et al. 1997; Foo, Jeyaratnam & Koh 1990; Stollery & Flindt 1988; US Air Force 1989; US Environmental Protection Agency 1994a, 1994b; World

Health Organisation 1989; Zenz, Dickerson & Horvath 1994). Furthermore, studies on the effects of chronic prolonged VSM have revealed changes in the brain structure that correlate with observed hearing, speech, vision and muscular dysfunction (ATSDR 1993). Both chronic and acute toluene misuse has been identified as a contributing factor to kidney damage, liver problems, upper airway problems and respiratory failure and acute cardiotoxicity (Benignus 1981b; Boewer et al. 1988; Chalmers 1991, cited in HealthInfoNet 2001; Ellenhorn et al. 1997; Fischman & Oster 1979; US Environmental Protection Agency 1994b; World Health Organisation 1989). Similar effects have also been documented in association with the use of solvents containing hexane, xylene, lead, copper, zinc, and tin, such as petrol and paint (ATSDR 1995; Chalmers 1991, cited in HealthInfoNet 2001).

In addition, research shows that children born to women who abused toluene-containing products during pregnancy commonly suffer symptoms similar to those of foetal alcohol syndrome. Specifically, these children demonstrate central nervous system dysfunction, attention deficits and hyperactivity, developmental delays, limb abnormalities, kidney problems, growth deficiency, and smaller brain sizes than other infants (American Conference of Governmental Industrial Hygienists 1991; Erramouspe, Galvez & Fischel 1996; Hersh 1989; World Health Organisation 1999a). These women also experience a significantly higher risk of spontaneous abortion and premature labour, and place their own health in jeopardy, particularly in terms of renal damage (Ellenhorn et al. 1997). While less research has been carried out into the misuse of other volatile substances during pregnancy, some evidence exists that exposure to butane may lead to similar, and possibly more serious, outcomes (Fernandez et al. 1986).

Although it has been noted that many of the non-fatal effects associated with high levels of exposure to volatile substances are reversible (Benignus 1981b; Gosselin, Smith & Hodge 1984; World Health Organisation 1990), not all researchers agree. Foo, Jeyaratnam & Koh (1990) reported the results of research investigating the effects of occupational exposure to toluene, which found significant associations between toluene exposure and neurobehavioural impairments in manual dexterity, visual scanning, and verbal memory. These impairments were identified in the absence of clinical symptoms or signs, suggesting persistence after reversal of physical effects. In line with these findings, Stollery and Flindt (1988) reported persistent memory impairments in female workers accidentally exposed to organic solvents. These impairments were measurable up to eight months after exposure. Permanent physical brain damage has also been documented in a case study of an individual who had regularly inhaled toluene over a 14-year period (American Conference of Governmental Industrial Hygienists 1986).

Some of the main difficulties identified in assessing the long-term outcomes of exposure to volatile substances concern the different populations studied. Specifically, much of the research has employed samples of individuals unintentionally exposed during industrial accidents and activities. These samples are typically in a much older age group than populations identified as most likely to engage in VSM, and the nature and level of exposure to specific volatile substances differ dramatically between those who engage recreationally and those who engage occupationally with the substances in question. However, given the ongoing status of brain development during adolescence (see Giedd et al. 1999), it is likely that, if any permanent effects of high levels of volatile substance exposure are going to be identified, it will be in the central nervous systems of individuals less than 15 years old. Furthermore, even if VSM use does not lead to permanent brain damage, whether through toxicity or through reduced blood oxygen levels during non-fatal heart failure, the short-term confusion and cognitive disturbances associated with chronic exposure are unlikely to be conducive to effective functioning within the school environment. The physical effects of volatile substance misuse may therefore also contribute to the high levels of school failure and drop-out reported among chronic users and the long-term socioeconomic consequences of such outcomes (Bates et al. 1997; Beauvais 1992; Bellhouse, Johnston & Fuller 2001; Chadwick, Yule & Anderson 1990; Creson 1992; Drugs and Crime Prevention Committee 2002b; Fleschler et al. 2002; Garriott 1992; Grunbaum et al. 1999; Mackesy-Amity & Fendrich 2000; Oetting & Webb 1992; Rose 2001; World Health Organisation 1999b).

Social factors associated with VSM

In addition to links between VSM and polydrug use, poor educational achievement and school drop-out, results of local and international research suggest an association between chronic VSM and poverty, homelessness, social exclusion, family disruption and dysfunction, lack of supervision, peer influences, aggression, crime and delinquency, mental health problems and 'cultural disintegration' and the effects of rapid cultural change within Indigenous communities (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 and Crime Prevention Committee 2002b; Fendrich et al. 1997; Howard et al. 1999, cited in Drugs and 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). It is argued that, in remote Indigenous communities, many of these factors (e.g. boredom and poverty resulting from unemployment) are accepted as implicit parts of the social environment.

In Australia, neither the school-based surveys nor the National Household Drug Survey compared Indigenous and non-Indigenous rates of reported VSM. However, research focusing on the drug use of urban Indigenous people (National Drug Household Survey 1994, cited in Drugs and Crime Prevention Committee 2002a) suggests higher rates of VSM within this population than in the broader Australian sample obtained during the 2001 National Household Drug Survey. Specifically, this research revealed that 7 per cent of Indigenous Australians reported having misused volatile substances. Of these, 4 per cent reported having used petrol, and 5 per cent said that they had misused other types of volatile substances, most commonly glue. Research carried out in rural communities suggests that reported rates of VSM among Indigenous Australian populations are even higher there than in urban areas (Halfpenny 2000, cited in Loxley, Toumbourou & Stockwell 2004). The claim that VSM is a part of more general polydrug use is supported in findings from one West Australian community, where 48 per cent of Indigenous 15–17-year-olds reported frequently engaging in these drug behaviours (Grey et al. 1997, cited in Loxley, Toumbourou & Stockwell 2004).

Differences in the social factors impacting on rural and urban Indigenous Australians and non-Indigenous Australians are accompanied by differences in the type and nature of VSM engaged in. Specifically, in remote Indigenous communities petrol is the volatile substance most commonly misused and adult involvement in VSM is said to be common (Ministerial Council on Drug Strategy 1998; Queensland Government 2002). More generally, in both rural and urban contexts, Rose et al. (1992, cited in Drugs and Crime Prevention Committee 2002b) state that young Indigenous Australians tend to misuse volatile substances at a higher intensity and over a longer period than non-Indigenous Australian young people. Researchers suggest a lack of available alternatives and/or resources to acquire alternatives as a possible explanation.

However, despite these and other conclusions about the prevalence and nature of VSM in Indigenous communities and among Australian Indigenous people generally, Brady (1992) notes that neither Indigenous status nor remoteness is sufficient to predict community involvement in the misuse of petrol. She indicates that, in many cases, two communities demonstrating similar levels of socioeconomic disadvantage and other factors associated with VSM will show very different VSM prevalence levels.

Pathways to VSM use

Despite the associations between VSM and social characteristics such as school failure and drop-out, family dysfunction, juvenile delinquency, mental health problems, and cultural disintegration, the exact nature of the influences determining these relationships remains unclear. For instance, while the results of a number of studies have indicated that family dysfunction frequently pre-dates VSM (e.g. Oetting & Webb 1992; White 1998, cited in d'Abbs & MacLean 2000), the stress on a family of having a child engaged in VSM has also been noted as causing or exacerbating the level of dysfunction present (Shaw 1999, cited in

d'Abbs & MacLean 2000), especially in families with problem-solving difficulties (Hops et al. 1990). Similarly, research has shown that some form of drug use usually pre-dates youth homelessness, but that 'time on the streets' often leads to increased VSM as money for other substances becomes scarce (Office of Applied Studies 2004; Wincup, Buckland & Bayliss 2003).

In the US, Stevens and Griffith (2001) identified a high level of co-occurrence between behaviours such as carrying a weapon, drinking alcohol, smoking marijuana, being sexually active, being involved in gangs and, most notably, engaging in VSM, but no statistically significant relationships were established between or among these behaviours. In Australia, Putnins (2003) identified a significant relationship between VSM and the risk of recidivism among juvenile offenders. However, the nature of this relationship is such that VSM is deemed indicative but not predictive of the likelihood of recidivism.²

More generally, as part of a British investigation into youth, Melrose (2000, cited in Worley 2001, p. 30) found that half of the young people interviewed had started 'using drugs after becoming "vulnerable" through offending, school exclusion and/or being looked after'. In terms of mental health, research has shown that, in some cases, individuals may come to use drugs as a form of self-medication to manage pre-existing problems (Kushner, Sher & Beitman 1990; Merikangas et al. 1998; Strakowski & DelBello 2000). However, in other cases, substance abuse appears to precede the development of mental health problems (Kushner, Sher & Beitman 1990; Strakowski & DelBello 2000) and some evidence exists that substance abuse may increase the likelihood of psychosis among vulnerable individuals (Jenner et al. 1998, cited in Department of Health and Ageing 2003).

