The Chroming Report
A Government framework for children-in-care
Contact for enquiries and proposed changes
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Acknowledgements
This version of the Chroming Report was developed and updated by the Commission for Children and Young People and Child Guardian.

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Information security
This document has been security classified using the Queensland Government Information Security Classification (QGISC) as PUBLIC and will be managed according to the requirements of the QGISC.
Explanatory Note

This is an edited report for public release, of an investigation conducted by the Commission for Children and Young People and Child Guardian about the quality of service delivery to children in care who are chroming.

In accordance with the provisions of the Child Protection Act 1999 and the Commission for Children and Young People and Child Guardian Act 2000, my publicly available report does not contain any information of a confidential nature. This is to protect the confidentiality of the subject children pursuant to section 189 of the Child Protection Act 1999 as well as to protect the privacy of the subject child’s family and officers from the relevant service providers who had contact with the subject children and their families.

Should you have any inquiries as to the contents of this report, please contact the Director, Systemic Monitoring and Review Program, Commission for Children and Young People and Child Guardian, on (07) 3211 6948.
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<td>Attention Deficit Hyperactivity Disorder</td>
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<td>AVSMI</td>
<td>Addressing Volatile Substance Misuse Initiative</td>
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<tr>
<td>Commission</td>
<td>The Commission for Children and Young People and Child Guardian</td>
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<tr>
<td>CC1</td>
<td>Counselling Centre 1</td>
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<tr>
<td>CCYPCG Act</td>
<td>Commission for Children and Young People and Child Guardian Act 2000 (Qld)</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Child</td>
<td>Children and young people less than 18 years of age</td>
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<td>CHP</td>
<td>Child Health Passport</td>
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<tr>
<td>CMC</td>
<td>The Crime and Misconduct Commission</td>
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<td>CPA</td>
<td>Child Protection Act 1999 (Qld)</td>
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<td>CPO</td>
<td>Child Protection Order</td>
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<td>CS1</td>
<td>Children’s Shelter 1</td>
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<td>CSAHSC</td>
<td>Child Safety After Hours Service Centre</td>
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<td>CSO</td>
<td>Child Safety Officer</td>
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<tr>
<td>CSS</td>
<td>The Department of Communities (Child Safety Services) and includes the former Department of Child Safety and the former Department of Communities</td>
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<td>CSSC</td>
<td>Child Safety Service Centre</td>
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<td>CV</td>
<td>Community Visitor</td>
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<td>CYMHS</td>
<td>Child Youth Mental Health Service</td>
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<td>DET</td>
<td>The Department of Education and Training (formerly the Department of Education, Training and the Arts) and also referred to as EQ (Education Queensland)</td>
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<tr>
<td>DG</td>
<td>Director-General</td>
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<td>DOC</td>
<td>The Department of Communities</td>
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<td>DOC (CSS)</td>
<td>The Department of Communities (Child Safety Services)</td>
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<td>DV</td>
<td>Domestic Violence</td>
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<td>ESP</td>
<td>Educational Support Plan</td>
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<td>Evolve</td>
<td>Evolve Interagency Services</td>
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<td>JAB</td>
<td>Juvenile Aid Bureau – now named Child Protection and Investigation Unit (CPIU)</td>
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<td>OPM</td>
<td>Operational Procedures Manual</td>
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<td>Police Powers and Responsibilities Act 2000</td>
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<td>PSU</td>
<td>Placement Services Unit</td>
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<td>Queensland Government Drug Strategy</td>
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<td>QH</td>
<td>Queensland Health</td>
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<td>QPS</td>
<td>Queensland Police Service</td>
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<tr>
<td>RCF</td>
<td>Residential Care Facility</td>
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<tr>
<td>SCAN</td>
<td>Suspected Child Abuse and Neglect</td>
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<td>SC</td>
<td>Subject child</td>
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<td>SEDU</td>
<td>Special Education Unit</td>
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<td>VSM</td>
<td>Volatile substance misuse – used interchangeably with the term ‘chroming’</td>
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<td>WHO</td>
<td>The World Health Organisation</td>
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<td>YJ</td>
<td>Youth Justice</td>
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<tr>
<td>YP</td>
<td>Young person</td>
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<td>YW</td>
<td>Youth worker</td>
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<td>ZM</td>
<td>Zonal Manager</td>
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Executive Summary

This is an edited report on a review by the Commission for Children and Young People and Child Guardian (the Commission) into the quality of service delivery to children in care who are chroming (my review). Chroming is a form of volatile substance misuse (VSM). My review was commenced following the receipt of two referrals from the Crime and Misconduct Commission (CMC) in relation to concerns raised about the service delivery by the former Department of Child Safety, now known as the Department of Communities, Child Safety Services (CSS) to two children in the care of CSS, subject child one (SC1) and subject child two (SC2).

In summary, my review determined that:

- The needs of and behaviours displayed by many children in care who are chroming are generally a response to some deeper underlying concern(s). Therefore it is important to address the underlying factors to each child’s involvement with chroming in conjunction with responding to the immediate needs of the child.

- There exists a form of ‘whole-of-government’ framework for responding to the needs of children in care who are chroming which consists of:
  - an “immediate response” protocol between the Queensland Police Service (QPS) and the Queensland Ambulance Service (QAS) focused on protecting the immediate safety and wellbeing of children in care who are involved in chroming
  - an interagency services program (Evolve) which provides therapeutic and behaviour support for children in care with complex and extreme needs, and
  - an initiative known as the ‘Addressing Volatile Substance Misuse Initiative’ (AVSMI) which is coordinated by the Department of Communities (DOC) and operates in conjunction with police powers included in the Police Powers and Responsibilities Act 2000.

- The current whole-of-government framework could be enhanced particularly in the areas of tailored education strategies, providing for the cultural needs of children in the development of policies and procedures and by extending the areas currently targeted by the ‘Addressing Volatile Substance Misuse Initiative’ (AVSMI).

- With the exception of the QPS, there appears to be an absence of policies and procedures by key government service providers to help guide and support the delivery of services to children in care who are chroming.

- Many community-based NGOs offer support and resources and the services of these agencies need to be appropriately utilised by government service providers.

- There appears to be an inconsistent approach by officers and staff of CSS when responding to the specific needs of a child who is in care and who is chroming.

- Children in care who are chroming require specialist intervention and therapeutic services that are facilitated and implemented by experienced, and appropriately educated and trained staff. Where ever possible, these services need to be based on research based interventions that are monitored and reviewed on a regular basis.

- There needs to be a collaborative approach towards the delivery of education and training to staff at all levels and across government and non-government agencies regarding the delivery of quality services to children in care who are chroming.
- There is no apparent provision:
  - for recording the number of children in care who are known to be involved with chroming, and
  - to map responses to those children so that learnings can be gained and improvements to service delivery made where appropriate.
- While it is important to provide services that target the immediate risks associated with children chroming, planning regarding therapeutic and behavioural services is important for addressing the underlying causes of a child chroming and the longer term needs of the individual child.
- It is important that an adequately resourced placement option with appropriately trained and skilled worker(s) is sourced prior to placing children with challenging behaviours such as chroming in care settings.
- There is a greater need for more effective information sharing between agencies in relation to the scope of resources and/or programs available to children in care who are chroming, or suffering from the effects of chroming, and the capacity of each agency to deliver those resources.
- In addressing the needs of children in care who are chroming, there needs to be a commitment to form genuine partnerships involving government, non-government and community sectors.

Report structure
My review report is structured as follows:

<table>
<thead>
<tr>
<th>Part</th>
<th>Title</th>
<th>Content</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>Introduction</td>
<td>Outlines the basis for my review including the terms of reference, jurisdiction, scope and other procedural matters.</td>
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<tr>
<td>One</td>
<td>What is chroming and its known effects</td>
<td>Provides a brief background as to what is chroming, its known side effects and other relevant research information related to chroming.</td>
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<td>Two</td>
<td>Case Studies</td>
<td>Provides a brief case study for each subject child and other additional information.</td>
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<td>Three</td>
<td>Identification of Issues</td>
<td>Provides an analysis of the delivery of services to each subject child and identifies broad issues relating to the delivery of those services.</td>
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<td>Four</td>
<td>Current Service Delivery Framework</td>
<td>Identifies the current service delivery framework for delivering services to children in care who are chroming and an analysis of its adequacy.</td>
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<tr>
<td>Five</td>
<td>Comment, Opinions and Recommendations</td>
<td>Provides comment, opinions and recommendations arising from my review.</td>
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Opinions and Recommendations made
As a result of my review, I formed eighteen opinions and made seven recommendations for stated action by a number of government agencies. Since finalising my review, I am pleased to advise that the relevant agencies have significantly progressed the implementation of the report recommendations. My officers will continue to monitor the satisfactory implementation of any outstanding recommendations.
Introduction

Background
I commenced my review after receiving two separate referrals from the CMC regarding CSS’s delivery of care to SC1 and SC2, both of whom were living in the child safety system. These services were the subject of separate investigations conducted by CSS, through the engagement of an external consultancy agency. Based on its review of services delivered to SC1 and SC2, the CMC advised me that it remained concerned regarding the following issues:

- The quality of services provided by CSS to SC1 and SC2 who were known to be chroming whilst in care.
- An apparent lack of relevant policies, procedures or guidelines to address service delivery to children in the care of, or entering the child safety system who are chroming and/or who are significantly affected by the effects of chroming.
- A failure by CSS to appropriately respond to systemic issues identified as a result of an external investigation into CSS’s service delivery to SC1 and SC2.
- The absence of any information as to what actions CSS intends to take to ensure complex cases such as these are dealt with in a more appropriate manner.¹

From an analysis of the two cases, I agreed that further action was required in response to the concerns raised by the CMC. I therefore informed the CMC of my intention to conduct a general review into the quality of services being delivered to children in care who are chroming pursuant to s. 18 of the Commission for Children and Young People and Child Guardian Act 2000 (the CCYPCG Act). The CMC accepted my approach stating:²

“We agree this is the appropriate course of action to address the systemic issues and, if necessary, make comment to improve the… handling of complex cases such as continued chroming of children while in care.”

My background research revealed that children in care, who take part in chroming, are a particularly vulnerable group of young people who require individualised and specialised services. These services are currently being provided by numerous government agencies and NGOs.

Terms of reference
The terms of reference for my review are as follows:

- Identify the systems, policies and practices of CSS and other relevant service providers for delivering services to children in care who are chroming
- determine the appropriateness and implementation of these systems, policies and practices (at both an individual and cross-agency level) for promoting and protecting the rights, interests and wellbeing of children in care who are chroming, and
- make any necessary comment, opinions and recommendations to address these issues.

¹ CMC letters regarding SC1 and SC2 respectively
² CMC letter responding to Commission’s proposed response to this matter
Jurisdiction
I have conducted my review pursuant to my monitoring functions contained in s.18 of the CCYPCG Act which enables me, “to monitor, audit and review the systems, policies and practices of the child safety department and other service providers that affect children in the child safety system.”

Under s.18 (4) of the CCYPCG Act, I am precluded from commenting specifically on the actions taken in an individual child’s case. Therefore, my review does not contain any opinions regarding the specific care provided to SC1 and SC2. Given the potential for those broad systemic issues identified as a result of my analysis of the service provided by CSS to SC1 and SC2 to impact on other children in the child safety system and who are chroming, I have used these two cases to help inform my review.

My monitoring and review powers also enable me to:
- analyse and determine the appropriateness of the various policies, practices and procedures in place for CSS and other relevant government agencies that guide the delivery of services to children in care who are chroming, and
- consider the systemic issues impacting upon the quality of services being delivered to children in care who chrome.

Obtaining information
Under s. 40 of the CCYPCG Act I may issue a statutory notice to a service provider requiring it to provide me with certain information and/or documents.

I issued a statutory notice to the Director-General (DG), CSS, requesting copies of all records relating to the two subject children and all policies, procedures, protocols and program information relating to CSS’s delivery of services to children in care who are chroming. In response, CSS provided me with extensive documentation relating to the two subject children.

I also wrote to a number of other government service providers outlining the details of my review and inviting each to provide me with information, such as policies, procedures, memorandums of understanding (MOU) and other documentation that may help guide the agency’s delivery of services and the fulfilment of cross-agency responsibilities, to children in care who are chroming. Responses were received from the following service providers:
- Queensland Police Service (QPS)
- Queensland Health (QH)
- the former Department of Education Training and the Arts (DETA) – now the Department of Education and Training (DET)
- Department of Communities (DOC)
- Disability Services Queensland – now the Department of Communities, Disability Services (DSQ).

I have primarily conducted a desktop review of the information provided to me by the named service providers. On the information provided, I determined it was unnecessary to interview any officers from the relevant agencies.

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3 Section 18(1)(a) CCYPCG Act
4 Section 18(4) CCYPCG Act
5 Since the machinery of government changes a number of departments merged with other departments and had name changes as a result.
6 This includes responses from the former Department of Child Safety and Disability Services Queensland.
Standard of proof and sufficiency of evidence
The CCYPCG Act is silent as to what standard of proof is required for me to form opinions in relation to the issues under review. There are two standards of proof, the criminal standard and the civil standard. The criminal standard requires proof beyond a reasonable doubt. The civil standard requires proof on the balance of probabilities.

I am of the view that the common law supports the application of the civil standard of proof to reviews conducted under the CCYPCG Act. I have taken it to mean that before forming an opinion, the evidence must establish that it is more probable than not that a particular event occurred or circumstances existed.7

The evidence I obtained for my review was the best possible evidence that was reasonably available to me. The opinions I have formed are the result of objective analysis of the evidence gathered during my review.

Although I am not bound by the rules of evidence, I observed those rules to the greatest extent practicable when analysing the evidence and forming my opinions. I assessed the cogency 8 of the evidence I obtained and applied the applicable standard of proof when forming opinions about that evidence.

Reporting procedures, recommendations and natural justice
Section 50 of the CCYPCG Act authorises me to make recommendations about matters arising from my review. However, before making the recommendations, I must give the agencies about which the recommendations relate a written copy of my proposed recommendations and a reasonable opportunity to comment on them.

Section 85(1) of the CCYPCG Act states that I must not include in a report, any comments adverse to an entity identifiable from the report, unless the entity has been given a copy of the comments and a reasonable opportunity to respond to them.