The apparently multidirectional nature of the links between VSM and issues affecting social and family function has led researchers, academics and policy makers to theorise that VSM may be just one of a number of 'psychosocial problems' (including crime, mental illness, suicide and use of other licit and illicit drugs) associated with specific developmental pathways commonly identified among vulnerable or 'disadvantaged' populations (Loxley, Tombourou & Stockwell 2004). Developmental pathways are regarded as the cumulative effects of the social, economic, psychological and biological risk and protective factors present in an individual's environment (National Crime Prevention 1999). Risk and protective factors are defined, as their names suggest, as factors that either predispose individuals towards psychosocial problems, or help to protect them from experiencing these problems (National Crime Prevention 1999). Developmental pathways are dynamic and subject to change across a lifetime, as are the risk and protective factors associated with them. Indeed, psychosocial problems resulting from early developmental pathways often become risk factors for similar problems in subsequent development.

Risk factors commonly associated with the development of psychosocial problems, and specifically drug use, during late childhood and adolescence include:

- early school failure
- childhood behaviour problems
- low intelligence
- perceived and actual levels of community drug use
- community disadvantage and disorganisation
- availability of drugs in the community
- parent-adolescent conflict
- favourable parental attitudes to drug use
- parental alcohol and drug problems
- parental rules permitting drug use
- not completing secondary school
- relationships with peers who are involved in drug use
- adolescent delinquency and conduct problems
- anxiety and depression in adolescence
- sensation seeking and adventurous personality traits in adolescence
- favourable attitudes to drug use in adolescence. (Loxley, Tombourou & Stockwell 2004)

2 Of note is that Putnins did not find any association between the use of a psycho-active substance at the time of offending and reoffending.

The impact of these risk factors may, however, be mediated by the existence of one or more protective factors such as social and emotional competence, intelligence, shy and cautious temperament in childhood, community opportunities for access to positive social activities, positive connection or attachment to family, school and community, low parental conflict, parental communication with and monitoring of children and religious involvement (Loxley, Toumbourou & Stockwell 2004). Furthermore, research has shown that, even if such protective factors do not prevent the development of specific psychosocial problems in individual young people, the existence of family support and stability within family relationships may enhance the effects of any subsequent interventions or treatment programs applied (Edwards et al. 1997, cited in Loxley, Toumbourou & Stockwell 2004).

Unfortunately, in adults, the cumulative effects of many of the risk factors influencing their children (e.g. drug use, family conflict, disharmony and instability), and others such as economic exclusion and social dispossession, tend to place them at risk of psychosocial problems of their own (Loxley, Toumbourou & Stockwell 2004; Maughan et al. 2000; Schoon, Parsons & Sacker 2004; Serbin & Karp 2004). Not only do these problems reduce the level of support available to young people in their care, but the behaviours that they model are often less than positive. In turn, a lack of positive role-modelling, together with the high level of mobility that families demonstrating multiple risk factors often demonstrate (National Crime Prevention 1999) may reduce the connection and attachment of young people to school and the wider community, thus contributing to an increased likelihood that these young people will leave school early. Since this is a risk factor also associated with the development of psychosocial problems in adulthood (National Crime Prevention 1999), it is not difficult to see how this cycle may perpetuate itself.

Interventions

Legislative restrictions

Within Australia and internationally, a large proportion of government-initiated interventions aimed at addressing the problems of VSM consist of legislative or regulatory restrictions on the sale and availability of products containing volatile substances. However, the effectiveness of these initiatives is rarely evaluated. Furthermore, where follow-up data are available, the outcomes frequently suggest displacement effects — that is, that young people simply change from the restricted substance to another, potentially more harmful, alternative. For instance, the high rate of butane-containing substances misused by British adolescents, and the associated fatalities, has been attributed, at least in part, to the introduction of the Intoxicating Substances Supply Act 1985, enacted in England, Wales and Northern Ireland. This Act was intended to control the supply of substances to young people under 18 years old. It prohibits sales of products containing volatile substances to young people if the retailer knows or ‘has reason to believe’ that the substance will be used to achieve intoxication.

While some argue that legislative reforms of this nature have had a positive impact on reducing the availability and use of volatile substances, others suggest that the effects have been less than desirable (Drugs and Crime Prevention Committee 2002a). After the introduction of the British Act, the number of fatalities associated with the use of glues decreased significantly, as did the number of fatalities attributed to ‘indirect causes’ such as accidents and asphyxiation (Taylor et al. 1997). However, during the same period, the number of fatalities attributed to gas fuels significantly increased, along with the number of fatalities attributed to ‘direct toxic effects’ (Taylor et al. 1997). Although no direct evaluation of the British Intoxicating Substances Supply Act 1985 has been carried out, these trends and the coincidental nature of their timing have generated considerable concern about the potentially negative outcomes of legislative intervention to control VSM.

One possible explanation of the apparent displacement from the misuse of glue to the misuse of other products is that retailers, at least until recently, had not been aware of the range of substances that might be used for the purpose of intoxication (Ives 1999, 2002). Indeed, surveys of UK retailers reveal that, throughout the late 1980s and 1990s, application of the Act tended to be restricted to limiting the sale of glues and, in some cases, aerosols.

In addition to highlighting a lack of awareness of the types of substances that can be used to achieve intoxication, Ives (1999) points to the retailers' difficulty in proving they 'have reason to believe' that a substance will be used for this purpose, or for retailers to make such an assessment at all. Given these criticisms and concerns, in 1999 the British government added 'Cigarette Lighter Refill (Safety) Regulations' to the Consumer Protection Act 1987. These regulations make it an offence to supply a cigarette lighter refill canister (containing butane or a substance with butane as a constituent part) to any person under 18 years of age. Consequently, the available evidence suggests a significant decline in butane-related fatalities (Field-Smith et al. 2002). However, as stated by community workers consulted as part of the Victorian Inquiry into the Inhalation of Volatile Substances (Drugs and Crime Prevention Committee 2002a), if young people are unable to purchase products containing volatile substances, whether as a result of legislative restrictions or due to their own financial circumstances, they 'will simply steal them' (p. 90). While the likelihood of this occurring may be somewhat reduced by retailers locking away products that they recognise to be in demand by those involved in VSM, the broad range of products containing volatile substances makes such a strategy impossible to maintain in the long term.

Legislation limiting the sale of volatile substances is not unique to the UK. Such legislation has also been enacted in most states of Australia, the United States, New Zealand, Japan and a number of European countries. In addition to many of these countries producing data supporting the displacement effects observed in the UK (Drugs and Crime Prevention Committee 2002a; Ives 1999), researchers in each location highlight concerns about the difficulty of enforcing the Acts involved. In some cases, the potential for young people to resort to stealing products containing volatile substances, or to come into contact with the police as a result of their possession of such products, has also been identified. Specifically, researchers emphasise the 'net-widening' effects that these interventions may have in terms of bringing young people into the criminal justice system, and this is also the main concern expressed by opponents of criminal justice responses to VSM (Meredith 2001, cited in Drugs and Crime Prevention Committee 2002a). As demonstrated during an Australian-based initiative aimed at increasing community awareness of VSM among retailers and administrators of public spaces, Meredith (2001) found that legal and regulatory interventions might simply serve to drive VSM out of public spaces and away from areas where users could be identified, thus reducing the likelihood that the issues underlying the use would be noted or addressed. If young people are 'forced' into the juvenile justice system as a result of legislative responses to VSM, not only will this compound their problems (d'Abbs & MacLean 2001, cited in Alcohol and Other Drugs Council of Australia 2003), but the stigma it brings may further reduce their chances of positive outcomes in the longer term.

Media campaigns

In 1992 the UK Department of Health introduced a national television advertising campaign aimed at educating parents of children and adolescents about the dangers of VSM. These advertisements were broadcast during peak viewing hours. They showed 'plain text on a black screen with accompanying sound-tracks' describing 'the death of a child and the reaction of family and friends' (Bland et al. 1997, p. 1). According to Bland et al. (1997, p. 1) the following excerpt provides a typical example of the advertisements included in this campaign:

This is a nine-year-old choking on a solvent ... This is his father being told of his death ... Sniffing aerosols, glue and gases kills 100 children a year ... Don't let the next be yours.

The campaign actively encouraged parents to take responsibility for preventing VSM-related fatalities. Each advertisement concluded by directing viewers to a booklet providing information for parents, accessible by telephoning a number given on the television screen. For the duration of the television campaign (one month), this information booklet was also advertised in newspapers and magazines. The campaign was followed by other, smaller campaigns of a similar nature but targeting both parents and young people.

During the 22 months after the media campaign, Bland et al. (1997) recorded a 43 per cent decrease in child fatalities attributed to VSM. This trend has continued, with Field-Smith et al.

(2002) estimating a 58 per cent decline to December 2000 in VSM-related mortality among UK youth aged under 18 years. Although adult VSM-related fatalities have also declined by about 22 per cent during this period, the effects are in no way as significant as those identified for children.

Despite the apparently positive outcomes of the UK campaign, various commentators have noted the potentially negative impact that mass media campaigns targeting VSM can have. Specifically, these types of interventions have been criticised on the basis that they may inadvertently 'promote' VSM, enabling potential users to become more aware of the means by which they may engage in such behaviour and alerting existing users to alternative and potentially more dangerous practices (Mundy 1995, Rodd & Leber 1997, Rose et al. 1992, all cited in Drugs and Crime Prevention Committee 2002b). Research suggests that the media portrayal of VSM is unlikely have any significant influence on the behaviour of young people who are not already at risk of engaging in this type of activity (Freedman 2002; Gauntlett 1998); however, for those who are already at risk the implications are significant. Within the Australian context, community workers providing input into the Victorian Inquiry into the Inhalation of Volatile Substances also argued that, by focusing on the use of volatile substances by Indigenous youth, media involvement may lead to a lack of resources and/or intervention for non-Indigenous users (Drugs and Crime Prevention Committee 2002a).

Another view is put forward by d'Abbs and MacLean (2001, cited in Drugs and Crime Prevention Committee 2002b, p. 494) who state that sensationalist media portrayals of Aboriginal VSM-related fatalities may 'deepen ... [the] despair over the issue', and such an effect may facilitate the perception that 'solutions' are unlikely to be found. They suggest that this perception has the potential to undermine the likelihood of 'constructive change such as increasing funding for services and programs addressing the problems underlying petrol sniffing and other risk behaviours'.

The debate about the media impact on VSM has led to the recognition that the ways in which public prevention and harm minimisation campaigns are designed and targeted have important implications for their outcomes. Specifically, it is emphasised that such initiatives should avoid providing details about 'abusable products' and methods of abuse. It is also suggested that the media refrain from providing inaccurate details regarding the medical effects of VSM, and misleading stories about the link between antisocial behaviours and VSM (Drugs and Crime Prevention Committee 2002b). Anecdotal evidence collected during the Victorian Inquiry into the Inhalation of Volatile Substances, showing a propensity for young misusers of volatile substances to 'play up' to the camera, has led to the conclusion that the media should avoid identifying or showing pictures of those involved in VSM. In communities where the prevalence of VSM remains low, commentators advocate limiting campaigns to those targeting parents, educators and welfare professionals (Drugs and Crime Prevention Committee 2002b).

Few other campaigns have been identified as demonstrating the apparently positive influence of the 1992 UK initiative, but some have been shown to be useful in directing public attention to issues associated with VSM, teaching skills relevant to minimising the harm associated with VSM, and creating publicity to launch other prevention and harm minimisation initiatives (Loxley, Toumbourou & Stockwell 2004). Furthermore, the evaluation of at least one Australian media campaign aimed at encouraging family-based discussion on drug use and associated risks has been shown to improve the level of communication occurring between parents and their children (Bertram et al. 2003). Although this outcome has not been empirically tested in terms of its relationship to changes in youth drug use, the fact that good family communication is identified as a protective factor against drug use suggests promise in approaches of this nature. Similarly, in research considering the reasons that former petrol users gave for ceasing involvement in VSM, Burns, d'Abbs & Currie (1995) identified advice given by family members as the main factor identified across all cases. They suggest, therefore, that information-based strategies should specifically target parents and caregivers. Nevertheless, they also acknowledge that, in most cases, acceptance of this advice was influenced by a desire for increased involvement in employment, education, training, recreation or family-based activities. Therefore, it is recommended that these strategies be viewed as just one of a number of preventive strategies that may be combined to address the issue of VSM.

Community-based interventions

On the basis of their review of the evaluation literature on interventions aimed at preventing and minimising the harm associated with drug use in Australia, Loxley, Toumbourou & Stockwell (2004, p. 144) state that, despite the apparently positive effects of many mass media campaigns, 'there is no good evidence that simple "one-off" media campaigns can alter the long-term development of drug use in the young'. Certainly, for young people who demonstrate the highest level of VSM risk, whose parents may themselves be drug users, and who may not even be residing with family or carers, this conclusion makes intuitive sense. Loxley, Toumbourou & Stockwell continue that 'there is better support for the use of mass media in combination with other strategies such as school-based health education or community mobilisation' (Loxley, Toumbourou & Stockwell 2004, p. 144).

Similarly, with specific reference to the use of petrol as an intoxicating substance, d'Abbs and Brady (2003) and d'Abbs and MacLean (2000) state that, despite the existence of a wide range of intervention methods, few are critically evaluated and very little is known about their effectiveness. Nevertheless, d'Abbs and MacLean (2000) maintain that evaluations of other drug-related interventions may prove useful in identifying the critical components of any VSM intervention process. In support of this contention, they emphasise that volatile substances are usually just one of a number of substances that an individual may choose to use if they are available. They argue that it is not the substance but the choice to become intoxicated that requires consideration.

d'Abbs and MacLean (2000, p. 12) refer to Zinberg's view of drug use (published in 1979 and 1984) as the product of interactions between the 'pharmacological properties of the substance concerned, attributes of individual users, and characteristics of the environment in which it takes place'; they see this as a useful framework within which to consider VSM-related intervention strategies. Using this framework as the basis for reviewing a range of immediate, medium-term and long-term intervention strategies aimed at preventing, stopping and treating VSM among young people in Australia, they conclude that 'the most effective long term strategies against petrol sniffing are likely to be those which broadly improve the health and well-being of young Aboriginal people, their families and communities' (p. 8).

Specifically, d'Abbs and MacLean describe this approach as part of the HALT model — a family counselling and education program based on the principles of community development, which was implemented in a number of Northern Territory communities in the late 1980s. This model was developed from the concept that, as a result of government assimilation policies, Indigenous social institutions had been undermined, and the capacity of community members to respond to the needs of their children had been weakened. In line with this view, Burns, d'Abbs & Currie (1995) report evidence of significant reductions in Indigenous petrol sniffing in the 1970s after large numbers of family groups left the communities in which they had been forced to settle, and returned to their historic 'homelands'. Of particular importance, in terms of the perceived effectiveness of the HALT model, was its focus on working with family members to promote their capacity to resolve problems, to 'redefine petrol sniffing as a problem which could be rectified' (d'Abbs & MacLean 2000, p. 63) and to take control of this process. The HALT team consisted of three individuals, each of whom brought skills that were considered crucial to the effectiveness of the intervention. The three people were an Indigenous Elder, a non-Indigenous psychologist, and an academic adviser who was skilled in administration and organisational facilitation.

Two external evaluations of the HALT program were undertaken a year after its introduction into Northern Territory communities, and both suggested that the program had been effective in eradicating VSM in these areas. In 1991 another external evaluation was undertaken to assess the long-term effects of the intervention process. Although the initial effects were found to have continued in two of the targeted communities, in others a core of volatile substance misusers was said to remain. Explanation of these differences included reference to the 'fit' between the HALT model and the methods traditionally used by community members to deal with problem behaviours. In addition, the evaluator stated that, in communities in which longer-term beneficial effects were observed, issues associated with petrol sniffing had already 'come to a head' before the intervention team arrived, and community members were primed and unified in their response to them (d'Abbs & MacLean 2000, p. 63).

d'Abbs and MacLean (2000) concluded that, for a program to be effective in the longer term, there must be:

- a strong community resolve and unified action, with active involvement from community members in its implementation
- a range of concurrent activities targeting users, the social setting in which use occurs, and the petrol itself.

In support of these conclusions, P d'Abbs (personal communication 2005) describes the Family Healing program, targeting young people in the north-west Queensland community of Mount Isa, as demonstrating 'promise'. This program was developed specifically to address the needs of young people involved in VSM. It is the result of collaboration between 12 local service providers and community representatives who, in response to community concerns about the incidence of VSM in Mount Isa, joined forces to form the Mount Isa Volatile Substance Misuse Action Group. Furthermore, unlike the Northern Territory programs, it operates from a regional centre.

The Family Healing program gives young people increased opportunities to engage in activities aimed at educational achievement, life skills development, employment, recreational participation and health promotion. The program facilitators also attempt to engage the family members of the young people in processes designed to strengthen family ties. Although program facilitators report some good short-term outcomes in terms of young people ceasing VSM and returning to school (Polson & Chiauzzi 2003), they find these are unsustainable unless the family is involved too. Maintaining such involvement, in the face of other social and economic pressures that family members of young people involved in VSM have to deal with, has proved difficult.

The way forward: the importance of structure

In terms of interventions to address and prevent VSM, d'Abbs and Brady (2003) identify structural problems in the distribution and administration of associated resources as the greatest barriers — both to achieving goals and to acquiring evidence showing the effectiveness of individual intervention strategies.

Specifically, they refer to the low priority given to the issue of VSM by government authorities, and the consequent reliance on communities and non-government agencies to respond to these issues. d'Abbs and Brady (2003) agree that community-driven responses are most likely to succeed in engaging and motivating participants. However, they also contend that, in the highly disadvantaged communities in which VSM is most likely to be a problem, community members have a limited capacity to respond to the demands placed on them. They also recognise that the problem of VSM has many dimensions, and addressing only one part of the problem is likely to lead to displacement effects elsewhere in the social system. They argue, therefore, that any intervention of this nature must involve significant government support, not only in the form of funding, but also in the development of medical, strategic, practical and epidemiological expertise; governments also need to develop policies and procedures that will not leave one agency 'holding the baby' (P d'Abbs, personal communication 2005).

d'Abbs and Brady (2003) advocate a coordinated, whole-of-government approach, in which different levels of government, and relevant departments operating within each level, decide on steps and allocate responsibilities aimed at systematically reducing risk factors and addressing VSM using multiple levels of intervention (preventing, stopping, treating and ensuring public safety).

d'Abbs and Brady also argue that community agencies need to play a role in this process, because youth workers and recreation officers possess the skills and 'on the ground' experience to effectively engage young people and their families in intervention activities, especially those who have already 'fallen out of' conventional social infrastructure (e.g. schools). Nevertheless, they emphasise that these individuals need appropriate training if they are to achieve the desired outcomes. In addition to the problems of sustaining the momentum and effectiveness of community-driven approaches, the perceived failings of socially oriented initiatives driven primarily by government legislation and associated

processes demonstrate the difficulties in responding to youth VSM in the absence of mutually supportive and respectful relationships between government and community agencies. Although documentation of these failings is rare, an example is provided in a recent review of the Scottish Solvent Abuse Act (1983).