My report contains recommendations that relate to the Department of Communities (including Child Safety Services and Disability Services), Queensland Health, the Department of Education and Training, and the Queensland Police Service (collectively called “the agencies”). My report also contains comments that could be considered adverse to the agencies. Accordingly, my report was provided to each of the agencies in provisional form for their comment and response pursuant to my statutory obligations.

I have carefully considered all relevant information, arguments and submissions put forward by the agencies and, where required, made amendments or additions to my report. However, I also ensured that I conducted this reporting process in accordance with my paramount statutory obligation to act independently and in a way that promotes and protects the rights, interests and wellbeing of children.9

De-identification
In deciding to de-identify my report for public release, I took into consideration the following:

7 Briginshaw v Briginshaw (1938) 60 CLR 336.
8 Cogency includes the credibility of witnesses, the reliability of documents, the inferences to be drawn from things, and the effect of the evidence as to the facts in issue generally. Cogency depends largely upon general considerations of probability.
9 CCYPCG Act, section 17. However, due to legislative changes that came into force on 1 April 2010, this section of the CCYPCG Act is now known as section 22.
• the sensitive nature of the matter under review
• the need to protect the identity and privacy of the subject children and other family members, including carers
• the confidentiality provisions of the CCYPCG Act and the CPA, and
• the intention of my report is to review issues at a systemic rather than a case specific level.
Chapter One: What is chroming and its known effects

What is chroming?
‘Chroming’ is a term used to mean ‘sniffing chrome based paint’, and is a specific form of volatile substance misuse (VSM). VSM involves the deliberate inhalation of the gas or fumes that are released from a solvent at room temperature, for the purpose of intoxication, ‘getting high’ and a subsequent change in mental state. VSM is also known as ‘inhaling’, ‘sniffing’, or ‘huffing’. Therefore, whilst my review focuses specifically on children in care who are chroming, the terms ‘VSM’ and ‘chroming’ are used interchangeably throughout my report.

Whilst VSM is not isolated to any one particular socio-economic group in society, previous research has suggested that VSM is often prevalent in lower socio-economic areas. Chroming is not considered to be an ‘illegal’ form of ‘drug use’ in Queensland. However, the Victorian Government reported in 2005, that inhalants were in the top ten drugs of concern, but their use was receiving limited attention in relation to addressing the problem.

Background information
In 1999, the World Health Organisation (WHO) released a report that included an overview of the intentional inhalation of volatile substances and its potential related side effects. The report identified a number of significant factors in relation to the practice of VSM:
- VSM is a very dangerous practice
- although some people are experimental or short-term users, there are some users who inhale volatile substances regularly over a long period of time
- VSM is generally associated with young people and vulnerable groups such as children who are homeless and Indigenous populations, and
- many common and readily available household products may be used for inhalation purposes.

What products enable a young person to chrome?
Inhalants and volatile substances produce a chemical vapour when exposed at room temperature. In Australia, approximately 250 products, many of which are readily available in the average household, are said to contain substances which can be inhaled in order to generate an intoxicated state. Volatile substances are usually divided into four main groups, namely:

12 Commission for Children and Young People Fact sheet 1: ‘Volatile substance misuse – frequently asked questions’
15 World Health Organisation (1999). Substance Abuse Department, Volatile Solvents Abuse – A global overview. Social Change and Mental Health, p1
16 World Health Organisation (1999), Substance Abuse Department, Volatile Solvents Abuse – A global overview. Social Change and Mental Health. p1
“solvents – liquids or semi liquids that vaporise at room temperature, such as glues and petrol
• gases – medical anaesthetics and fuel gases, such as lighter fuels.
• aerosols – sprays containing propellants and solvents, such as aerosol paints (used with chroming), and
• nitrites – amyl nitrite or cyclohexyl nitrite found in room deodorisers.”

Some of the more well-known products associated with VSM include: 20
• aerosols – such as spray paint, hair spray, air freshener, deodorant, fabric protector
• adhesives – such as model plane glue, rubber cement, household glues
• solvents and gases – such as nail polish remover, paint thinner, correction fluid, toxic markers, cigarette lighter fluid, petrol, nitrous oxide, butane, propane and helium, and
• cleaning agents – including dry cleaning fluid, stain remover, degreasers.

What are the signs of someone chroming? 21
There are no specific combinations of symptoms or a specific clinical presentation that is able to confirm a person’s misuse of solvents. 22 At times it can be difficult for people such as general practitioners to ‘diagnose’ whether a young person is in fact involved with VSM. However, it is suggested the following signs may signal such involvement: 23
• the smell of vapour on their breath
• a rash or sore spots around their mouth
• red, watering eyes and a runny nose
• a drunk appearance such as someone falling over
• paint stains around the mouth, skin or on the clothes, and
• confusion or disorientation.

Long-term effects of volatile substance misuse?
Research suggests that the ‘high’ experienced from inhaling volatile substances is achieved quickly. However, the ‘high’ sensation also disappears quite quickly. 24 Furthermore, chroming and VSM can also lead to a number of long-term health issues such as: 25
• heart, liver and kidney damage
• loss of hearing
• damage to the central nervous system and brain
• damage to the bone marrow
• anaemia
• weight loss
• sneezing and coughing
• nosebleeds, and
• depleted supply of oxygen in the blood.

20 Commission for Children and Young People Fact sheet 1: ‘Volatile substance misuse – frequently asked questions’
21 Commission for Children and Young People Fact sheet 1: ‘Volatile substance misuse – frequently asked questions’
25 Commission for Children and Young People Fact sheet 1: ‘Volatile substance misuse – frequently asked questions’
What effect do volatile substances have on people and communities?  
Chroming impacts upon both the individual and the broader community, with some young people who are involved with chroming, also becoming involved with crime, vandalism, suicide and accidents. One research report outlines that where there are a small number of users in a small community, their involvement with VSM may disproportionately impact negatively on the overall wellbeing of the community.  

The effects of volatile substances vary from person to person and are dependent on a number of variables such as:

- the amount of substance inhaled
- the duration and frequency of inhalation
- whether the inhalation is being combined with other drug use, and
- the make up of each individual, such as age, weight, sex, mood, past experience of drug and inhalant use.

One author described the side effects of VSM as being similar to those experienced by a person who is intoxicated due to alcohol consumption. Some of the clinical side effects that may be induced by VSM intoxication include:

- impaired muscular coordination
- visual disturbances
- headaches
- ringing in the ears
- heart palpitations
- abdominal pain, and
- nausea and/or vomiting.

The toxicity a person is exposed to with substance misuse varies from person to person. In fact, the WHO pointed out in its 1999 report that it is nearly impossible to measure the 'dose' of volatile substance that a person has inhaled. Also, the WHO report highlights factors such as the frequency of VSM; the length of each episode of VSM; how a person breathes in the substance – including breathing through the mouth or nose, or both, and re-breathing exhaled air when a paper or plastic bag is used, will all vary the impact of VSM for each individual.

Why do children and young people become involved with VSM?  
The obvious lures for young people to become involved in chroming are the ready availability of a large range of inhalants that are relatively inexpensive. Involvement with chroming and VSM often occurs due to boredom which stems from a number of influences including unemployment, low self esteem, a perceived lack of alternatives, relationship difficulties, homelessness and loneliness.

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The reasons for children and young people becoming involved with VSM are wide and varied with some of the more widely reported reasons including:  
- to overcome boredom and loneliness
- to overcome hunger pains, and
- to dull or block emotional and physical pain.

In 2008, the Australian Government reported that a large percentage of people involved with VSM often present with a high rate of psychological disorders such as depression, anxiety, stress and poor self-esteem. The report outlines that young people involved with VSM are often disproportionately involved in crime and are more likely than young people not involved with VSM, to be placed in detention. The report also suggests the concept that VSM is associated with future drug use (such as cannabis and alcohol); childhood physical and/or sexual abuse; and homelessness.

A majority of the research suggests that specific VSM ‘styles’ will vary from community to community and often on an episodic basis. ‘Petrol sniffing’ as a form of VSM is a concern in many Indigenous communities, with certain research indicating that petrol sniffing began to emerge in a number of Indigenous communities in the 1960s. One author discusses that VSM typically occurs amongst teenagers in an experimental context, and that petrol sniffing remains a problem for a number of Indigenous communities including those in the Northern Territory and top end of Australia.

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Chapter Two: Case studies

In this chapter I provide a brief overview of each subject child’s involvement with chroming whilst in care. During the course of my review, I also became aware through the Commission’s complaints and child death functions, of a number of other young people in care who had been involved in chroming. A brief summary of information for each of these young people is also included.

2.1 Case study: subject child one

CSS received information regarding the alleged chronic substance abuse by a male Indigenous child (SC1) and his parent’s inability to manage his behaviour. The information provided stated that SC1 had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), had an intellectual impairment and was also involved with chroming. SC1 was also alleged to have been displaying sexualised behaviour such as exposing himself and masturbating in public whilst intoxicated as a result of having chromed.

CSS in cooperation with SC1’s parents attempted to find a suitable placement for him in an attempt to manage his challenging behaviours. As can be seen from the following sequence of events, most of these placements broke down, largely due to SC1’s high care needs and an inability to address his challenging behaviours:

- SC1’s first placement at a youth shelter broke down within a couple of days due to SC1’s high care needs and the service’s inability to meet those needs
- SC1 was moved to a placement providing services to young Indigenous people. It is reported that this placement subsequently broke down due to SC1’s ‘defiant’ behaviours
- SC1 ‘self-placed’ with his parents which quickly broke down due to conflict between SC1 and his parents and SC1’s challenging behaviours
- SC1 again ‘self-placed’ with his maternal aunt
  After one week spent with his maternal aunt, SC1 again returned to his parents, and
- one week later, SC1 again absconded and was eventually placed by CSS in commercial accommodation and under the supervision of a youth worker (YW).

Due to ongoing substance abuse concerns, SC1 was subsequently admitted to a substance withdrawal service. However, the program was ‘unable’ to accommodate SC1’s cigarette smoking habit and therefore SC1 only remained for three days of the eleven day program. After exiting the program, SC1 returned to the previous commercial accommodation supervised by a YW.

It would appear the main reason for SC1 consistently absconding from his numerous placements was to obtain paint for the purpose of chroming. Given the numerous placement breakdowns and the repeated failure to manage his challenging behaviours, SC1 was eventually assessed as being a ‘child in need of protection’ and he came into the care of CSS.

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38 Case study based on information provided to the Commission from the Child Safety Services in relation to SC1.
Eventually an application for a Child Protection Order was filed by CSS and granted by the Children’s Court and a placement for SC1 was arranged with a residential care facility (RCF2). The following significant events occurred during SC1’s time with RCF2:

- SC1 was referred to Evolve, a therapeutic service targeted towards children and young people in care. The Evolve panel met and discussed SC1’s case. However, it was determined that SC1 did not meet the criteria to enable admission to the support program. It is not clear why SC1 did not meet the criteria for admission.
- During his placement with RCF2, SC1 continued to abscond in order to obtain paint and to engage in chroming. A review of CSS’s records indicates that SC1 would steal paint from local hardware stores and also travel to a larger centre to obtain paint, before returning to his placement ‘under the influence’ of paint.
- SC1’s behaviour would escalate, while intoxicated due to chroming. SC1 would become physically violent and aggressive towards RCF2 staff when they attempted to confiscate SC1’s paint and/or cigarettes. On one occasion, SC1 destroyed RCF2 property during his attempts to recover paint that had been confiscated and locked in a store room by YWs.
- At times, SC1 would also exhibit sexualised behaviour such as exposing himself and masturbating in public whilst under the influence of paint. SC1’s sexualised behaviours were becoming more extreme and aggressive and were occurring on a more frequent basis.

During this time, SC1 consistently had substances removed from him by Child Safety Officers (CSOs), YWs, police, and hospital staff. Irrespective of already having suffered a stroke and receiving information about the dangers and negative impact of chroming on his health, SC1 still continued to chrome.

Struggling to manage SC1’s chroming habit and challenging behaviours, YWs from RCF2 repeatedly requested assistance and support from CSS. CSS canvassed a variety of options in an attempt to respond to SC1’s needs. Meetings with external service providers were requested in order to secure assistance, advice and support for CSS officers and YWs with managing and responding to SC1’s many challenging needs and behaviours. Such assistance was not always readily available.

CSS also sought assistance for SC1 from Hospital 1 as well as a number of substance withdrawal support services. CSS’s records provide that SC1 was not accepted by these services as he failed to meet the intake criteria for the said programs/services.

Following a sequence of reported incidents that occurred while SC1 was ‘intoxicated’ from chroming, YWs at RCF2 were advised by CSS officers that should SC1 continue to chrome and be aggressive, QPS and the QAS were to be contacted for assistance.

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39 The following information was obtained from the Evolve website www.childsafety.qld.gov.au/partners/government/evolve.html: Evolve Interagency Services (Evolve) provides therapeutic and behaviour support services for children and young people on custody or guardianship child protection orders to the chief executive of Department of Communities (Child Safety, Youth and Families) and in out-of-home care who have severe and complex behavioural and psychological issues and/or disability behaviour support needs.
On one occasion, SC1 absconded from his placement and attended Child Safety Service Centre 1 (CSSC1) to recover his push bike, which had been confiscated in an attempt to prevent him from absconding and subsequently chroming. Later that day, SC1 returned home to his parent’s house affected by paint. In line with CSS advice, QAS and QPS were contacted; SC1 was conveyed to hospital and was later returned to RCF2.

A case summary prepared by CSO1 outlines that, “[RCF youth] workers, [SC1] and CSO all agreed that [SC1] would relinquish any paint he had at 5:00pm every day to workers. [SC1] agreed. The paint would be locked away for the night. The following morning a change in shift occurs at 8:15am, it was agreed that the day’s activities would be planned at this time if [SC1] had not absconded and been chroming.”

Furthermore, the external consultant was provided with a taped recording of a telephone conversation between QPS and CSO1 regarding SC1’s involvement with chroming. Within the transcript, CSO1 is quoted as having stated:

“At this time I can’t get anything where he actually fits into any services. What we’re trying to do with the placement…at the moment is just to put in some behavioural management strategies and hopefully, you know dwindle down his use…his chroming over a period of time.”