Responding to recognition that VSM was a social issue and required socially oriented intervention, combined with a political imperative to prevent young people becoming involved in the criminal justice system, in 1983 the Scottish Social Work Act of 1968 (now incorporated in the Children Act 1995) was amended to include the Solvent Abuse (Scotland) Act. Under the Solvent Abuse (Scotland) Act 1983 (and subsequent provisions within the Children Act 1995), VSM was identified as a ground for police to refer children and young people to the Scottish 'Children's Reporter'. The Children's Reporter is responsible for investigating each case that is referred to him or her and identifying whether supervision, care and protection, or alternative forms of statutory or community based social intervention are required. While the Scottish Act was developed to ensure that action was taken to address the welfare issues of children and young people involved in VSM, there have been no evaluations specifically focused on the effectiveness of this strategy. However, the processes involved in administering the legislation have been subject to a certain amount of criticism. Specifically, Rose et al. (1992, cited in Drugs and Crime Prevention Committee 2002a) argue that making referrals in relation to VSM compulsory has undermined the working relationship between police and welfare staff, a relationship that was perceived as very positive prior to the introduction of the Act. In addition, consultation in response to a recent review of the Scottish Children's Hearing Process resulted in identification of the perceived need for more resources to be dedicated to family support projects and initiatives (Stevenson & Brothie 2004).

As stated in a review of international decision-making and services for children and young people (Buist and Whyte 2004, p. 107), 'Studies suggest that the absence of collaboration with parents tends to have a negative impact on the success rate of interventions involving children and young people.' Buist and Whyte remark, however, that the families of young people involved with intervention-based services are themselves likely to demonstrate a very high level of need. This highlights the danger that the needs of the children and young people will be overtaken by the needs of their caregivers. These comments highlight the potential for a single case of VSM to lead to the identification of multiple needs, involving many people, all of which must be addressed through different mechanisms to ensure the consistency of the approaches used.

In contrast, a review of the Australian National Drug Research Institute 'Indigenous Australian and Other Drug Projects' database revealed that, of the 112 projects identified using the search words 'volatile substances', 'petrol', 'inhalant', 'sniffing' 'VSM' and 'chroming', only five used more than one approach to intervention, and the vast majority were limited to harm-minimisation projects. These projects focus on reducing participants' use of volatile substances and/or encouraging safer practices during use. Although such projects have been shown to be useful in responding to other forms of drug use, such as alcohol (Loxley, Toumbourou & Stockwell 2004), in the case of VSM, the toxicity of the substance (including the significant risk of adverse neurological effects or death) undermines the acceptability of this type of response, especially if it is the only response offered. Clearly, a new approach to VSM intervention needs to be developed.

Conclusion

Volatile substance misuse (VSM) involves the purposeful inhalation of highly toxic chemical compounds to achieve intoxication. Depending on the compound inhaled, this practice has been shown to be associated with increased risk of cardiovascular, respiratory, renal, antenatal and neurological damage as well as neurobehavioural impairments. In addition, the confusion and cognitive distortions that occur as an immediate result of VSM place those involved at increased risk of causing physical harm to themselves or others.

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

Only a small proportion subject themselves to regular exposure over several years. Volatile substances are seldom an individual's drug of choice but, rather, a cheap and easily accessible alternative when other drugs are not available. As regular users age and gain access to increased social and economic resources, VSM tends to decline as the use of other substances such as alcohol and marijuana increases. Indeed, chronic VSM during youth is associated with substance abuse problems in later life. It is also associated with school failure and drop-out, family dysfunction and abuse, crime and delinquency, mental health problems and cultural disintegration. Rather than being the cause or result of any one of these issues, however, VSM is perceived to be just one of a number of psychosocial problems associated with vulnerable or socioeconomically disadvantaged populations. 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.

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. 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, often more dangerous substances. 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, but those targeting children have been criticised for promoting the practice.

Researchers argue that, to address VSM and associated issues effectively, a range of intervention strategies need to be employed. Specifically, it is suggested 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).

Strategies that systematically respond to issues associated with each of these factors are generally believed to hold the greatest promise for reducing the prevalence and impact of VSM. It is emphasised, however, that strong commitment must be obtained from both community and government stakeholders. In particular, researchers highlight the need for these stakeholders to collaborate in the development and implementation of social change initiatives, and to ensure that the capacity and infrastructure supporting these initiatives are sustainable and conducive to achieving the intended outcomes.

Appendix H: Analysis of QPS calls-for-service data and activity reporting index

Calls for service

Calls-for-service data for the 2003–04 financial year for all trial sites were received from the QPS. These data include:

- members of the public requesting police assistance by telephone (000 and directly to police communications rooms)
- members of the public making reports directly to police establishments
- jobs that police attend as a part of general patrols.

These calls are received by Police Communications and jobs are subsequently issued to operational police through a computer dispatch system.

Across the state, the QPS uses two entirely separate systems to store ‘calls for service’ information — CAD and IMS (computer-aided dispatch and the Incident Management System). The CMC received a small subset of data from the CAD system (which covers all trial areas except Mount Isa), and the full dataset from the Mount Isa IMS. Call records kept during the 2003–04 financial year have been used to determine the volume of police calls about volatile substance misuse in each of the trial areas.

There is no requirement for an officer to mention VSM in a job description; when it is mentioned, it may be described in a variety of ways. Consequently, after limiting the number of CAD records to those containing words such as ‘sniff’, ‘inhale’, ‘chrome’, ‘petrol’ and ‘paint’, and their variants, researchers read all records to search for instances where VSM was reported to or detected by the QPS.

Using this method, 2519 calls for service were received in the trial areas in the 2003–04 financial year.

While the raw numbers of ‘calls for service’ give an indication of police workload, the numbers of calls for service per 100 000 residents indicate the prevalence of the problem in the local community. As can be seen from the information presented in Table H1, inner Brisbane has both a large workload and a high prevalence. This may be partially due to volatile substance users travelling in from suburban areas to the inner city to use.

Table H1. Calls-for-service data (June 2003 – July 2004)

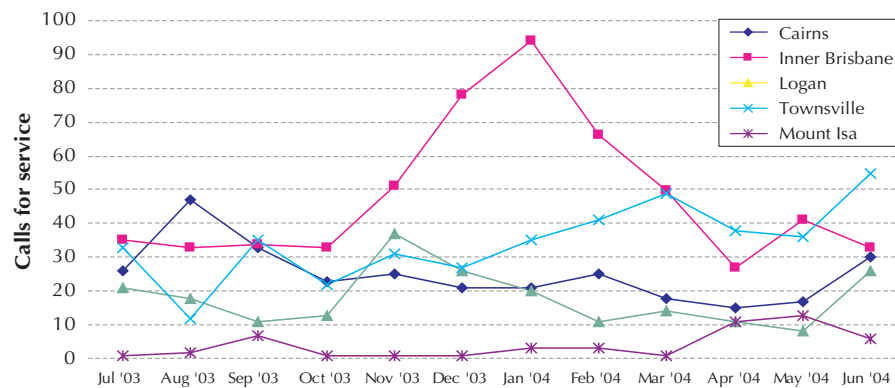
Trial area	Calls for service	Calls for service per 100 000 residents
Cairns	460	301
Inner Brisbane	1258	575
Logan	189	216
Townsville	346	414
Mount Isa	266	50

It may also be that there are different patterns of VSM away from the inner city area. For example, VSM in private locations such as homes, or concealed areas such as creek beds or underground pipes, would attract fewer calls for service.

According to CAD and IMS data, calls for service in the inner Brisbane area were highest in January and December 2003–04. It is possible that this represents a seasonal trend; but, without additional data covering a longer timeframe, such a determination cannot be made.

Logically, an increase in calls for service represents an increase in VSM. However, the increase may reflect an increased awareness by the police and or an increased community perception resulting in more calls from the general public.

Figure H1. Calls for service by month



Statistically, the data do not show school holidays to be a significant factor in VSM-related calls for service.

Calls-for-service information can provide a powerful measure of both police workload and community concern about VSM. However, as with any data source, there are some limitations with its use.

- A primary limitation of the calls-for-service data is that they do not contain verified codes. Calls for service are initially assigned a reported code, which reflects the type of job as it is called in to police by the public (e.g. paint or glue sniffing). On arrival at the job, the officer informs the police communications room of the type of situation actually occurring. Due to the time taken for police to attend a call, VSM codes are often not verified because the incident cannot be detected when the officer arrives. In addition, a proportion of calls turn out, on police investigation, to relate to behaviour other than VSM.
- Secondly, as a call needs to be routed through a police communications room, jobs that are not called in by radio or telephone (especially officer-initiated jobs such as flag-downs and the like) are not always recorded in the system. This is a particular problem for autonomous units such as police beats. It should be noted that all trial areas have police beats.
- A third limitation is that only a small subset of data was received from the CAD system, covering all trial sites except Mount Isa. As a result, analysis of the types of jobs received, and of time and day of the week, could only be performed on the Mount Isa IMS data (representing approximately 3% of the dataset). Given that Mount Isa data are not representative of the trial sites and that it is also the only site where coding can confirm VSM, further analysis has not been conducted.

Activity reporting index

Activity reporting index (ARI) data for the 2003–04 financial year for all trial sites were received from the QPS. The ARI contains information obtained from the gathering of ‘activity reports’. These reports are used for recording field interrogations, suspect motor vehicles and the activities of suspect persons. Activity reports should not be obtained for a person when that person is arrested (QPS *Operational procedures manual*, Issue 25, December 2004).

The 2003–04 data have been used to assist with ascertaining the volume of police interactions regarding volatile substance misuse in the trial areas. Unlike calls-for-service data, it is not mandatory for police to record details of interactions in the ARI. The data reported here should be viewed more as a function of officer workload than an actual number of VSM incidents.

The same search terms and methods were used to locate VSM cases in the ARI as for the calls-for-service data; that is, a search for the following words and their variants: chrom*, sniff*, glue, inhal*, paint and petrol. The free-text portions of the index were then manually read to determine whether chroming was detected by the QPS. Unfortunately, there is no requirement for an officer to note whether a person is misusing volatile substances.

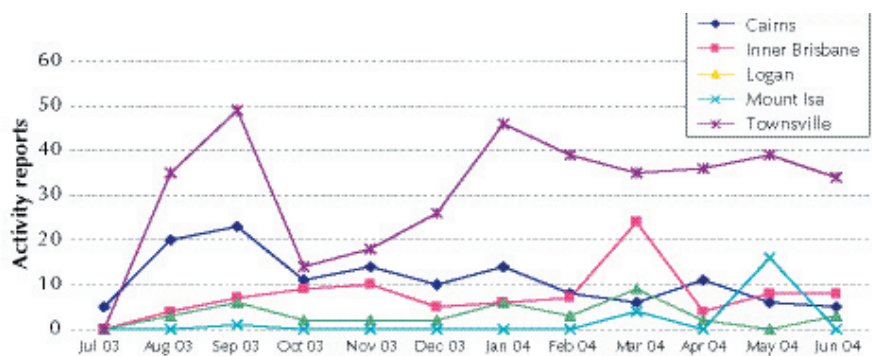
Despite this, there were 781 activity reports that explicitly mentioned VSM or a related search term.

Table H2. Activity reporting index data (June 2003 – July 2004)

Trial area	Activity reports	ARIs per 100 000 population
Cairns	143	219
Inner Brisbane	147	321
Logan	42	37
Townsville	425	355
Mount Isa	24	182

While the number of activity reports from an area give an idea of the number of interactions that police have with suspected volatile substance misusers, the rate per 100 000 population gives an indication of the prevalence of the problem in an area. It can be seen that Townsville takes many VSM-related activity reports, and VSM also appears to be particularly prevalent in this area. In contrast, Logan takes few VSM activity reports.

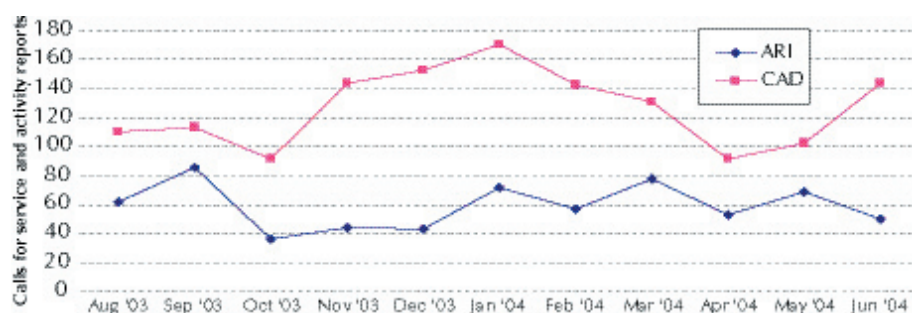
Figure H2. Activity index reports by month



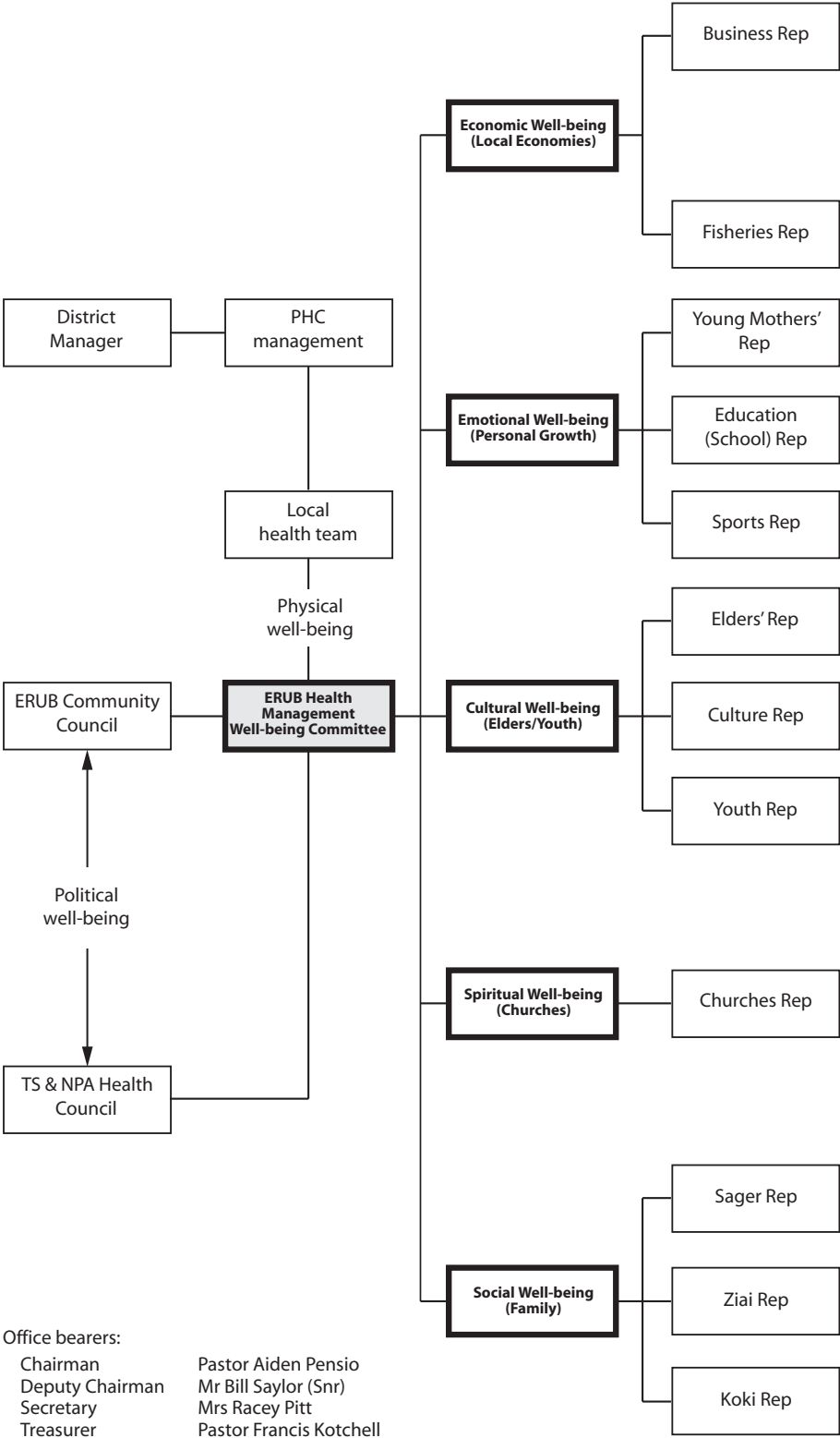
As with the calls-for-service data provided, according to the ARI data there does not appear to be any appreciable rise or fall in the numbers of reports taken by police during any financial year. Nor does there seem to be any particular seasonal pattern in the numbers of activity reports taken by police for any of the sites.

Statistical tests to determine correlation confirmed that there is no correlation between the numbers of calls for service received and the numbers of activity reports taken in this time period. This can be seen from Figure H3.