When asked what was being done to deal with SC1’s situation, CSO1 provided the following advice:

“What we’re doing. We weren’t too sure if [the RCF] were going to keep him full-time…it was a referral made to another agency…their place was…chockablock and I can’t get him in there for God knows how long…I went down…and did a placement agreement with [the RCF] and now that we know he’s going to be down there for a while longer, we’re able to put some strategies in place. What we’ve got going on in terms of that stuff at the moment is that come five o’clock of the afternoon…[SC1] brings all of his paint down to the workers and it gets locked away. They do activities all the next day…when they get home he can have his paint but he’s got to have it in the confines of the yard and what we’re hoping to do is just restrict him from chroming…minimise chroming and do it in a more structured way rather than him taking off because that is what he has been doing.”

During an electronic record of interview with external consultants, CSO1 is quoted as stating “there has never been a plan to return [SC1’s] paint to him”. The investigator has gone on to explain, “she explained that [SC1’s] home had backed on to forestry. [CSO1] stated that she had said to [SC1], ‘Come on, mate. If you go and get all of your paint that you’ve got stashed all around the place and hand it in by 5:00 this afternoon, you might be able to go and do some activities tomorrow, mate.”
It is important to reflect upon the learnings from SC1’s case in order to better inform future responses to children in care who are involved with chroming. It is also important to reflect upon some pertinent points made by the external investigator in response to the allegation that “the subject child was permitted by [CSO1] to chrome at his placement...” It is these learnings that will help to better inform service providers at a systemic level of the challenges faced by front-line staff tasked with delivering services to this vulnerable group of children and young people. Some examples of the ‘learnings’ I have referred to include:

- “there was clear evidence that the subject child suffered from a chroming addiction that, combined with his intellectual impairment, resulted in behaviours that were difficult to manage.”
- “the information indicated that...carers were inadequately trained and equipped to prevent the subject child from absconding and chroming. From the information provided by witnesses, the Investigator was of the opinion that [CSO1] and [RCF] carers made concerted efforts to support the subject child and stop him accessing paint.”
- “whilst [CSO1’s] decision was shown to be ill advised...she appeared to be acting in good faith in very difficult circumstances.”

Eventually, SC1 came to the attention of QPS officers while chroming. Following information obtained from CSO1, QPS remained concerned about the continuing safety and wellbeing of SC1 and consequently referred the matter to the CMC.

The CMC assessed the concerns raised by QPS as requiring further investigation and devolved the matter to CSS for investigation. CSS commissioned an external agency to undertake the required investigation. The external investigator’s report was then provided to the CMC for review.

2.2 Case study: subject child two

CSS obtained a child protection order for subject child 2 (SC2); a female indigenous child, following the receipt of information about an alleged sexual abuse of a female indigenous child during an ‘informal placement’. SC2 was subsequently taken into care due to her mother’s inability to provide appropriate care given the mother’s history of chronic substance abuse (chroming), domestic violence and transience.

SC2 was initially placed in the care of a family member. However, given SC2’s extreme behaviours including defiance, aggression and emotional outbursts the placement broke down and SC2 was moved into the care of another family member, resulting in this placement also breaking down. SC2 was eventually placed in a residential care facility (RCF1), under the supervision of YWs.

While living in RCF1, SC2 was referred to Evolve and provided with therapeutic services by QH to address her complex behaviours and care needs. The rationale for this referral included the subject child’s:

44 External Consultant Investigation report regarding SC1 (provided to the Commission by the CMC)
45 External Consultant Investigation report regarding SC1 (provided to the Commission by the CMC)
46 Case study based on information provided to the Commission from CSS in relation to SC2.
inappropriate behaviour towards males of an older age
past history of sexual abuse, and
self-harming.

While receiving services through Evolve, SC2 was diagnosed by a psychiatrist as having a ‘Major Mood Disorder’.

During SC2’s placement with RCF1, YWs reported evidence to CSS that SC2 was chroming. YWs found SC2 sniffing air freshener at the facility and also believed SC2 had been sniffing nail polish. YWs also reported that SC2 had allegedly been sexually abused by a male during a ‘chroming session(s)’.

I became aware of this information through receipt of a Serious Issue Form (SIF) from one of the Commission’s Community Visitors (CV). The CV raised concerns that CSS and QPS had failed to respond ‘appropriately’ to the alleged sexual abuse of SC2, noting SC2 had not been interviewed by the relevant agencies. In accordance with my statutory obligations contained in s. 25 of the CCYPCG Act, I referred these concerns to CSS, the CMC and the QPS. 47

The CMC determined the matter warranted further action and devolved the matter to CSS for investigation. Once again, CSS commissioned an external investigation and the subsequent report was provided to the CMC for review. The CMC considered that the report raised a number of concerns, including a number of possible systemic issues. Accordingly, the CMC referred the matter to me for further possible action.

2.3 Additional information

During the course of my review, I became aware of five other young people in care reportedly involved with chroming. I therefore determined to conduct a brief review of information held in respect of these young people, in the hope of further informing my review. This additional information suggests that there is an increasing number of children and young people in care who are involved in chroming. A brief (de-identified) summary of each of these matters is outlined below.

2.3.1 Subject child three and subject child four 48

I am informed that subject child three (SC3) and subject child four (SC4) were located by their school vice-principal ‘wagging’ school with the intention of ‘sniffing’ for the day. The vice-principal contacted their carer and arrangements were made for the children to attend a health centre. A follow up visit also occurred and included a health check and a referral to a psychologist. The children attended fortnightly appointments with the psychologist for a period of time.

The Commission’s Community Visitor for these subject children passed this information onto the CSO for both SC3 and SC4, who agreed to contact a counselling centre which offered a diversionary and educational program for teenagers involved with chroming. Whilst there was some delay in referrals being

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47 Due to legislative changes coming into effect on 1 April 2010, section 25 of the CCYPCG Act now replaces the former section 20.
48 Information pertaining to SC3 and SC4 was provided to the Commission by the relevant ZM. The information collated by the relevant CV and attached to the ZM’s e-mail is undated.
made to the counselling centre, the counselling centre provided the two SC’s carer with a kit providing general tips on how to respond to children chroming. The two SC were also provided counselling by the counselling centre.

SC4 later informed the CV that she was no longer chroming or smoking. SC4 reported that she had developed a headache that she couldn’t shift and that this frightened her. SC4 had also benefited from a number of counselling sessions provided by the counselling centre and sessions with the psychologist.

SC3 continued to chrome and whilst SC3 did not deny that she still chromed, she would ‘withdraw’ when the topic of chroming was raised with her.

A Zonal Manager from the Commission’s Community Visitor Program informed the Commission’s Complaints Team of the concern that these two SC were suspected of being involved with chroming.

2.3.2 Subject child five
Subject child five (SC5) identifies as being Aboriginal, and has an extensive child protection history. SC5 was taken into care after she presented to a local health clinic intoxicated due to having sniffed petrol. SC5 was identified as having an involvement with chroming and requiring protection due to there being no family members willing and able to protectively care for her.

Information received in relation to SC5 further provides:
- SC5 has a history of not attending school
- SC5’s extensive child protection history relates to her parent’s substance abuse, domestic violence and chroming
- SC5 has been involved with chroming since the age of at least 10
- SC5 had been placed with three different residential care facilities
- SC5 regularly absconds from placements and continues to display challenging behaviours such as sniffing petrol, aggression towards others and property damage, which led to her being charged with common assault and wilful damage
- prior to SC5’s entry into care, she had been engaged with a substance withdrawal service and a mental health service for children and young people, and
- SC5’s current case plan did not include any information regarding therapeutic interventions or strategies to address her chroming.

2.3.3 Subject child six and subject child seven
In the Commission’s “Annual Report: Deaths of children and young people in Queensland 2008-2009”, I reported that two young people aged 15–17 years of age, subject child six (SC6) and subject child seven (SC7), died as a result of inhaling volatile substances (chroming). As SC6 and SC7 were in the child safety system at the time of their deaths, the service delivery provided to these two young people by CSS was reviewed by the Queensland Child Death Case Review Committee (CDCRC).
As discussed with SC1 – SC5, the following complex issues were evident for SC6 and SC7:

- complex behavioural needs
- mental health issues
- history of using volatile substances, and
- engaging in criminal activity.
Chapter Three: Identification of issues

To help inform my review I conducted a detailed analysis of the information provided to me by CSS in relation to SC1 and SC2. In this chapter I have:

- provided details of the service delivery to SC1 and SC2 by numerous government agencies and NGOs in response to their involvement with chroming, and
- identified and discussed a number of issues around the delivery of those services.

3.1 Case Analysis: delivery of services to subject child one and subject child two

3.1.1 An interagency response

The case notes for SC2 provided that early on, efforts were being made for meetings to take place that would focus on a multi-agency approach regarding the coordination of care for SC2, as opposed to solely relying on input from CSS. The following entries in SC2’s case notes provide:

“Services to be provided to the child and the source of the services:
- [SC2] requires psycho education on drugs and alcohol, sexual health and family planning (women’s business, body changes, STDs, contraception, and the impact of chroming on the [sic] brain development). RCF1 has resources pertaining to this need and can link to [therapeutic support service] for a coordinated approach.”
- Connections with other state departments and agencies:
  - Testing for STDs
  - Referral to [support service] ‘recently submitted’
  - Two meetings were held to address school behaviours.
- “The overarching goal of [SC2]’s proposed placement with RCF1 is to provide a period of stability and intensive intervention, so that [SC2] can transition back to mainstream placement and support arrangements with an increased capacity to regulate her behaviour and make positive choices.”

It is clear from CSS’s records that CSS engaged the services of Evolve in order to assist with the management of SC2’s challenging and complex needs (including her involvement with chroming). In this case, the Evolve panel consisted of officers from QH, DSQ and DET.

Evolve Interagency Services promotes that “a referral to Evolve is aimed at building the capacity of a child and their support network to:

- reduce frequency and intensity of challenging behaviour
- increase placement stability
- increase participation in educational programs and improve education outcomes
- form positive peer relationships and secure attachments
- increase participation in community activities to facilitate their wellbeing
- enhance communication with the key people involved with their care
- promote greater understanding of their behaviour and the best way to respond to their needs.”

49 SC2, CSS records
50 Evolve Interagency services – Practice Resources guidelines
My research into VSM by young people suggests that all of the factors noted above are important in addressing the continued use of chroming by children in care. So it is considered appropriate that referrals were made to Evolve for both SC1 and SC2.

I also note from SC2’s case notes that the Evolve Therapeutic Services Individual Care Plan for SC2 included the following statement under the heading of ‘goal’: 51

“To eliminate substance abuse and for [SC2] to remain drug and alcohol free: 24/7 supervisory care by RCF1, education in substance abuse, school to contact RCF1 if aware of substance use.”

At one stage, there was a 12 week break in services provided to SC2 as no one was available from Evolve to provide the required support services. It was considered not to be in SC2’s best interests to engage the services of a private psychiatrist during this period of time. 52

Shortly after he came into care, a referral to Evolve was also made for SC1. The Evolve panel met and determined that SC1 did not meet the criteria to enable admission to the support program, the reasons for which are not stated.

Consequently, meetings were requested with external service providers to secure assistance, advice and support for CSOs and YWs with managing and responding to SC1’s many challenging needs and behaviours. The outcome of those meetings was that SC1 was referred to CYMHS for support and counselling regarding his substance abuse, RCF2 staff were to ensure that SC1 attended his medical appointments and RCF2 staff were to attend a substance abuse program so that they could provide support to SC1.

The following statement by a CSS Zonal Director contained in CSS’s records for SC1 summarises the difficulty experienced by SC1’s CSO and RCF2 workers in the absence of other support: 53

“The CSO and RCF2 workers have been attempting to contain and restrict SC1’s behaviours… the CSO has been attempting to balance the risk to SC1’s health and safety and the risk of SC1’s behaviours to the community… This has understandably been a most difficult and arduous task, particularly in view of the lack of support/assistance from other allied health professionals.”

While the case notes for SC1 and SC2 provide for a multi-agency approach by government agencies including QH, DSQ and DET, there is a lack of information to indicate to what extent these services were linked and to what extent information was shared with other key service providers (e.g. the RCF) to enable a holistic approach to service delivery.

Three clear issues arise from this information:
1) the availability of resources to provide for ongoing support by the Evolve support teams
2) the criteria for admission to the Evolve support program may be limiting, thus resulting in a greater reliance on the involvement of NGOs (including

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51 SC2 CSS records
52 SC2 ICMS printout record
53 SC1 CSS records
RCFs and private counsellors/psychologists) and other community based support programs, and
3) the extent to which the services are linked to provide for a holistic approach to service delivery to children in care who are involved with chroming.

3.1.2 Queensland Police Service
QPS was involved in responding on numerous occasions to instances where SC1 and SC2 were found to be chroming and the resultant behaviours associated with them having chromed. QPS officers are often involved with delivering frontline immediate response services to children who are involved with chroming. QPS policies and procedures make provision for officers responding in cases where assistance is required to ensure the safety and wellbeing of the young person and the broader community. Appropriately addressing and responding to SC1 and SC2's involvement with chroming was important to ensure that the already stretched resources of QPS were not adversely and unnecessarily impacted upon.

The following are some examples of QPS involvement with SC1:

**Example 1**
Police escorted SC1 home after being located in another person’s spa bath. SC1 then proceeded to chrome in the back yard of RCF2 and later attempted to break into the filing cabinet to obtain paint. The YW has noted, “the police took his paint but now he has another one probably stolen or bought it. He is sniffing again.”

**Example 2**
After having intercepted SC1 under the influence of paint, police contacted CSS to advise that SC1 had been attempting to hitch hike on the highway, and then ran away from police when they attempted to intercept him. SC1 ran to RCF2 where police located him. SC1 was cautioned for the offence ‘Obstructing Police’ and the police confiscated paint and cigarettes. CSS records further provide:

- CSO1 spoke to a female QPS Child Protection and Investigation Unit (CPIU) officer (QPS officer 1) and advised of SC1’s history with CSS.
- QPS officer 1 queried with CSO1, “If [SC1] was in departmental care, then why is he still chroming and why aren’t you [the department] taking the paint off him?”
- CSO1 advised QPS officer 1 that CSS were taking the paint off SC1 and attempting to control his behaviours by “weening [sic] him off paint gradually with his compliance…. that by working with [SC1] in this way, workers may be able to control his behaviours and ensure that all parties know when and where he is at all times.”
- QPS officer 1 voiced concern at the apparent lack of care shown by workers when SC1 ran from them and ran home to his RCF. The CSO further advised that ‘At this time the department has no other placement for [SC1] and therefore are attempting to moderate and control his behaviours’. QPS officer 1 stated, ‘[SC1] would be better off in detention than dead.’ QPS officer 1 wanted to know if anything else was being done so that SC1 doesn’t die. The CSO responded that ‘the department had not been successful in having [SC1] accepted into any service due to his chroming. The CSO advised that [SC1] does not fulfil agency criteria for assistance,[ QPS officer 1] advised that she would be looking into it and would be back in contact with the CSO.”