Figure H3. Activity reporting index data versus calls-for-service data



Appendix 1: Torres Strait Islands Health Management Committee organisational structure



References

Print and online publications

- Agency for Toxic Substances and Disease Registry 1993, *Toxicological profile for toluene*, US Department of Health and Human Services, Public Health Service, Atlanta, Georgia.
- Agency for Toxic Substances and Disease Registry 1995, *Toxicological profile for xylenes (update)*, US Department of Health and Human Services, Public Health Service, Atlanta, Georgia.
- Agency for Toxic Substances and Disease Registry 2000, *Toxicological profile for toluene*, US Department of Health and Human Services, Public Health Service, Atlanta, Georgia.
- Alcohol and Other Drugs Council of Australia 2003, *Policy positions of the Alcohol and Other Drugs Council of Australia: 1.4 Inhalants (volatile substances)*, Alcohol and Other Drugs Council of Australia, Deakin.
- American Conference of Governmental Industrial Hygienists 1986, *Documentation of the threshold limit values and biological exposure indices*, 5th edn, Cincinnati, Ohio.
- American Conference of Governmental Industrial Hygienists 1991, *Documentation of the threshold limit values and biological exposures indices*, 6th edn, Cincinnati, Ohio.
- Australian Bureau of Statistics 2002, 'Health — mortality and morbidity: mortality of Aboriginal and Torres Strait Islander peoples', *Australian social trends 2002*, Australian Bureau of Statistics, Canberra.
- Australian Institute of Health and Welfare 2005, *2004 National Drug Strategy Household Survey: first result*, Drug Statistics Series no. 13, Australian Institute of Health and Welfare, Canberra.
- Bates, SC, Plemons, BW, Thurman-Jumper, P & Beauvais, F 1997, 'Volatile solvent use: patterns by gender and ethnicity among school attenders and dropouts', *Drugs and Society*, vol. 10, pp. 59–75.
- Beauvais, F 1992, 'Volatile substance abuse: trends and patterns', in C W Sharp, F Beauvais & R Spence (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research, Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- Bellhouse, R, Johnston, G & Fuller, A 2001, *A report on volatile solvent use in Victoria for the Victoria Department of Employment, Education and Training*, Department of Employment, Education and Training, Melbourne.
- Benignus, V A 1981a, 'Neurobehavioral effects of toluene: a review', *Neurobehavioral Toxicology and Teratology*, vol. 3, no. 4, pp. 407–15.
- Benignus, V A 1981b, 'Health effects of toluene: a review', *Neurotoxicology*, vol. 2, pp. 567–88.
- Bertram, S, Barbir, N, Ball, J & Carroll, T 2003, *National Illicit Drugs Campaign: evaluation of phase one*, Department of Health and Ageing, Canberra, viewed 1 December 2004, <http://www.drugs.health.gov.au/download/nidc_eval.pdf>.

- Bingham, E, Cohrssen, B & Powell, C H 2001, *Patty's toxicology volumes 1–9*, 5th edn, John Wiley & Sons, New York.
- Bland, J M, Taylor, J, Roberts, I, Benbow, E & Cairns, A 1998, 'Deaths from accidental poisoning in teenagers', *British Medical Journal*, vol. 316, no. 7125, p. 146.
- Bland, J M, Taylor, J C, Norman, C L, Anderson, H R & Ramsey, J D 1997, *Volatile substance abuse: possible effect of a national campaign*, St George's Hospital Medical School, Department of Public Health Sciences, London, viewed 30 November 2004, <www.sghms.ac.uk/depts/phs/vsa/camp.htm>.
- Boewer, C, Enderlein, G, Wollgast, U, Nawka, S, Palowski, H & Bleiber, R 1988, 'Epidemiological study on the hepatotoxicity of occupational toluene exposure', *International Archives of Occupational Environmental Health*, vol. 60, pp. 181–6.
- Brady, M 1992, *Heavy metal: the social meaning of petrol sniffing in Australia*, Aboriginal Studies Press, Canberra.
- Buist, M & Whyte, B 2004, *International evidence to Scotland's Children's Hearing Review: decision making and services relating to children and young people involved in offending*, Criminal Justice Social Work, Development Centre for Scotland, Edinburgh.
- Burns, C B, d'Abbs, P & Currie, B J 1995, 'Patterns of petrol sniffing and other drug use in young men from an Australian Aboriginal community in Arnhem Land, Northern Territory', *Drug and Alcohol Review*, vol. 14, pp. 159–69.
- Carroll, A, Houghton, S & Odgers, P 1998, 'Volatile solvent use among western Australian adolescents', *Adolescence*, vol. 132, no. 132, pp. 877–89.
- Chadwick, O, Yule, W & Anderson, R 1990, 'The examination attainments of secondary school pupils who abuse solvents', *British Journal of Educational Psychology*, vol. 60, no. 2, pp. 180–91.
- Chick, J & Cantwell, R 1994, *Seminars in alcohol and drug misuse*, Gaskell, London.
- Cleland, J G & Kingsbury, GL 1977, *Multimedia environmental goals for environmental assessment*, US Environmental Protection Agency, Washington, DC.
- Coleman, H, Charles, G & Collins, J 2001, 'Inhalant abuse by Canadian aboriginal youth', *Journal of Child and Adolescent Substance Abuse*, vol. 10, no. 3, pp. 1–20.
- Creson, D L 1992, 'Comments on psychosocial characteristics', in C W Sharp, F Beauvais & R Spence (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research, Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- d'Abbs, P & MacLean, S 2000, *Petrol sniffing in Aboriginal communities: a review of interventions*, Cooperative Research Centre for Aboriginal and Tropical Health, Darwin.
- d'Abbs, P & Brady, M 2003, 'Other drugs, other people, other places: the policy response to Indigenous petrol sniffing in Australia', paper presented at Australian Institute of Criminology Conference on Inhalant Use and Disorder, Townsville 7–8 July 2003.
- Department of Communities 2004, Newsletter: *Crime Prevention Queensland*, Department of Communities, viewed 25 May 2005, <<http://www.communities.qld.gov.au/community/crimeprevention/publications/documents/pdf/safer7.pdf>>.
- Department of Health and Ageing 1999, *National youth suicide prevention strategy: setting the evidence-based research agenda for Australia (literature review)*, Australian Government, Canberra.
- Department of Health and Ageing 2003, *National Comorbidity Project: current practice in the management of clients with comorbid mental health and substance use disorders in tertiary care settings*, National Drug Strategy and National Mental Health Strategy, Commonwealth of Australia, Canberra.

- Department of Human Services 1996, *School students and drug use: 1996 survey of alcohol, tobacco and other drug use among Victorian secondary school students*, Drug Treatment Services Unit, Aged, Community and Mental Health Division, Melbourne, viewed 25 May 2005, <<http://www.health.vic.gov.au/drugservices/downloads/ssdu.pdf>>.
- Doring, G, Baumeister, F A, Peters, J & von der Beek, J 2002, 'Butane abuse associated encephalopathy', *Klinische Padiatrie*, vol. 214, no. 5, pp. 295–8.
- Drugs and Crime Prevention Committee 2002a, *Inquiry into the inhalation of volatile substances: discussion paper*, Parliament of Victoria, Melbourne, viewed 25 May 2005, <http://www.parliament.vic.gov.au/dcpc/Reports%20in%20PDF/Volatile_Substances_discuss_paper.pdf>.
- Drugs and Crime Prevention Committee 2002b, *Inquiry into the inhalation of volatile substances: final report*, Parliament of Victoria, Melbourne, viewed 25 May 2005, <http://www.parliament.vic.gov.au/dcpc/Reports%20in%20PDF/USA%20Report_www.pdf>.
- Echeverria, D, Fine, L, Langolf, G, Schork, T & Sampaio, C 1991, 'Acute behavioural comparisons of toluene and ethanol in human subjects', *British Journal of Industrial Medicine*, vol. 48, no. 11, pp. 750–61.
- Ellenhorn, M J & Barceloux, D G 1988, *Medical toxicology: diagnosis and treatment of human poisoning*, Elsevier Science Publishing Company Inc., New York.
- Ellenhorn, M J, Schonwald, S, Ordoz, J & Wasserberger, J 1997, *Ellenhorn's medical toxicology: diagnosis and treatment of human poisoning*, 2nd edn, Williams & Wilkins, Baltimore, Maryland.
- El-Menyar, A, El-Tawil, M & Al Suwaidi, J 2005, 'A teenager with angiographically normal epicardial coronary arteries and acute myocardial infarction after butane inhalation', *European Journal of Emergency Medicine*, vol. 12, no. 3, pp. 137–41.
- Erramouspe, J, Galvez, R & Fischel, D R 1996, 'Newborn renal tubular acidosis associated with prenatal maternal toluene sniffing', *Journal of Psychoactive Drugs*, vol. 28, no. 2, pp. 201–4.
- Fendrich, M, Mackesy-Amiti, M, Wislar, JS & Goldstein, PJ 1997, 'Childhood abuse and the use of inhalants: differences by degree of use', *American Journal of Public Health*, vol. 87, pp. 765–9.
- Fernandez, F, Perez-Higueras, A, Hernandez, R, Verdu, A, Sanchez, C, Gonzalez, A & Quero, J, 1986, 'Hydranencephaly after maternal butane-gas intoxication during pregnancy', *Developmental Medicine and Child Neurology*, vol. 28, no. 3, pp. 361–3.
- Field-Smith, M E, Bland, J M, Taylor, J C, Ramsey, J D & Anderson, H R 2002, *Trends in death associated with abuse of volatile substances*, vol. 15, St George's Hospital Medical School, Department of Public Health Sciences, London.
- Fischman, C M & Oster, J R 1979, 'Toxic effects of toluene: a new cause of high anion gap metabolic acidosis', *Journal of the American Medical Association*, vol. 241, pp. 1713–15.
- Flanagan, R J & Ives, R J 1994, *Volatile substance abuse*, United Nations Office on Drugs and Crime Bulletin, pp. 49–78.
- Fleschler, M A, Tortolero, S R, Batumler, E R, Vernon, S W & Weller, N F 2002, 'Lifetime inhalant use among alternative high school students in Texas: prevalence and characteristics of users', *American Journal of Drug and Alcohol Abuse*, vol. 28, no. 3, pp. 477–95.
- Foo, S C, Jeyaratnam, J & Koh, D 1990, 'Chronic neurobehavioural effects of toluene', *British Journal of Industrial Medicine*, vol. 47, pp. 480–84.