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54 RCF2 Incident Report included in SC1 CSS records
55 SC1 CSS records
56 SC1 CSS records
Example 3

The following day SC1 absconded from his placement and attended a hardware store (it is assumed with the intention of obtaining paint). Police were called and advised SC1 that there was a restraining order in place, preventing him from going within 200 metres of the store.

Example 4

SC1 insisted he wanted to go for a walk on his own. Police later located SC1 on a jetty, chroming and threatening to throw himself in the river. SC1 was taken home by police, but later walked away again prompting the YW to contact ‘on-call’. The YW notes that SC1 had advised him, “that he [SC1] wanted to chrome to get high that is the reason why he has left.” The YW remained at RCF2 in case SC1 returned. SC1 did eventually return approximately an hour and a half later.

Example 5

SC1 allegedly stole spray paint after having gone for a walk on his own. The store from which the paint was stolen, contacted police who proceeded to charge SC1 with stealing.

Example 6

CSS was advised SC1 was likely to be charged with public nuisance offences as SC1 had been found in a neighbours yard and spilt paint on a neighbour’s concrete and dog when yelled at by the neighbour to leave his yard.

Example 7

SC1 climbed onto the roof of RCF2 at which point the YW advised the SC that the police had been contacted. SC1 reportedly climbed down from the roof and ran to the vacant house across the road. “The police showed up… I told them to check the house across the road and that is where he was found still chroming. He was disrespectful and argumentative towards the police. The police had to lift his shirt up to check for paint…he refused.”

Whilst QPS officers are regularly called to provide assistance to YWs and/or respond to other disturbances brought about as a result of a young person chroming, it is understandable that in some instances QPS may not be in a position to respond as is demonstrated by this entry in the case notes for SC2:

“CSAHSC and police called each time [SC2] absconded, workers spent entire day trying to encourage to return. Police stated too busy to be returning [SC2] home.”

Under the CPA, a police officer may take a child under the age of 12, who is at risk of harm, to a safe place. Therefore, this legislation may be applied to children and young people who are involved in chroming/VSM provided they are under 12 years of age. While the act of chroming is not illegal (thereby limiting the action to be taken by QPS), the Police Powers and Responsibilities Act 2000 does allow for a police officer to confiscate volatile substances being misused or reasonably suspected of being misused for the purposes of inhalation. Many of the examples

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57 SC1 CSS records
58 RCF2 Incident Report included in SC1 CSS records
59 RCF2 Incident Report included in SC1 CSS records
60 SC1 CSS records
61 SC1 CSS records
62 SC2 ICMS printout

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above reflect QPS’s use of these powers, particularly QPS involvement in confiscating volatile substances.

### 3.1.3 Queensland Ambulance Service

As noted above, chroming can have a significant impact on a young person’s health and wellbeing which is why QAS should be involved in an immediate response to incidents involving chroming where the young person’s wellbeing is at risk. For example on one occasion, RCF2 workers sought assistance from QAS for SC1 who had ‘heart problems’ as a result of chroming. As already noted above, heart palpitations is one of the common side effects of chroming, therefore it is important that carers are aware of the importance of seeking QAS assistance when a child or young person has been chroming.

CSS records for SC1 provides that following this incident, his CSO confirmed with RCF2 that:

“...if [SC1] does present as under the influence police and paramedics should be contacted immediately on every occasion. The health risks to chroming are high and unpredictable. Confirmed that paramedics will be contacted immediately and [SC1] will always be medically assessed”.

In a case note by a Zonal Director involved in SC1’s case, it provides:

“As it is not illegal to chrome, police have had little involvement... the CSSC had established a plan to summon an Ambulance every time [SC1] presented under the influence. This occurred numerous times and on almost a daily basis for some weeks early in departmental intervention”.

Once again, these examples also highlight the importance of early intervention and prevention strategies to help address a young person’s involvement with VSM, so that QAS resources are not unduly impacted upon by responding to incidents of children and young people affected by VSM.

### 3.1.4 Education Queensland

It is noted that both SC1 and SC2’s chroming adversely impacted on their attendance at school. Some examples taken from SC1’s case notes provide:

**Example 1**

A meeting was held regarding the service delivery needs of SC1, with notes from the meeting providing:

“Education Queensland (EQ) —...Recently SC1’s behaviour has deteriorated due to substance abuse. School is hoping for Evolve assistance in transitioning [SC1] to work or TAFE.”

Due to SC1’s intellectual impairment and his chronic addiction to chroming it was always going to be difficult to cater for SC1 in the educational stream. While SC1 had previously attended special education units, as he got older this no longer appeared to meet his needs.

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SC1 CSS records
Refer to Chapter one of this report
SC1 CSS records
SC1 CSS records
SC1 CSS records
SC1 CSS records
Example 2

SC1’s CSS notes state that SC1 was enrolled to attend school, but due to his VSM, he had been suspended for a number of days. Re-entry to school was discussed. However, it was identified that SC1’s educational needs were unlikely to be met through the structured education setting.

In the case of SC2, a DET representative was on the Evolve panel. However, other than a notation that SC2’s school was to notify RCF1 if it became aware of SC2’s substance use, there is no other information to indicate what other actions were required of DET.

Other than providing drug education programs within the school environment and school counselling services, DET was largely unable to cater for the specific needs of SC1 and SC2 and their involvement with chroming. One of the common causes for children in care chroming is boredom and lack of diversionary activities, so if the child cannot be catered for in the mainstream education system then this may indirectly impact on the child’s ability to stop chroming and may also add to the child’s low self esteem.

None of the information provided to me indicates whether SC1 or SC2 had an Education Support Plan (ESP). However, there is information that SC2’s CSO had requested that her school prepare an ESP but no other additional information to indicate that this occurred or the contents of the ESP.

3.1.5 Disability Services Queensland

Given SC1’s known intellectual impairment, it was appropriate for CSS to seek support and assistance from DSQ. Officers from DSQ, RCF2 and CSS took part in a case plan review for SC1 and emerging from this process were the following actions:

- encouraging SC1 to engage in appropriate social networks and activities, and
- attending a support program to assist SC to cease his offending behaviours

DSQ was also part of the Evolve panel for SC2 and appear to have been involved in providing education on substance abuse to SC2. As there are references in SC2’s case notes that she had no understanding of the effects chroming had on her health and wellbeing, it was appropriate for SC2 to be provided with this education.

3.1.6 Queensland Health

As noted above, at the time SC1 came into care, he already had a medical history of having suffered a stroke. SC1’s case notes also indicate that SC1 was underweight and suffering from stomach aches, headaches and heart palpitations; which are all noted side effects of chroming. Likewise, information held in relation to SC2 provides that some of the symptoms she was experiencing included frequent headaches and stomach aches.

Given the unpredictable nature of known side effects of chroming on a young person’s health, it is very important that young people involved with chroming receive regular medical monitoring and intervention and that health providers are fully informed as to the young person’s chroming misuse.

Each child who is placed in care is required to have a Child Health Passport (CHP) which includes a comprehensive health assessment and health plan with

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69 SC1 CSS records
appropriate follow up of any identified health needs. While it is noted that RCF2 was to ensure SC1 attended his medical appointments, none of the records indicate whether he had a CHP. While there is evidence contained in CSS’s records regarding SC2 of her having a CHP, it is noted that there is no mention of her suspected involvement with chroming contained in her CHP.

It is known that both SC1 and SC2 did receive a range of health services from QH. The following are some examples of the provision of health services to SC1 and SC2:

**Example 1**
CS’s records regarding SC1 state:

“\[SC1\] has been transported by police to [a QH public hospital] on a number of occasions…the hospital has made no referral for [SC1] to attend [a Queensland Health run therapy service].”

**Example 2**
At one stage, SC1 was conveyed by QAS to a public hospital emergency department. However, CSS notes state:

“I said to the nurse what is the point of waiting in the room if he would not be monitored constantly. She said if he was 17 and not in care he would choose to leave himself. I rang ‘on call’ to seek advice on whether we could leave, as [SC1] was hungry and thirsty. On call seeked [sic] advise [sic] and informed me that if I wanted to monitor him at home then we could leave. I spoke to the nurse and she said they cannot detain him so we left.”

There is another reference in CSS’s records for SC1 which indicate that when taken to hospital suffering from the effects of chroming, hospital staff usually periodically monitor SC1 over several hours until he is allowed to leave.

**Example 3**
SC1 was going fishing with his YW during which time SC1 went to the toilet and emerged with paint and a bottle for chroming. The YW proceeded to drive SC1 to the hospital, during which time SC1 continued to chrome with the bottle being held under his shirt.

**Example 4**
SC2 was taken to hospital after having ingested dishwashing liquid and pen ink. SC2 was assessed as having no mental illness and therefore no mental health treatment would be required.

**Example 5**
SC2 was transported to the local hospital after threatening to kill herself. SC2 was considered to be a low to moderate suicide risk and was subsequently released from hospital.

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70 SC1 CSS records
71 SC1 CSS records
72 SC1 CSS records
73 SC1 CSS records
74 SC1 CSS records
75 RCF2 Incident Report included in SC1, CSS records
76 SC2, Department of Families records
77 SC2 CSS ICMS records
**Example 6**

CSS’s records regarding SC2 state:

> “Assessment by [medical practitioner]…as [there being] no evidence of acute mental illness. [SC2’s] presentation is in keeping with the developmental disruption commonly seen in children with a history of chronic relationship trauma. No medication due to absence of psychiatric symptoms.”

Frontline-staff delivering health services to children in care who are chroming need to consider whether the needs of the child could be better met by an appropriate referral for other medical intervention and or therapeutic support. None of the records in my possession indicate whether this already occurs on a consistent basis.

It is important that every child in care who is or has been involved in chroming has a CHP so that an appropriate health plan including regular health checks, medical monitoring and intervention is established.

### 3.2 Identification of service delivery issues

CSS has primary case management responsibility for relevant children and young people in care which includes appropriate case planning and suitable placement environments. My review of the service delivery provided to SC1 and SC2 identified a number of broad issues in relation to these responsibilities which require specific attention and corrective action.

#### 3.2.1 Case planning: appropriately assessing and responding to the ‘needs’ of the subject child

My review has revealed that children who are living in care and who are involved with chroming will often present with an array of complex emotional, physical and psychological care needs. It is therefore important that a holistic and coordinated cross-agency approach is taken when delivering services to this cohort of children.

In order to provide effective services to a child in care who is chroming, it seems vital that an early assessment of the child’s needs, the presence of any intellectual impairment and/or behavioural problems, past traumas and any possible stressors or triggers impacting upon the child’s life are identified and considered as part of the child’s initial and longer-term case planning. Where necessary, appropriate support services need to be quickly identified and referrals made so that services are made available to the young person on a regular and ongoing basis. Ineffective and ill-informed intervention with young people in care who are chroming may lead to further disengagement by the young person, an increased sense of guilt and shame, as well as regression by the young person.

Meeting the individual needs of a young person involved in chroming will also be dependent on the young person’s CSO having a good knowledge of referral pathways for relevant support services.

Table 1 provides a succinct summary of the available information in relation to the assessments made concerning SC1.

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78 SC2 ICMS print out
79 SC2 ICMS print out
### Table 1: Summary of subject child 1’s ‘needs’ assessment

#### Assessment made

**Historical information obtained by CSS:**
- SC1 attending Special Education Unit (attended special education units during primary and secondary schooling)
- Delays in language, perceptual skills, motor skills and academics; oppositional behaviour and poor on task behaviour; testing generally supportive of a diagnosis of developmental delay
- SC1 referred for psychiatric assessment; Dexamphetamine prescribed due to “explosive/impulsive behaviour at home and school”

**Current:**
- Identified as having developmental delays including:
  - An intellectual impairment
  - Requiring assistance with daily life skills and self care. SC1 requires prompting to shower and attend to hygiene requirements, and
  - “requiring constant one-on-one supervision for most of his time in care. Over the last four weeks, he has also required constant supervision for the safety of others in addition to himself.”

**Concerns identified included:**
- Previous suicide attempt by SC1
- SC1 crying and missing his parents and siblings
- SC1 stated he did not want to be placed with RCF2 anymore
- SC1 wants his motorbike fixed as he is missing out on what is an enjoyable activity for SC1
- At times SC1 becomes lonely and bored, and then becomes angry and breaks things due to the boredom
- Concern about SC1’s health: SC1 complaining about headaches, nausea, pale, head spins, extremely underweight for his height
- SC1 associating with another YOUNG PERSON who lives in the same street, “being goaded …to smash and break property…”, and
- Concern about SC1’s wellbeing over the Christmas period.

**SC1’s case notes also contain the following information:**
- It was likely SC1 would return to his parent’s care after he had been provided with rehabilitation and detoxification services
- The only strength identified for SC1 was his family/origin relationships
- SC1 to be referred to the Child Youth Mental Health Service (CYMHS) for support and counselling regarding substance misuse
- CSS to ensure SC1 attends counselling
- RCF2 to ensure SC1 attends medical appointments
- RCF2 workers to attend a substance abuse program, and
- CSO had arranged for ‘Drug Arm’ to facilitate an education session for YWs regarding behaviour management strategies for people who chrome.

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80 SC1 CSS record
81 An intellectual impairment is characterised by “significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills. This impairment originates before age 18.
82 SC1 CSS record
83 SC1 CSS record
CSS has advised that the target group for referrals to Evolve is children and young people in care with severe psychological and behavioural problems. Severe psychological and behaviour problems are defined as those which significantly impact on daily functioning and developmental needs. While SC1 was referred to Evolve in an attempt to respond to his challenging needs and behaviours, the case notes indicate that he did not meet the criteria to enable admission to the Evolve interagency program.

The above assessments do not appear to provide for any early intervention or support services in relation to known past sexual abuse (which may have been one of the underlying reasons for SC1’s increasing display of sexualised behaviours). As SC1’s sexualised behaviours were closely linked to his chroming misuse, appropriate support services focused on addressing this past abuse should have been included as part of his long term case planning.

The records in my possession do not indicate what ready access SC1’s case workers had to necessary information that may have helped direct the case planning for SC1 (refer to the information contained in Chapter One of this report). Furthermore, an apparent absence of any specific policies and/or guidelines by CSS in relation to responding to the care needs of children involved in chroming (other than the Evolve interagency program) would have also added to the difficulty in ensuring SC1’s case planning was appropriate and targeted towards obtaining the best possible outcomes for him.

I am also concerned that there was a lack of intervention strategies to address SC1’s intellectual impairment. While it is noted that SC1’s school was looking to Evolve to transition him to work or TAFE, it is unclear what other options were canvassed in relation to addressing his intellectual impairment. Once again, providing a young person with meaningful activities can be instrumental in helping address their involvement with chroming.

For SC1, being placed in the care of CSS was primarily due to his involvement with chroming and his associated challenging behaviours. However, it became increasingly apparent that being away from his home and family was in fact a stressor in SC1’s life, which as research indicates, can be one of the many reasons a young person may continue to chrome. While it is noted that SC1’s case plan included ‘home visits’ this was on the proviso he wasn’t intoxicated, which posed a problem given his excessive involvement with chroming. It was therefore imperative that SC1’s case planning included him receiving the support he needed to enable him to appropriately address his inhalant misuse.

For SC2, a background of neglect, sexual abuse and having been exposed to domestic violence and substance abuse (SC2’s mother was a chronic substance abuser) and separation from her family were all factors which required early assessment to determine the impact these factors posed to her ongoing health and wellbeing, particularly given her young age at the time she entered into the care of CSS. SC2’s case notes appear to indicate that it was not until fresh allegations of sexual abuse were made approximately five years later that CSS referred SC2 to Evolve for therapeutic support given her inappropriate behaviours towards males of an older age, past history of sexual abuse and self-harming. Through Evolve, SC2 was also linked with a psychiatrist who eventually diagnosed SC2 as having a “Major Mood Disorder”. Other symptoms reported were low energy, initial insomnia, irritability and sadness.
The following entries are taken from SC2’s case notes:

- SC2 was experiencing headaches and frequent mood fluctuations.
- YW concerned SC2 at risk of suiciding at which point police were contacted.
   On one occasion, suicide risk management form was completed in relation to this incident and included the following information (in part), “all substances that were potentially able to be sniffed – aerosols, nail polish and remover - have been secured by youth workers.”
- A short time later, SC2 was identified as having a “conduct disorder identified in a report by Evolve therapist ... aligned with contextual factors including removal from home, sexual abuse, inadequate parental supervision, institutional upbringing, emotional neglect and contextual factors.”

Case notes for SC2 provide that there were a number of reported concerns that SC2 was involved with chroming. The manager of RCF1 advised a CSO that one of the said concerns for SC2 was chroming. The manager advised that whilst no-one had actually witnessed SC2 chroming, there were a number of behaviours being exhibited by the child “that were those of the aftermath of chroming - self-harm, suicidal ideation, disordered.”

A case note in relation to a case planning meeting, provides that “all participants agreed that [SC2] requires a coordinated approach to behaviour management and individual therapy. The placement providers agreed to work with the Evolve team to implement behaviour management strategies”. The case notes do not indicate what action was taken by the CSO in response to the possibility that SC2 was chroming.

A psycho-therapist employed by RCF2 again raised a concern with CSS that “[SC2] continues to chrome and has not received appropriate support services to address this issue”.

While it is acknowledged that the immediate safety and wellbeing of the young person requires interventions/strategies that are a form of ‘first response’, longer term planning which includes a well coordinated multidisciplinary and cross-agency response is also necessary to effectively address the underlying factors impacting on the young person’s chroming (e.g. past sexual abuse, exposure to substance abuse, intellectual impairment and other known stressors).

### 3.2.2 Management of risk factors for children in care who are chroming

Based on my analysis of SC1 and SC2’s case notes, and the cases of SC3-SC7, it is noticeable that children who are living in care and involved with chroming, are predisposed to an array of significant risk factors such as absconding, behavioural issues including violence and sexualised behaviours. The appropriate management of these risk factors is therefore seen to be a fundamental component of addressing the child’s involvement with chroming.

Table 2 provides a brief summary of the information contained in the case notes for SC1 and SC2 in relation to the presence of these risks factors.

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84 SC2 Department of Families record
85 SC2 Department of Families record
86 SC2 Department of Families record
87 SC2 ICMS print out
88 SC2 CSS FAMYJ & CPIS record
89 SC2 FAMYJ & CPIS record
90 SC2 CSS records
Table 2: Risk factors in subject child one and subject child two's case notes

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Subject child one</th>
<th>Subject child two</th>
</tr>
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</table>
| Absconding        | • SC1 frequently absconded from his placements and often engaged in chroming during the periods that he was missing, which could be for up to six hours at a time.  
                    • He would often return to his placement under the influence of paint. | • “[SC2] has recently made some incorrect choices such as substance misuse, absconding, sexual activities, smoking.”  
                    • “It is suspected that [SC2] has been chroming whilst wandering … in the company of unknown persons.”  
                    • “It is suspected [SC2] is chroming (reported by members of the …Community) and has done so on occasions during her absconding from the shelter.” |
| Behavioural issues| • SC1’s behaviour would escalate when he was intoxicated due to chroming. He becomes physically violent and aggressive towards RCF2 staff when they attempt to confiscate SC1’s paint and or cigarettes.  
                    • One occasion he destroyed RCF2 property in his attempts to recover paint that had previously been confiscated and locked in the store room by YWs. | • History of extreme behaviours including defiance, aggression and emotional outbursts.  
                    • On one occasion, a doctor responded to SC2’s assault against a YW, whereby the SC ‘pushed’ the YW down the hallway. It is also reported that SC had pushed one of the YWs against a wall. “I’ve recently reviewed [SC2]’s chart because [CSS officer] requested some feedback and it seem(s) pretty evident that oppositional behaviour is a longstanding pattern for [SC2]…In particular circumstance (sic) the behaviour described wasn’t really outside adolescent norms, although I’m aware it can be.”  
                    • SC2 advised her CV that she ‘had committed a number of offences re. property destruction, vandalism and assault.’ |
| Sexualised behaviours| • “… it was reported that [SC1] had returned to his placement under the influence of paint. During the period he was under the influence, [SC1] became aroused and became very sexual towards another young person. [SC1] was later observed to be exposing himself to the young person. Police were called to intervene after [SC1] and the other young person refused to return to their | • the following information was documented about SC2:  
                    “I am not sure if you have been informed that there is information to suggest that [SC2] has been chroming [with the man she has been having sex with] and various others.” |

91 SC1 CSS record  
92 SC2 ICMS print out
The presence of these risk factors demonstrates the difficulty in responding to the needs of children in care who chrome. Many of these risk factors were also present for SC3 - SC7, which supports the suggestion that these risks factors are closely related to chroming. As noted previously, a number of the young people who formed part of my review were a risk to themselves, with several knowingly self-harming, some having suffered suicide ideations or attempted suicide and two having died due to a close link with chroming. This is very concerning and needs to be given careful consideration when determining how best to provide effective services to those children who chrome.

### 3.2.3 Recognising risk factors

To assist service providers in appreciating the importance of recognising these risks and how they may address them, I provide the following comments:

- Carers/YWs must have the requisite knowledge and skill to recognise that a young person’s chroming is often closely linked to challenging and high-risk behaviours. Training is also necessary for carers/YWs to enable them to provide protective barriers and to respond in a way that minimises adverse consequences.
- Chroming issues can take some time to rectify, and generally only with significant support and counselling by appropriately trained professionals and carers.

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93 SC1 CSS record
94 SC1 CSS record
risk factors such as undiagnosed personality disorders, avoidant coping strategies and attachment concerns are some of the underlying risk factors associated with substance misuse. Where a young person is under the influence of a volatile substance and is taking part in risk-taking behaviours, this may place the young person at greater risk of accidental death, or may form the basis of a suicide attempt. Requests for professional assistance should be an early response to help safeguard the young person’s safety and wellbeing.

The impact of chroming on a young person’s central nervous system may ultimately lead to changes in the young person’s ability to reason, to accurately perceive and interpret their surroundings, and their ability to rationally approach a situation. These factors in themselves, pose a significant risk to the child or young person who is chroming, as well as to the carer/YWs involved with supporting the young person.

Where a child or young person is known to be chroming, it is important that the young person receives regular health checks and health professionals are actively engaged in possible intervention and treatment options.

Where a young person presents to a hospital in response to health concerns associated with chroming, discharge or release should only be considered after there has been a holistic assessment made of the young person’s needs and necessary supports established.

It is important that residential service providers who are delivering primary care to children in care who are chroming, have appropriate policies and procedures in place to guide appropriate responses, and these are periodically reviewed to ensure they are in keeping with ‘good/accepted practice’, and

CSS’s and those RCFs who commonly provide care to children in care who are chroming, need to be well informed about those specific services/programs focused on assisting young people who chrome that are available in their area, what is required to access those services/programs and how to access other advisory services that can provide information to assist in case planning and the management of those common risks factors associated with chroming.

### 3.2.4 Suitability of placement

A careful and considered approach when placing children in care (with a known involvement with chroming) into an environment which will be conducive to assisting in the management of the young person’s chroming should be a critical first step. To do this, it is clearly important to have as much background information about the young person as possible. This includes information about the possible underlying factors as to why the young person may be chroming and resultant behaviours. Stability of placements and continuum of support services will factor highly in any success story. However, for this cohort of young people, placements will always be problematic due to their challenging behaviours and complex needs. It is accepted that the “ideal” placement may not always be available due to limited placement options to cater for these types of needs/challenging behaviours. As CSS’s Placement Services Unit (PSU) is now primarily responsible for locating suitable placements for children in care, it is important that CSO’s provide relevant information to the PSU in relation to a young person’s background, presence of challenging behaviours and known vulnerabilities/stressors.

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Even though sufficient information was held about both SC1 and SC2’s history of chroming, sexualised behaviours, aggression and other challenging behaviours, both experienced difficulties with their placements due to an inability by the RCF to cope with their high needs and contain their risk taking behaviours.

The following represents information contained in SC2’s case notes in relation to the concerns held by CSS officers about the suitability of her placement:

- A CSO noted, “there is a significant history of Matters of Concern in relation to [RCF1]. Although the nature of concerns has varied, there has been consistency in the poor skill level of the staff. There have been several dismissals resulting from poor practice. This is the responsibility of the organisation. There needs to be an improvement in employment practices and staff training.” 96
- “The manager advised that their service did not have any CSS guidelines in regard to behaviour management and that they were concerned about ‘inconsistencies in this regard.” 97
- A CSS officer completed a Matter of Concern assessment regarding RCF1 and documented that “on the whole…there were significant weaknesses in relation to the day to day management of children with challenging behaviours; staff were not sufficiently equipped with strategies to use when complex situations arise; staff were not sufficiently trained in implementing strategies that work long term…and operational procedures of RCF1 were not sufficiently effective to manage two children with complex behaviours.” 98

Whilst these records clearly provide that CSS officers held concerns about RCF1’s ability to provide an appropriate standard of care for SC2, there is an absence of information to state what support was offered/provided by CSS to help address the deficiencies.

There is information to indicate that RCF1 was an unlicensed facility at the time SC2 was placed there. CSS has advised that it considers children can be placed with an unlicensed provider pursuant to s. 82(1)(f) of the CPA. 99

However, for placements made under s.82(1)(f) of the CPA, there is an expectation that the CSO has considered (the facility’s) policies of behaviour intervention/management, recruitment and selection, and Matters of Concern. CSS’s licensing procedures requires active involvement by CSS with the RCF to ensure that the RCF is able to meet the Standards of Care in the CPA, as well as the minimum CSS standards. If there is a breach of those standards of care, then the RCF’s licence can be suspended and thus children cannot be placed with them.

Whilst the fact that a RCF is licensed is no guarantee of its ability to provide quality care, the fact that it has already been through the licensing process is a way of ensuring that appropriate consideration has been given to whether the RCF is aware of its service delivery expectations; the experience, skills and personal development of its staff; and the existence of appropriate policies, processes and guidelines in relation to such issues as behaviour management and crisis response.

96 SC2 ICMS print out
97 SC2 FAMYJ & CPIS print out part 2
98 SC2 ICMS print out
99 Section 82 (1)(f) of the CPA provides that the chief executive may place the child in the care of an entity if the chief executive is satisfied that entity would be the most appropriate for meeting the child’s particular protection and care needs.
It is noted that RFC1 had come to the attention of CSS’s assessors during the interim licensing period and that its behaviour management policies were lacking in detail. A Senior Practitioner had assessed that a majority of the issues in respect of RFC1 related to systemic issues (both within the care facility and CSS) as opposed to the particular decisions/actions/inactions of individual workers.100

Other factors that may also impact upon a placement decision include the location of the placement to possible linked services/supports and/or possible risks (e.g. hardware store within easy walking distance to a placement), mix of other young persons residing at the placement (e.g. other known young people who chrome), youth workers experienced in caring for young people with high care needs/behavioural issues/addictions and the ratio of youth workers to young people (availability of one-on-one care). Where appropriate, consultation should also be made with family members, previous carers, other professionals and known supports.

SC1’s regular absconding, ability to readily access inhalants for chroming and the risks to himself and others as a result of his chroming, led to considerations about what may be a more suitable long term placement option. It is noted that a CSS ZM made the following statement regarding future placement options for SC1: 101

“...the CSO and RCF2 workers have discussed the possibility of a placement in a house in a rural area away from the wider community. In effect, this will limit [SC1]’s access to therapeutic services, however he has not been accepted by any other agencies to this point and his relative isolation may assist in reducing his risk to himself and others.”

However, this needed to be assessed in light of the fact that being away from his home and family was a well known stressor in SC1’s life, which, as research indicates, can be one of the many reasons a young person may continue to chrome.