- Freedman, J L 2002, *Media violence and its effect on aggression: assessing the scientific evidence*, University of Toronto Press, Toronto.
- Fuke, C, Miyazaki, T, Arao, T, Morinaga, Y, Takaesu, H, Takeda, T & Iwamasa, T 2002, 'A fatal case considered to be due to cardiac arrhythmia associated with butane inhalation', *Legal Medicine (Tokyo)*, vol. 4, no. 2, pp. 134–8.
- Garriott, J C 1992, 'Death amongst inhalant abusers', in C W Sharp, F Beauvais & R Spence (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research, Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- Gauntlett, D 1998, 'Ten things wrong with the "effects model"', in R Dickinson, R Harindranath & O Linné (eds), *Approaches to audiences — a reader*, Edward Arnold, London.
- Giedd, J N, Blumenthal, J, Jeffries, N O, Castellanos, F X, Liu, H, Zijdenbos, A, Paus, T, Evans, A C & Rapoport, J L 1999, 'Brain development during childhood and adolescence: a longitudinal MRI study', *Nature Neuroscience*, vol. 2, no. 10, pp. 861–3.
- Goodman, L S & Gilman, A (eds) 1975, *The pharmacological basis of therapeutics*, 5th edn, Macmillan, New York.
- Gosselin, R E, Smith, R P & Hodge, H C 1984, *Clinical toxicology of commercial products*, 5th edn, Williams & Wilkins, Baltimore, Maryland.
- Gray, M Y & Lazarus, J H 1993, 'Butane inhalation and hemiparesis', *Journal of Toxicology — Clinical Toxicology*, vol. 31, no. 3, pp. 483–5.
- Groppi, A, Poletini, A, Lunetta, P, Achille, G & Montagna, M 1994, 'A fatal case of trichlorofluoromethane (freon 11) poisoning: tissue distribution study by gas chromatography-mass spectrometry', *Journal of Forensic Sciences*, vol. 39, no. 3, pp. 871–6.
- Grunbaum, J A, Kann, L, Kinchin, S A, Gowda, V R, Collins, J L & Kolbe, L J 1999, '1998 US youth risk behavior surveillance: national alternative high school youth risk behavior survey', *Morbidity and Mortality Weekly Report*, vol. 48, no. 7, pp. 1–44.
- Haddad, L M 1990, *Clinical management of poisoning and drug overdose*, 2nd edn, WB Saunders, Philadelphia.
- Health Canada 1999, *Summary report of the AFN/MSB joint health policy forum*, Health Canada, Ottawa.
- HealthInfoNet 2001, *Other aspects — volatile substances and petrol sniffing*, viewed 19 October 2004, <http://www.healthinfonet.ecu.edu.au/html/html_health_specific_aspects/other_aspects/substance_use/volatile_substances.htm>.
- Hersh, J H 1989, 'Toluene embryopathy: two new cases', *Journal of Medical Genetics*, vol. 26, pp. 333–7.
- Hops, H, Tildesley, E, Lichtenstein, E, Ary, D & Sherman, L 1990, 'Parent–adolescent problem-solving interactions and drug use', *American Journal of Drug and Alcohol Abuse*, vol. 16, pp. 239–58, viewed 24 May 2005, <<http://www.abs.gov.au/Ausstats/abs@.nsf/0/cd784ff808c14658ca256bcd008272f6?OpenDocument>>.
- Indian and Inuit Health Committee, Canadian Paediatric Society (CPS) 1998, 'Inhalant abuse', *Paediatrics & Child Health*, vol. 3, no. 2, pp. 123–6.
- Ives, R 1999, Laws controlling the sale of sniffable products, *Educari*, viewed 25 November 2004, <www.vsa.educari.com>.
- Ives, R 2002, *Volatile substance abuse: the needs and opinions of parents, professionals, retailers and environmental health officers in Northern Ireland*, Health Promotion Agency, Belfast.

- Joe, G W, Garriott, J C & Simpson, D D 1991, 'Physical symptoms and psychological distress among inhalant abusers', *Hispanic Journal of Behavioral Science*, vol. 13, no. 3, pp. 297–314.
- Johnston, L D, O'Malley, P M & Bachman, J G 2002, *Monitoring the future: national survey results on drug use, 1975–2001*, vol. 2, *College students and adults ages 19–40*, National Institute on Drug Abuse, Bethesda, Maryland.
- Kikuchi, A & Wada, K 2003, 'Factors associated with volatile substance use among junior high school students in Kanto, Japan', *Addiction*, vol. 98, no. 6, pp. 771–84.
- Kushner, M G, Sher, K J & Beitman, B D 1990, 'The relation between alcohol problems and anxiety disorders', *American Journal of Psychiatry*, vol. 147, no. 6, pp. 685–95.
- Langa A 1993, 'Volatile substance abuse: a brief report', *British Journal of Clinical Practice*, vol. 47, no. 2, pp. 94–6.
- Lewis, R J 1996, *Sax's dangerous properties of industrial materials*, 9th edn, vols 1–3, Van Nostrand Reinhold, New York.
- Liang, Y L 1997, *1996 Texas school survey of substance abuse among students: grades 7–12*, Texas Commission on Drug and Alcohol Abuse, Austin, Texas.
- Liu, LY 2003, *2002 Texas school survey of substance use among students: grades 7–12*, Texas Commission of Alcohol and Drug Abuse, Austin, Texas.
- Ljubotina, D, Galic, J & Jukic, V 2004, 'Prevalence and risk factors of substance use among urban adolescents: questionnaire study', *Croatian Medical Journal*, vol. 45, no. 1, pp. 88–98.
- Loxley, W, Toumbourou, J W & Stockwell, T 2004, *The prevention of substance use, risk and harm in Australia: a review of the evidence*, Australian Government, Department of Health and Ageing, Canberra.
- Mackesy-Amiti, M E & Fendrich, M 2000, 'Trends in inhalant use among high school students in Illinois: 1993–1995', *American Journal of Drug and Alcohol Abuse*, vol. 26, no. 4, pp. 569–90.
- MacLean, S 2003, 'Just a dirty kind of drug: young people's perceptions of chroming', paper presented at Australian Institute of Criminology Conference on Inhalant Use and Disorder, Townsville 7–8 July 2003.
- Makkai, T 1994, *Patterns of drug use: Australia and the United States*, Commonwealth Department of Human Services and Health, Australian Government Publishing Service, Canberra.
- Maughan, B, Pickles, A, Rowe, R, Costello, EJ & Angold, A 2000, 'Developmental trajectories of aggressive and non-aggressive conduct problems', *Journal of Quantitative Criminology*, vol. 16, no. 2, pp. 199–221.
- McGarvey, E L, Canterbury, R J & Waite D 1996, 'Delinquency and family problems in incarcerated adolescents with and without a history of inhalant use', *Addictive Behaviors*, vol. 21, no. 4, pp. 537–42.
- Merikangas, K R, Mehta, R L, Molnar, B E, Walters, E E, Swendsen, J D, Auilar-Gaziola, S, Bijl, R, Borges, G, Caraveo-Anduaga, J J, DeWit, D J, Kolody, B, Vega, W A, Wittchen, H U & Kessler, R C 1998, 'Comorbidity of substance use disorders with mood and anxiety disorders: results of the International Consortium in Psychiatric Epidemiology (ICPE)', *Addictive Behaviors*, vol. 23, no. 6, pp. 893–907.
- Ministerial Council on Drug Strategy 1998, *National Drug Strategic Framework 1998–1999/2002–03*, Australian Government, Canberra, viewed 25 May 2005, <<http://www7.health.gov.au/pubhlth/publicat/document/ndsfs.pdf>>.
- National Centre of Social Research/National Foundation of Educational Research 2004, *Drug use, smoking and drinking among young people in England 2003*, Department of Health, London.