Likewise, a placement away from her home community, but with supportive contact to occur with friends and family was also considered for SC2. One of the reasons for this was that SC2’s family was considered to be un-protective and modelled different social norms and expectations including acceptance of drug use and teenage pregnancy, rather than discouraging them. However, when CSS was attempting to place SC2 it was recognised that it would be difficult separating SC2 from her community in order for her to make gains with social opportunities.

In summary, the following comments may provide some assistance when determining the suitability of a placement for children with complex needs and other issues such as chroming:

- the experience of and skill mix amongst staff/YWs employed by the RCF
- existence of policies, procedures and guidelines by the RCF that help guide the type of care and responses when dealing with “high needs” young people
- whether the service provider is licensed
- the physical location of the facility, i.e. readily located to linked services and other supports

100 SC2 ICMS print out
101 SC1 CSS case notes
any prior “Matters of Concern” in relation to the placement
whether the facility has provided care to another child or young person in similar circumstances – was this successful, any improvements made to better cater for future care to this cohort of young people
possible risks associated with mix of other young people currently placed at the RCF
what diversionary activities is the facility able to offer
what education options are available for the child or young person
what support is available in the local and/or surrounding community, and
ability to maintain links to family and community, particularly where cultural considerations apply.

Through the Commission’s complaints function I have also become aware of a number of ‘high needs’ young people who, when placed in care had no prior history of chroming but became involved once they started mixing with other young people involved with chroming and placed with the same carer/RCF.

3.2.5 Availability and acceptance for support programs/services
The following information taken from the case notes for SC1 provides details of the numerous and varied attempts made by CSS officers to obtain much needed professional assistance in an attempt to address SC1’s behaviour and chroming.

<table>
<thead>
<tr>
<th>Subject child</th>
<th>Attempt made</th>
</tr>
</thead>
</table>
| SC1           | Prior to SC1 being placed in emergency accommodation with RCF2, a number of (unsuccessful) attempts had been made to engage SC1 with a number of substance withdrawal programs
As a result, it was eventually determined that SC1’s parents were unwilling and unable to care for him due to his ongoing substance abuse and challenging behaviours. CSO1 noted that she contacted three services in order to obtain assistance for SC1; however on each occasion she was advised by the services that they were unable to assist.
CSO1 attempted to refer SC1 to an interagency support service, but was informed it was unlikely that SC1 would meet the criteria to access these services.
“RCF2 workers again asked for support, assistance and education on chroming and responding and managing [SC1]’s complex and challenging behaviours. The CSO informed workers that she was still attempting to locate support.”
SC1 was eventually accepted into the substance withdrawal program but he only lasted three days of the 11 day program as the program could not cater for his smoking habit. The CSO noted that SC1 was ‘unwilling’ to stop smoking, and therefore it was considered that there were limited options 102
“[SC1] has been transported by police to a [public hospital] on a number of occasions… the hospital has made no referral for [SC1] to attend [QH run therapy service].” 103

Given the lack of available professional support programs for chroming, it fell primarily to the RCF’s/carers to manage and provide frontline support to SC1 and SC2 in response to their chroming. The case notes for SC1 provide that after CSO1

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102 SC1 CSS records
103 SC1 CSS records
was unsuccessful in obtaining assistance from a number of substance withdrawal/support programs and that “…working with supervision and containment of [SC1’s] behaviours were priority considerations due to the lack of appropriate placement options and limited resources to manage the young person’s chroming substance misuse.”

The following notation in SC1’s case notes by a CSS Zonal Director reflects the frustration obviously felt given the limited options available for proper assistance for SC1:

> “The CSO and RCF2 workers have been attempting to contain and restrict [SC1’s] behaviours… the CSO has been attempting to balance the risk to [SC1]’s health and safety and the risk of [SC1]’s behaviours to the community… This has understandably been a most difficult and arduous task, particularly in view of the lack of support/assistance from other allied health professionals.”

Good communication between the case workers and the RCF is required to ensure that strategies intended to assist/address the SC’s needs are appropriate and regularly monitored to assess the effectiveness of the strategies included in the SC’s case/action plan.

There are numerous examples contained in the case notes for both SC1 and SC2 that demonstrate the advice provided to, and the various actions taken by, RCFs and youth workers in attempting to address SC1 and SC2’s chroming and resultant behaviours. Some of those examples include:

### 3.2.5.1 Subject child one’s case notes

#### Example 1

CSO1 has noted in CSS notes for SC1 that during SC1’s placement with RCF2 the YWs had been confiscating paint which resulted in SC1:
- becoming physically aggressive towards workers
- absconding from the placement only to return hours later affected by paint
- breaking down a door to the office where his paint was secured, and
- police being called on a regular basis to assist with the confiscation of SC1’s paint.

#### Example 2

It is noted that a YW from RCF2 attended a movie with SC1 in an attempt to divert SC1 away from chroming with the results of the outing being:
- YW advised that he had notified the ‘on-call’ person from RCF2
- “YW is hopeful [SC1] will come back inside when he runs out of paint. It is not clear how [SC1] obtained the paint”
- “YW advised to contact CSAHSC if assistance is required overnight with managing [SC1]. Youth worker will seek assistance from QPS if YP has an episode similar to previous night”, and
- the YW contacted CSAHSC and advised that SC1 was outside chroming and that he attempted to ‘coax’ SC1 inside, but that SC1 had refused. The YW
was advised to stay with SC1 and to keep him calm, and that if in three hours there were no signs of improvement, then police would be called.\textsuperscript{108}

**Example 3\textsuperscript{109}**

Staff members from RCF2 were asking CSO1 for assistance on how to manage SC1’s behaviours and his chroming. It is noted that SC1 entered the placement on an emergency care basis. CSO1 advised staff that they should contact police if SC1’s behaviours became aggressive, and to request SC1 be conveyed to a hospital for intake and assessment with the mental health unit, which the CSO noted she had contacted to advise of the possibility of this occurring.

**Example 4\textsuperscript{110}**

CSO1 made the following case notes in SC1’s CSS records, regarding the actions taken by herself and YWs in response to the service delivery needs of SC1:

- “In believing and working within a zero tolerance framework and keeping the child’s best interests as paramount [CSO] and [RCF2] workers have been attempting to balance the risk to the YP [SC1] and the very real risk to the community.”
- “With this in mind CSO workers have actively sought to contain and restrict [SC1]’s behaviours. In no way have CSOs or workers condoned, encouraged, supplied or purchased paint or cigarettes for [SC1].”

Additional issues identified by CSO1 include:

- RCF2 support was only meant to be short-term
- SC1 would become aggressive towards workers when they attempted to remove paint from him. On one occasion, SC1 broke a door to obtain paint from a locked room, and
- SC1 would abscond from his placement and return hours later under the influence of paint.

**Example 5\textsuperscript{111}**

CSO1 documented the following ‘placement agreement’ and interventions for SC1 during his time at RCF2, including:

- RCF2 staff asked if they should be taking SC1’s paint. CSO advised that they should do whatever they thought necessary at the time, with their safety being paramount. Hand written note states that this includes confiscating paint.
- SC1 able to visit family on Fridays and phone the family at any time. However, in both instances, SC1 is not to be affected by paint.
- RCF2 staff requested support, education and training regarding chroming and dealing with SC1’s behaviour.
- CSO1 notes that SC1 had been advised that if he continues to chrome, police will be phoned and he may go to hospital or jail.
- CSO advised SC1 that if he absconds a car may hit him and therefore she confiscated his bike.
- SC1 was told that if he continues to chrome, he will die.

**Example 6\textsuperscript{112}**

The following intervention plan was developed by CSO1 and RCF2 staff for SC1:
• “RCF2 workers, [SC1] and CSO1 all agreed that [SC1] would relinquish any paint he had at 5:00 pm every day to workers. [SC1] agreed. The paint would be locked away for the night. The following morning a change in shift occurs at 8:15am, it was agreed that the day’s activities would be planned at this time if [SC1] had not absconded and been chroming.”

• “CSO has not had the opportunity to make referrals for [SC1] to attend [an appropriate mental health support service] or provide him with educational options in his current area due to being provided with no information regarding transition dates…”

In an attempt to provide some guidance and direction to RCF2, CSO3 provided the following direction to RCF2 for implementation: 113

- “no illicit drugs are allowed on premises
- all children and young people with substance abuse issues must be referred to drug and alcohol treatment services. Referral to drug and alcohol treatment will also be measured as part of the quarterly data collection that monitors improvements for children and young people in residential care.
- children and young people are not permitted to have any non-prescribed inhalants in their possession or use such inhalants in residential care facilities. Items which are essential to the day-to-day operation of the residential service and which could be used by clients as inhalants are to be securely stored
- strategies relying on passive observation of clients using substances are not permitted
- staff are expected to do everything reasonable and consistent with safe work practices to stop young people from using non-prescribed inhalants, to remove inhaling implements as soon as possible, and to reinforce that using non-prescribed inhalants is not permitted
- in situations where children and young people present to the residential care facility in a substance affected state our duty of care remains to ensure that they are appropriately assisted. This includes seeking medical intervention where required and monitoring the young person’s wellbeing, and
- due to the health risks associated with chroming, I would recommend that paramedics be called on every occasion when [SC1] appears affected by the substance. If you are aware that [SC1] has paint in his possession, and [SC1] is unwilling to surrender paint, could you please contact police for their assistance and support in the removal of the paint.”

Example 7 114

In an attempt to prevent SC1 from chroming, the YW had taken him for a drive. However, upon their return to the placement, SC1 did in fact abscond for the purpose of chroming. SC1 was later located by his YW chroming on the street outside the placement. SC1 then moved to the road advising the YW that this was not in the premises. However, the YW advised that this was still not allowed. The YW advised SC1 that he was going to call the police, at which stage SC1 picked up a piece of timber. He eventually handed over his paint and the bottle he had used for chroming and went to bed.

113 SC1 CSS records
114 SC1 CSS records
3.2.5.2 Subject child two’s case notes

Example 8

It is noted in SC2’s case notes, that RCF1 advised CSS of the following information:

“In regard to sniffing claims, we have always approached [SC2] sensitively and in private – as you know, unfortunately when workers try to bring up the subject, [SC2] erupts in violent anger that ‘I do not sniff’”.

“When [SC2] first came into our care, we were directed to dissuade [SC2] from chroming behaviours and were also directed to remove any substances that [SC2] may use for this act. Since [SC2] has been with us, workers have found many instances of acquired bottles of liquid paper, nail polish and remover, glue sticks, aerosols etc. At one point, in her bathroom, after removal of such items, workers found cotton buds that had been dipped in the contents of the toilet bowl “blue” liquid. It was this night that workers found faeces all over the bathroom walls and bench tops. Since this incident, [SC2]’s nail polish and texta pens have been removed from her room, however when [SC2] requests her nails to be polished or to colour in, a worker either helps her to paint her nails and therefore makes it into an event for the girls, or is supervised in using the pens and they are put away. I also note that at times of [SC2]’s erratic behaviour, workers have found implements for chroming in her possession. If you disagree with our program, we will of course, be directed to return some/all of these items to [SC2]’s bedroom.”

Example 9

SC2’s notes state that a male YW was driving to work when he was contacted by a colleague who advised that SC2 had broken a window and assaulted a female YW. The male YW arrived at the residential care facility and located SC2 under a table. The male YW attempted to remove SC2 from under the table, during which time SC2 began to hit the male YW in the chest and pull his hair. CSS notes state (in part):

“YW believes that [SC2] was under the influence of a substance and her behaviour was indicative of such use given paint had been found it was possible she had been chroming. YW said that [SC2] had been displaying erratic behaviour prior to the actual events.”

The RCF responded by YWs counselling SC2 and ensuring “all substances are now lock [sic] away in a large metal chest until workers believe that [SC2] will not take advantage or misuse them. [SC2] will be constantly monitored and counselled in regard to these problems.’ It is understood that SC2 had indicated that her behaviours had been associated with the fact she had been missing her family.

Example 10

The manager of RCF1 advised CSS that staff only use restraint as a last resort when responding to her frequent violent outbursts and in a crisis situation. The YWs attempted to dissuade SC2 from this course of behaviour. However, chroming issues take some time to rectify and only with much support and counselling.
Example 11

A plan was devised for SC2’s care over an Easter period. The plan provided that staff were to be aware of the environment when SC2’s behaviour escalates, e.g. being aware of knives, medications, detergents. Otherwise, QPS was to be contacted so that SC2 could be taken to hospital for a mental health assessment.

These examples clearly demonstrate the extreme difficulty in providing assistance to young people in care who are chroming. The lack of availability of professional support services/programs and or allied health professionals appears to often result in inadequately trained and skilled YWs having to take an ad hoc and mostly reactive approach to dealing with the behaviours associated with chroming, often with adverse outcomes for themselves. The most common result is that intervention by QPS officers and health professionals including the QAS is required.

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118 SC2 CSS records
Chapter Four: Current Service Delivery Framework

In this chapter I seek to address the following terms of reference:

- Identify the systems, policies and practices of CSS and other relevant service providers for delivering services to children in care who are chroming.

- Determine the appropriateness and implementation of these systems, policies and practices (at both an individual and cross-agency level) for promoting and protecting the rights, interests and wellbeing of children in care who are chroming.

Delivering services to children in care who are chroming is a complex, challenging and multi-faceted process. The child’s on-going safety, health and wellbeing will be largely dependent on a robust system that provides for the delivery of effective support services and interventions (with a focus on prevention and early intervention) that will lead to improved outcomes for the subject child.

My review of the appropriateness and implementation of the current framework for delivering services to children in care who are chroming was assessed against the services provided to both SC1 and SC2 as discussed in Chapter Three. My review also identified a number of underlying systemic issues that impacted on the delivery of services to both young people. Rectifying these issues will require a systems approach focused on improving practice particularly in the areas of assessing and responding to the immediate and long-term needs of the child, identifying suitable placements, a greater understanding of the risks associated with chroming and its effects and the availability of support from government, non-government and community based programs and services.

4.1 Background Information

4.1.1 Other previous learnings

In 2002, the Commission released a report titled, 'Volatile Substance Misuse in Queensland'. One of the learnings from the report was that in order to effectively address the issue of VSM (for young people), it is imperative to explore the reasons behind a young person’s involvement with VSM.119

The report also noted that in order to successfully address the issue of VSM intervention strategies would need to:120

- occur at a local and community level
- receive high levels of community support
- provide young people with alternative activities
- not marginalise young people who are involved with VSM
- limit accessibility of volatile substances, and
- provide counseling and support services that focus on the needs of the young person involved with VSM.

In 2008 the Australian Government released a report on VSM interventions. The report captured a number of significant factors that justify why chroming/VSM requires dedicated attention and the development of sustainable intervention strategies. These include:

- a large percentage of young people involved with VSM often present with a high rate of psychological disorders such as depression, anxiety, stress and poor self esteem
- young people involved with VSM are often disproportionately involved in crime and are more likely to be placed in detention than young people not involved with VSM, and
- VSM is often associated with future drug use (including cannabis and alcohol), childhood physical and/or sexual abuse and homelessness.

An article in an issue of the Medical Journal of Australia highlights the following concerns relating to inhalant misuse by children and young people:

- early adolescence is an age at which experimental VSM tends to occur. However, only a small number of these young people become regularly involved with VSM
- there is a lack of data and research regarding VSM amongst children and young people, including the limited availability of longitudinal data
- there is limited research available regarding the effectiveness and results of treatment that is based on best-practice evidence
- a national framework that is informed by research is essential, and
- coordination of local services needs to occur as a matter of priority.

4.1.2 Developing a service delivery framework

One of the key elements in the development of a framework to target VSM is the development of a coordinated strategy involving the skills and resources of key service providers, police, community agencies, local groups, schools and NGOs. The CMC also support this concept, having previously reported that no one agency should ever be solely responsible for the management of VSM.

For any framework to be effective it must also include the necessary education for those service providers responsible for the delivery of services under the framework. In the 2002 report, ‘Inquiry into the Inhalation of Volatile Substances’, prepared by the Victorian Drugs and Crime Prevention Committee, it was suggested that tailored education strategies should be developed for the following people/groups of people who are exposed to/or involved with VSM:

- some young people and adolescents
- schools
- professionals other than teachers and educators (doctors, nurses, social workers, youth and substance abuse workers)
- parents, guardians and caregivers

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123 “A service delivery framework is a set of principles, standards, policies and constraints used to guide the design, development, deployment, operation and retirement of services delivered by a service provider with a view to offering a consistent service experience to a specific user community in a specific business context” (http://en.wikipedia.org/wiki/Service_delivery_framework).
The need for RCF workers to be trained in how to respond to children and young people involved in chroming was a common theme identified in CSS records for both SC1 and SC2.

Another important element of any service delivery framework is the development of appropriate policies, procedures and guidelines that support the effective delivery of such services. I note that the Victorian Government has developed a number of policy and protocol documents to assist officers with providing services to young people who are involved with VSM.126

The 2006 Queensland Government Drug Strategy (QGDS) emphasises that while the government plays a crucial role in developing drug prevention strategies, a partnership approach with non-government agencies such as community, private sector, education research centres, prevention programs, and research is also crucial.127 Furthermore, the actual implementation of drug prevention strategies is highly dependent on the work of teachers, police, social workers, general practitioners, Indigenous health workers, mental health and health promotion officers.128

Lastly, as one commentator noted:

"Insistence by governments that communities must take ‘ownership’ of the problem should be replaced by a commitment to genuine partnerships involving government, non-government and community sectors.” 129

In Queensland, both government agencies and NGO’s are responsible for the delivery of services to children in care who are chroming. My focus has been to review the systems, policies and practices of the government agencies involved in the delivery of those services.

### 4.2 Current Service Delivery Framework

My review has revealed that there is a form of ‘whole-of-government’ service delivery framework for responding to the needs of children in care who are chroming which consists of:

- an ‘immediate response’ protocol between the Queensland Police Service (QPS) and the Queensland Ambulance Service (QAS) focused on protecting the immediate safety and wellbeing of children in care who are involved in chroming
- an interagency services program (Evolve Interagency Services) which provides therapeutic and behaviour support for children in care with complex and extreme needs, and
- an initiative known as the ‘Addressing Volatile Substance Misuse Initiative’ (AVSMI) which is coordinated by the Department of Communities (DOC) and

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126 See Part 4.3 of this report.
The AVSMI was introduced in 2006 by the Queensland Government as a whole-of-government response to the misuse of volatile substances, for example, chroming and petrol sniffing.

QPS letter dated 25 November 2008 DN 21334, reference number so cr 08/10232.

QPS letter dated 25 November 2008 DN 21334, reference number so cr 08/10232.

QPS letter dated 25 November 2008 DN 21334, reference number so cr 08/10232.

Queensland Police Service (QPS) and Queensland Ambulance Service (QAS) response to volatile substance misuse, included as Attachment 2 in QPS letter dated 25 November 2008.

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Queensland Police Service (QPS) and Queensland Ambulance Service (QAS) response to volatile substance misuse, included as Attachment 2 in QPS letter dated 25 November 2008.

4.2.1 Queensland Police Service

In response to my request for information, the QPS provided a detailed response which included information about a number of legislative, training and policy initiatives that have been undertaken in response to the issues of VSM. In particular, the response states (in part) that, “local protocols, standing operating procedures, action groups and resources have also been established in a number of areas throughout the State.” QPS also advised that it “has been an active participant in the whole-of-government response to volatile substance misuse (VSM) over recent years in conjunction with a wide range of other government departments.” The QPS response included a number of attachments containing specific information about its policies and procedures, a summary of which is contained in the following table.

Table 3: Summary of QPS policies and procedures relevant to VSM

<table>
<thead>
<tr>
<th>Title of attachment</th>
<th>Summary of main points</th>
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| QPS Operational Procedures Manual (OPM) (section under review at the time of receiving information) | - Information is available on the QPS intranet site in relation to VSM
- there is an option for officers/staff to provide comment and/or feedback in relation to the site
- OPM s. 4.14.3 ‘Potentially harmful things’ and s. 6.5.5 ‘Potentially harmful things – volatile substance misuse’ provides operational, in particular ‘first-response’ officers, with information to aid with their understanding of VSM as well as information to assist officers with responding to incidents of VSM
- a ‘web-based’ training package is also available to staff, and
- a VSM ‘Information Z Card’ is a resource that officers are able to access through the site. I have included a copy of the ‘Information Z Card’ as Attachment 1. |
| “Queensland Police Service (QPS) and Queensland Ambulance Service (QAS) response to volatile substance misuse” | - An ‘immediate response’ protocol was developed between the QPS and the QAS. The protocol includes information that police should know about VSM, including:
  - legislation
  - appropriate places of safety
  - risks of self-harm for users
  - types of VSM
  - reactions of VSM users to police including potential agitation and violence which in turn may lead to cardiac irregularity or sudden death
  - Officers should “have knowledge of referral pathways so that the reasons ‘why’ people misuse volatile substances can be addressed by appropriate agencies”.134
  - Protocol highlights that the role of the police is to maintain public safety and order. In performing their duties, officers are advised to remain aware of the |

130 The AVSMI was introduced in 2006 by the Queensland Government as a whole-of-government response to the misuse of volatile substances, for example, chroming and petrol sniffing.

131 QPS letter dated 25 November 2008 DN 21334, reference number so cr 08/10232.


133 QPS letter dated 25 November 2008 DN 21334, reference number so cr 08/10232.

134 Queensland Police Service (QPS) and Queensland Ambulance Service (QAS) response to volatile substance misuse, included as Attachment 2 in QPS letter dated 25 November 2008.
<table>
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| following factors when responding to VSM incidents: | - the least intrusive strategy should be the first response, and escalated as required  
- the local environment and conditions that the user is located in may require different responses, and  
- the age of person involved with VSM may (will) require differing responses |
| - pages 3-4 of the QPS/QAS policy contain information for frontline officers responding to a VSM incident, including: | - for police, the document requires that police assess the person’s medical risk and contact QAS if necessary  
- the QAS will attend and provide treatment to users of VSM in accordance with the QAS Clinical Practice Manual and the QAS Code of Practice  
- QAS officers are encouraged to discuss project DOV and any other services that could be provided to the patients and that they should obtain consent from the person to refer them to a project DOV coordinator \(^{135}\), and  
- there are two flow charts included with the policy - one that directs the initial response of QAS officers and the second that directs the response of QPS officers to incidents of VSM. Copies of these documents can be seen at pages 5 and 6 respectively of Attachment 2. |

| On line learning package – Volatile Substance misuse | - This package has been developed in conjunction with the Legal Services Branch and Training Support Program of the QPS. The program is designed to teach and assist officers to comply with legislation and operational procedures when dealing with people affected by VSM, and  
- the topics covered by the online package include:  
  - potentially harmful things (VSM)  
  - legislation  
  - what is a place of safety  
  - declared locality areas  
  - powers to search and seize  
  - powers to detain  
  - dealing with persons affected by a potentially harmful things(s)  
  - QPRIME, and  
  - scenario/questions. |

| Overview of information provided by the Drug and Alcohol Coordination Unit about VSM – available on the QPS Bulletin Board (intranet) | - This document includes information about VSM and its effects on people. It also includes information for officers to consider when responding to incidents of VSM  
- the policy discusses where a person is under seventeen, the officers should contact the parents or guardian, and  
- the policy has a very brief section regarding suggested actions officers should take in relation to moving children under the age of twelve to a place of safety. |

| Adolescent inhalant abuse: Data-based recommendations for | - QPS has included with their response, a copy of the executive summary for this article  
- the aim of the project was to utilise evidence to help |

\(^{135}\) Project DOV (Drug Overdose Visitation Program) was a program that enabled QAS officers when responding to someone who has overdosed the offer of a visit by a Teen Challenge councillor within 48 hours of the overdose. It is understood that program has now ceased.
### Title of attachment | Summary of main points
--- | ---
Enhancing Queensland Police Service response policy (Foote, Kate; Kelly, Adrian; Mazerolle, Paul; Bond, Christine and Cherney, Adrian (2007) Adolescent inhalant abuse: Data-based recommendations for enhancing Queensland Police Service response policy) | maximize the effectiveness of QPS responses to VSM incidents, and  
- refer to Attachment 3 which contains details of the research literature.

National Drug Strategy Law Enforcement Funds – Committee representative list |  
- the QPS Assistant Commissioner is listed as the Queensland Police Board representative.

### 4.2.2 Department of Communities - Child Safety Services
In its letter dated 5 February 2009, CSS provided me with the following information in relation to its service delivery to children in care who are chroming.

**Evolve Interagency Services - an interagency model**
In relation to Evolve, I was provided with the following information about this interagency service:

- “The Evolve Interagency Services program provides therapeutic and behaviour support for children in out-of-home care with complex and extreme needs
- The program includes therapeutic and behavioural intervention through Queensland Health (QH) Therapeutic Services Teams and Disability Services Queensland (DSQ) Behaviour Support Teams (Attachment 5 is a copy of the Information sheet for Evolve provided to me by CSS)
- The Department of Education Training and the Arts and the Child Safety Services participate in the program to ensure therapeutic and behaviour support interventions are sustained by appropriate educational support, suitable placement environments and appropriate case planning
- This program is currently provided across seven locations…. Any referrals are considered on a priority basis by an interagency panel. Children and young people accessing the service are supported for approximately 18 months and work toward specific goals to address challenging behaviours and build the capacity of the carers and other support agencies to better respond to the child’s challenging behaviours
- It has been identified that a significant proportion of children and young people accessing Evolve have highly sexualised and/or sexually abusive behaviours. It is recognised effective intervention with these children requires specialised knowledge and skills and Evolve is committed to improving responses to this cohort
- As part of improving responses to children with sexually abusive behaviour, the Evolve program has developed a project to map service delivery and training needs and options for staff, non-government
agencies and carers and develop recommendations regarding further development in this area.

- “The target group for referrals to Evolve is children and young people in care with severe psychological and behaviour problems. Severe psychological and behaviour problems are defined as those which significantly impact on daily functioning and developmental needs.”
- “Depending on the child or young person’s age, their developmental stage, history of abuse and neglect and whether they have a disability, problems can manifest in a range of ways including severe depression, self-harming, violence to others and property and sexual acting out.”

Key partners of the Evolve Interagency Services include:
- **CSS** which:
  - holds custody or guardianship of the child or young person
  - has case management responsibility for the child or young person
  - funds therapeutic and behaviour support services provided by Evolve Therapeutic Services teams (QH) and the Evolve Behaviour Support teams (Disability Services Queensland)
- **QH** which:
  - provides a therapeutic services team made up of psychologists, occupational therapists, social workers, nursing clinicians, Indigenous mental health workers and child and youth psychiatrists who “provide intensive mental health therapeutic interventions to children and young people who experience trauma related psychological and behavioural problems as a result of abuse and neglect”
  - QH teams have “evaluation, research and professional development coordinators who undertake research, training and practice supervision. Each team is managed by a team leader who is Queensland Health’s representative on the Evolve Panel.”
- **DSQ** which:
  - “provides behaviour support services to children and young people with a disability who have psychological and behavioural problems that have resulted from trauma from abuse and neglect and/or from having a disability.”
- **DET** which:
  - “supports the collaborative model of service delivery through linking therapeutic and behaviour support services with the Education Support Planning services which has been established to provide school based support and education services to children and young people in care.”

**Principles of the interagency model:**
- “Service responses are based on the goal of the best outcomes for the child or young person rather than the capacity or responsibility of each service system or department
- the team will embrace a culture of shared responsibility and ‘owning’ solutions through the development of networks and relationships, not just systems and processes.

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136 This project commenced in September 2008, and was due to conclude in February 2009. It was sponsored through the Child Safety Directors Network managed through QH, and its aim was to improve responses to children and young people "who engage in sexually abusive behaviours.'

137 Attachment 4 – Evolve Interagency Services Information sheet

138 Attachment 4 – Evolve Interagency Services Information sheet
a balance of ‘ground-up’ expertise regarding the particular needs and situations of the child or young person, with ‘top-down’ authority and expertise to consider and implement options and strategies

- effective communication between service providers across all departments/agencies and all levels, the child or young person and their support system is essential, and

- children who have been maltreated require specialised, sensitive and consistent care
  - the child or young person is considered in their social and cultural context and, whenever possible, interventions will focus on developing supportive social environments rather than on the child or young person in isolation, and
  - the views of the child or young person and their support system must be considered (including obtaining consent for information sharing and participation in care or treatment planning wherever possible)."