- National Crime Prevention 1999, *Pathways to prevention — developmental and early intervention approaches to crime in Australia*, Attorney-General's Department, Canberra.
- Oetting, E R & Webb, J 1992, 'Psychosocial characteristics and their links with inhalants: a research agenda', in C W Sharp, F Beauvais & R Spence (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- Office of Applied Studies 2004, *Substance use among youths who had run away from home: the National Survey on Drug Use and Health Report*, US Department of Health and Human Services Substance Abuse & Mental Health Services Administration, Rockville, Maryland.
- Polsen, M & Chiauuzzi, A 2003, 'Volatile substance use in Mount Isa: community solutions to a community identified issue', paper presented at Australian Institute of Criminology Conference on Inhalant Use and Disorder, Townsville 7–8 July 2003.
- Putnins, A 2003, 'Substance use and the prediction of young offender recidivism', *Drug and Alcohol Review*, vol. 22, no. 4, pp. 401–8.
- Queensland Government 2002, *Kainedbiipitli (a new dawn): preventing crime in Torres Strait Island communities*, Crime Prevention Queensland, Department of the Premier and Cabinet and Department of Aboriginal and Torres Strait Islander Policy, Brisbane, viewed 25 May 2005, <<http://www.communities.qld.gov.au/community/crimeprevention/publications/index.html>>.
- Queensland Health 2003, *Queensland Poisons Information Centre: poisoning*, viewed 25 May 2005, <<http://www.health.qld.gov.au/PoisonsInformationCentre/poisoning.htm>>.
- Queensland Police Service (QPS) 2004a, *Volatile substance misuse: training package*, Queensland Police Service, Brisbane, viewed 8 December 2004, <<http://www.qldpol/qupid/sostrng/vsm/mod0/index.stm>>.
- QPS 2004b, 'Background', *Volatile substance misuse, drug and alcohol coordination*, Queensland Police Service, Brisbane, viewed 8 December 2004, <http://www.qldpol/qupid/policing_advancement/drug_alch/vsm/bground.htm#what%20is>.
- QPS 2004c, 'Legislation', *Volatile substance misuse, drug and alcohol coordination*, Queensland Police Service, Brisbane, viewed 8 December 2004, <http://www.qldpol/qupid/policing_advancement/drug_alch/vsm/legislation.htm>.
- Ramirez, J R, Crano, W D, Quist, R, Burgoon, M, Alvaro, E M & Grandpre, J 2004, 'Acculturation, familism, parental monitoring and knowledge as predictors of marijuana and inhalant use in adolescents', *Psychology of Addictive Behaviors*, vol. 18, no. 1, pp. 3–11.
- Rohrig, T P 1997, 'Sudden death due to butane inhalation', *American Journal of Forensic Medicine and Pathology*, vol. 18, pp. 299–302.
- Rose, J 2001, *Volatile substance abuse: background paper*, Western Australia Solvents Abuse Working Party, Department of Health and Drug Alcohol Office, viewed 25 May 2005, <<http://www.dao.health.wa.gov.au/pdf/vsa-background-2001.pdf>>.
- Schoon, I, Parsons, S & Sacker, A 2004, 'Socioeconomic adversity, educational resilience, and subsequent levels of adult adaptation', *Journal of Adolescent Research*, vol. 19, no. 4, pp. 383–404.
- Serbin, L A & Karp, J 2004, 'Intergenerational transfer of psychosocial risk: mediators of vulnerability and resilience', *Annual Review of Psychology*, vol. 55, pp. 333–63.
- Siegel, E & Wason, S 1992, 'Sudden sniffing death following inhalation of butane and propane: changing trends', in Sharp, CW, Beauvais, F & Spence, R (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research,

- Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- Smart, R G 1992, 'Epidemiology of inhalant abuse: a Canadian view', in C W Sharp, F Beauvais & R Spence (eds), *Inhalant abuse: a volatile research agenda*, National Institute on Drug Abuse Research, Monograph Series, US Department of Health and Human Services, Rockville, Maryland.
- Stanton, W R, Carmont, S A S, Ballard, R & Lowe, J B 2000, *Alcohol, cigarette and illicit drugs use among Years 7 to 12 students in Queensland: 1999*, ASSAD Survey Report no. 5, Centre for Health Promotion and Cancer Prevention Research, Brisbane.
- Stevens, P & Griffith, J 2001, 'Youth high risk behaviours: survey and results', *Journal of Addictions and Offender Counselling*, vol. 22, no. 1, pp. 31–46.
- Stevenson, R & Brothie, R 2004, *Getting it right for every child: a report on the responses to the consultation on the review of the Children's Hearing system*, Youth Justice and Children's Hearings Division, Scottish Executive, Edinburgh.
- Stollery, B T & Flindt, M L 1988, 'Memory sequelae of solvent intoxication', *Scandinavian Journal of Work, Environment and Health*, vol. 14, no. 1, pp. 45–8.
- Strakowski, S M & DelBello, M P 2000, 'The co-occurrence of bipolar and substance use disorders', *Clinical Psychology Review*, vol. 20, no. 2, pp. 191–206.
- Taylor, JC, Norman, CL, Bland, JM, Ramsey, JD & Anderson, HR 1997, *Trends in death associated with abuse of volatile substances 1971–1975*, St George's Hospital Medical School, Department of Public Health Sciences and the Toxicology Unit, Department of Cardiological Sciences, London.
- Toumbourou, J W, Dimsey, L & Rowland, B 2004, *Preventing harms associated with volatile substance abuse*, Drug Information Clearing House, Prevention Research Evaluation Report 11, Australian Drug Foundation, West Melbourne.
- United Nations 1999, *Youth and drugs: a global overview*, Commission on Narcotic Drugs, vol. 42.
- US Air Force 1989, 'Toluene', *The installation restoration toxicology guide*, vols 1–5, Wright-Patterson Air Force Base, Ohio.
- US Environmental Protection Agency 1994a, *Coversheet for toluene*, Integrated Risk Information System Online, Office of Health and Environmental Assessment, Cincinnati, Ohio.
- US Environmental Protection Agency (Office of Pollution Prevention and Toxics) 1994b, *Chemical summary for toluene*, viewed 25 November 2004, <http://www.epa.gov/opptintr/chemfact/s_toluen.txt>.
- Watson, S, Gibler, B & Hassan, M 1986, 'Ventricular tachycardia associated with non-fluorocarbon aerosol propellants', *Journal of the American Medical Association*, vol. 256, pp. 78–80.
- White, V 2001, *Australian secondary students' use of over-the-counter and illicit substances in 1999*, National Drug Strategy, Monograph Series No. 46, Commonwealth Department of Health and Aged Care, Canberra, viewed 25 May 2005, <<http://www.health.gov.au/pubhlth/publicat/document/mono46.pdf>>.
- Williams, B, Sanson, A, Toumbourou, J & Smart, D 2000, *Patterns and predictors of teenagers' use of licit and illicit substances in the Australian Temperament Project cohort*, commissioned by the RE Ross Trust.
- Williams, D R & Cole, S J 1998, 'Ventricular fibrillation following butane gas inhalation', *Resuscitation*, vol. 37, no. 1, pp. 43–5.

- Wincup, E, Buckland, G & Bayliss, R 2003, *Youth homelessness and substance use: report to the Drugs and Alcohol Research Unit*, Home Office Research Study No. 258, Home Office, London.
- World Health Organisation 1989, *International Agency for Research on Cancer monographs on the evaluation of the carcinogenic risk of chemicals to man, 1972–present*, vol. 14, p. 101.
- World Health Organisation 1990, *Environmental Health Criteria 113: fully halogenated chlorofluorocarbons*, pp. 90–91.
- World Health Organisation 1999a, *International Agency for Research on Cancer monographs on the evaluation of the carcinogenic risk of chemicals to man, 1972–present*, vol. 71, p. 845.
- World Health Organisation 1999b, *Volatile solvents abuse: a global overview*, Substance Abuse Department, World Health Organisation, Geneva, viewed 25 May 2005, <http://whqlibdoc.who.int/hq/1999/WHO_HSC_SAB_99.7.pdf>.
- Worley, C 2001, *Buzzing, sniffing, tooting*, Institute of Social Work and Applied Social Studies, Staffordshire University, Staffordshire, England.
- Zenz, C 1988, *Occupational medicine — principles and practical applications*, 2nd edn, Mosby-Yearbook, Inc., St Louis, Missouri.
- Zenz, C, Dickerson, O B & Horvath, E P Jr (eds) 1994, *Occupational medicine*, Mosby, St Louis, Missouri.

Legislation

Queensland Acts discussed in the report

- Child Protection Act 1999*
- Crime and Misconduct Act 2001*
- Criminal Code Act 1899*
- Juvenile Justice Act 1992*
- Mental Health Act 2000*
- Police Powers and Responsibilities Act 2000*
- Police Powers and Responsibilities and Other Acts Amendment Act 2000*
- Police Powers and Responsibilities and Other Legislation Amendment Act 2003*
- Police Powers and Responsibilities Amendment Regulation 2004*
- Police Service Administration Act 1990*
- Public Safety Preservation Act 1986*
- Summary Offences Act 2005*
- Transport Operations (Passenger Transport) Act 1994*
- Vagrants Gaming and Other Offences Act 1931*

Other Australian Acts discussed in the report

- Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic.)*
- Intoxicated Persons (Care and Protection) Act 1994 (ACT)*
- Law Enforcement (Powers and Responsibilities) Act 2002 (NSW)*
- Petroleum Products Regulation Act 1995 (SA)*
- Police Offences Act 1935 (Tas.)*

Protective Custody Act 2000 (WA)

Public Intoxication Act 1984 (SA)

Summary Offences Act 1966 (Vic.)

Volatile Substance Abuse Prevention Act 2005 (NT)