**Child Health Passports**

Child Health Passports (CHP) is an initiative by CSS which was developed in consultation with QH. The purpose of the CHP is to meet the health needs of children in care and to ensure children in care receive effective and coordinated health care. The initiative requires children entering care receive a comprehensive health assessment and health plan with appropriate follow up of any identified health needs. The CHP records the child’s health information and provides carers with the information they need to ensure that children receive appropriate health care and treatment throughout their time in care and improve their health and wellbeing. Implementation of CHPs began in January 2007 and it is noted that all children in care were to have a completed CHP by 2010.

CSS provided the following additional advice in respect of this initiative:

- “The Department is currently implementing Child Health Passports (CHPs) to identify and address the health needs of all children in out-of-home care. The CHP involves:
  - the collection of key health information regarding a child and relevant family history
  - a health assessment conducted by a health professional on an annual basis
  - the receipt of a report from the health professional regarding health needs and any follow-up required
  - addressing required health follow-up through ongoing case planning, and
  - the provision of relevant health records to the carer/s as a health record for the child as they move through the care system.”

- “The health assessment is an age appropriate check that covers a number of domains assessed by the health professional. These domains include:
  - physical and developmental assessments
  - nutritional assessment
  - immunisation status
  - vision, hearing and dental screenings
  - psychosocial and behavioural assessment, and
  - mental health assessment.”

- “This health assessment would be a process to identify and advise on appropriate health related responses to a range of behaviours, including use of illicit substances and sexualised/sexually abusive behaviour.”
Follow-up may include referral to relevant specialists and allied health services.” (more detailed information is included as Attachment 6)

Addressing volatile substance misuse initiative

In its response, CSS informed me of an initiative by the Department of Communities (DOC) which provides that in Queensland, DOC carries the primary responsibility for coordinating responses to VSM. Furthermore:

- “Department of Communities funding has been provided to the communities of inner-Brisbane, Logan, Mt Isa, Townsville, Cairns, Caboolture and Rockhampton to deliver services under an extended service model – the Addressing Volatile Substance Misuse Initiative
- This initiative provides safety and support services to young people who engage in, or who are at risk of engaging in, the misuse of volatile substances in the community. The initiative includes elements of recovery care and support, outreach services, short-term support to abstain from volatile substance misuse, case management services, diversionary activities and provision of advice, support and education to families, service providers and communities.”

4.2.3 Queensland Health

QH responded to my request for information, stating in part that it is “supportive of the whole-of-government response to addressing volatile substance misuse, and in particular the ‘extended service delivery model’ which replaced places of safety in early 2008.” Unfortunately QH has not advised me of its specific involvement in this strategy, or of any continuing work/strategies that it is involved with in this regard.

QH expands on the ‘whole-of-government’ model stating:

- the new model focuses on prevention and early intervention
- “the model includes supervision of rest and recovery for intoxicated young people, as well as case management, short and long-term individual and family support, outreach services, brokerage and diversionary activities for young people who are, or at risk of using volatile substances,”
- that the aforementioned approach will help service providers to address the underlying issues for children misusing inhalants.

With regards to policies, practices and procedures, QH has not provided any specific information that pertains to the delivery of services by QH to children in care who are involved with chroming.

However, it is pleasing to see that the current involvement by QH in the provision of therapeutic services to children and young people in care through the Evolve support services includes the provision of teams of evaluation, research and professional development coordinators who undertake research, training and practice supervision and that each team leader is QH’s representative on an Evolve panel. This sharing of knowledge can only help inform a good practice response in relation to the delivery of services through the Evolve program.

139 Letter from DG QH to CCYPCG, dated 19 November 2008, reference no. DG053158
140 Letter from DG QH to CCYPCG, dated 19 November 2008, reference no. DG053158
4.2.4 Department of Education and Training

As with QPS and QH, I invited the DET to contribute information that it deemed relevant to my review. The Director-General (DG) of DET responded by advising that there are currently no specific policies relating to children and young people who are involved with VSM. However, additional information was provided in relation to a number of other policies which was considered relevant to my review.

I was advised that DET’s ‘Student Protection Policy’ was revised in January 2008 and it includes a section on what actions staff should take when responding to children who are self-harming. “...sniffing/inhalation is a harm category identified on the ‘SP5: Record of Self-Harm or Risk of Self-Harm’ used by schools to report incidents of self-harm.” As part of completing the said ‘form’, school principals communicate with various other staff such as guidance officers, school nurses etc. based on the information obtained. However, DET does point out that the form itself is used for internal data collection purposes. Based on the collaborative input of the principal and other relevant school staff, a determination is made as to whether a referral needs to be made to services such as Child Youth Mental Health Services.

From a child safety perspective, DET advised that there is a requirement for staff to formally report concerns to CSS where a parent/carer is deemed to not be behaving protectively towards a child. DET advised that this avenue could also be utilised to report concerns about a child self-harming (including chroming and VSM), namely:

“The Queensland School Drug Education Strategy and Education Queensland’s Drug Education and Intervention in Schools policy assist schools to implement drug education programs that are relevant and appropriate to the needs of their students and school community.”

The policy requires that state schools develop a drug education program which includes the drug education priorities that will be addressed and the consultation processes that have been incorporated when developing drug education programs and procedures. DET advised that should chroming be identified as an issue for a child then it may be addressed through the school’s drug education program. I have also been advised that the said programs do not specifically address the needs of children in care; rather they focus on the risks associated with using illicit and non-illicit drugs including inhalants.

With regards to sharing of information and working collaboratively, DET advised that there are several policies including ‘Disclosing Student Personal Information to the Queensland Police Service (QPS)’ and ‘Information Sharing Under the Child Protection Act (1999)’. I am advised that these documents guide staff on the steps to be taken when sharing information with the QPS where a student has been harmed, or is at risk of being harmed. Nevertheless, I am advised that these documents do not specifically address or relate to the reporting of concerns regarding chroming.

DET’s response also included information about ESPs. The development of ESPs is a process undertaken in partnership with CSS. “ESPs focus on participation, wellbeing and academic achievement, and provide a process through which

141 Letter from Department of Education, Training and the Arts, dated 12 November 2008, reference 08/169772
142 In its letter to the Commissioner dated 19 January 2012, the Department of Education and Training advised that the Form SP-5 Record of Self-Harm or Risk of Self-Harm has been discontinued. Schools now make all reports of student self-harm, including chroming, where the parent/carer is not acting protectively on the SP-4: Report of Suspected Harm or Risk of Harm form.
143 Letter from Department of Education, Training and the Arts, dated 12 November 2008, reference 08/169772
education and child safety personnel can work collaboratively in the best interests of children in out-of-home care, including dealing with issues such as chroming.  

4.2.5 Disability Services Queensland

Included in the response from the DG of DSQ, was an acknowledgement of the importance of providing appropriate services to children in care who are chroming stating that, “chroming is considered to be most common in children and young people aged 11 to 14 and can sometimes lead to an acquired brain injury. Chroming is not considered to be a disability according to the Disability Services Act 2006, however, it is understood that some young children and people with a disability in care may engage with chroming.”

I was advised that DSQ does not have in place any specific policies, procedures or guideline resources that aid with the delivery of services to children and young people who are involved with chroming.

From a cross-agency perspective, I am advised by DSQ that, “Evolve Behaviour Support Services provide behaviour support services to children and young people in care who present with severe psychological and behaviour problems. These services are based on positive behaviour support, use a holistic approach and are provided within a collaborative interagency model. There may be some instances where the children and young people receiving Evolve services have participated in chroming.”

DSQ also advised that it has an MOU with CSS, which is designed to promote effective communication and a collaborative approach to service provision generally to children in care.

4.2.6 Department of Communities: The ‘Addressing Volatile Substance Misuse Initiative’ (AVSMI)

DOC’s response also expanded on its work concerning the Addressing Volatile Substance Misuse Initiative (AVSMI). DOC confirmed it responds to the needs of young people who are involved with chroming through its AVSMI. For a copy of the document ‘Addressing Volatile Substance Misuse (VSM) Initiative’, please refer to Attachment 7 of my report. More specifically DOC advised:

- the AVSMI is designed to tackle VSM through the support of police powers under the Police Powers and Responsibilities Act 2000
- the initiative enables police officers, in selected areas within Queensland, to respond to young people’s involvement with VSM
- the initiative targets 12-17 year olds in seven locations throughout Queensland
- “the policies and practices for dealing with children who are chroming are developed by the contracted non-government organisations to guide the work of their staff. These policies and procedures must be in keeping with information provided by the department about the funded service model.”

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144 Letter from Department of Education, Training and the Arts, dated 12 November 2008, reference 08/169772
145 Letter received from Department of Communities, Disability Services Queensland (DSQ), dated 2 February 2009
146 Letter received from Department of Communities, Disability Services Queensland (DSQ), dated 2 February 2009
“the Police Powers and Responsibilities Act 2000 provides a mechanism for police and service providers to work together. The Act provides police with powers to detain a young person and take them to a place of safety.”

the AVSMI ensures that places of safety are in fact available to police, in cases where family or friends are not suitable or available to provide care to the young person who is intoxicated

in the areas targeted by the AVSMI, service providers are encouraged to work with police and to develop appropriate referral pathways for young people who are intoxicated due to their involvement with VSM

DOC encourages ‘close links’, including the development of policies, with partner organisations. Also, DOC meets with service providers on an annual basis and has support staff located in regional areas

DOC provides funding to the non-government care agencies that respond to the needs of, including the delivery of services to, children who are involved with chroming

when the DOC receives notification of a child chroming, it refers the young person to a non-government support service and requests that the service investigates the issue and responds appropriately

when a child under the age of 12 comes into contact with a volatile substance misuse service, the child will be referred to CSS, whose officers will then take a key role in responding to the child’s needs, and

in 2008, a Service Department Workshop was held between DOC and service providers, during which a number of issues were discussed including improvements that could be made to service delivery on an ongoing basis.

More recently, the DG of DOC advised me that it will be conducting a review of the AVSMI, with a view to helping inform the future delivery of services in the following areas: Brisbane, Logan, Caboolture, Rockhampton, Townsville, Cairns and Mt Isa. I am pleased to report that two of my officers have been nominated to represent the Commission and to work as part of the project’s working group.

4.3 The Victorian framework

The Victorian Government has developed a number of policy and protocol documents to assist officers with providing services to young people who are involved with VSM. In summary, the Victorian Government has developed:

• a ‘chroming policy’ aimed at providing clear and consistent guidelines regarding the delivery of services to children in care

• a number of operational guidelines to help enhance the capacity of frontline officers to respond effectively to the needs of young people who use inhalants. An overview of the policy and guidelines is included as Attachment 8, and

• an Interagency Protocol between the Victorian Police and agencies nominated in the Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003 (Vic). The protocol aims to encourage a consistent and integrated service response to young people involved with inhalant misuse. A summary of the Interagency Protocol details is included in Attachment 9.

147 Copies of the Victorian Government documents are included as Attachments 8 and 9 in my report.
148 The Victorian Government’s, Department of Human Services Management response to inhalant use.
149 The Victorian Government’s, Department of Human Services Management response to inhalant use.
150 “Interagency Protocol between nominated agencies.”
4.4 Adequacy of the existing service delivery framework

4.4.1 Assessment of the existing service delivery framework

Based on the information above and outlined in Chapter Three of this report, I consider that the current framework for the delivery of services to children in care who are chroming provides for a collaborative interagency response and includes a form of ‘whole-of-government’ approach. In forming this opinion, I note the framework provides:

- a holistic approach in delivering cross-agency support services
- for an ‘immediate response’ protocol between QPS and QAS, the two agencies best placed to respond to ensuring the immediate safety, health and wellbeing of a child suffering inhalant intoxication
- a focus on prevention and early intervention
- for therapeutic and behaviour support services determined by a panel of professionals to address the often complex emotional, physical and psychological care needs of a child or young person who is involved in chroming
- services tailored to the individual needs of the child or young person
- teams focused on research and the provision of training and professional development
- educational support around inhalant misuse and targeted support programs
- an initiative (AVMSI) overseen by DOC (lead agency) to tackle VSM through the support of police powers and the provision of places of safety in cases where family/friends are not suitable or available
- a funding source to non-government care agencies that responds to the needs of children in care involved in chroming
- a referral pathway for non-government support services
- availability of support staff in regional areas, and
- an annual review process where service issues and improvements are discussed.

4.4.2 Possible improvements to the existing service delivery framework

Like any service delivery framework, its effectiveness will largely depend on the policies and procedures that guide and support it, the knowledge, skill base, experience, dedication and diligence of those officers responsible for the delivery of key services (particularly frontline officers) and the availability of resources.

With the exclusion of QPS, I found a general lack of policies and procedures by each of the service providers (who provided information for the purposes of my review) in relation to the delivery of services to children in care who are chroming. This may have contributed to some of the less than optimal service delivery provided to SC1 and SC2 by CSS and other service providers as discussed above.

The introduction of policies and procedures would need to focus on meeting the specific care needs of the young person and providing them with a suitable environment which:

- is culturally appropriate
- meets their educational needs
- is sufficiently resourced to respond to known risks associated with chroming e.g. absconding and violent behaviours
- has good community support and can provide safe places when there are no family/friends able to do so, and
is focused on preventing the child or young person from entering the youth justice system.

I note that DOC has advised that it encourages ‘close links’, including the development of policies with partner organisations. One way in which these links could be fostered would be by the development of an interagency protocol between all program partners outlining the necessary processes to support the implementation of the initiative and each party’s’ roles and responsibilities. In developing these policies and procedures, I have provided at Attachment 10 of this report a table incorporating some issues and factors for consideration. This includes policy development around social stigma and marginalisation of chroming users, addressing attachment issues and links with mental health. The table is by no means exhaustive, but rather an overview of some topical issues requiring consideration and appropriate policy development where required.

I congratulate QPS on its comprehensive suite of operating procedures, the development of the ‘immediate response’ protocol with QAS, its online learning package for officers and the development of other information about VSM readily available on its intranet.

Implementing strategies for dealing with children in care who are chroming in local communities is also seen as an important aspect of the current framework. I have therefore included some possible examples of the types of strategies that may be introduced at a community level in Attachment 11.

The current framework does not appear to provide for a partnership approach in relation to tailored education strategies for young people around VSM and other people who may come into contact with young people who are involved in VSM (e.g. social workers, doctors, nurses, Indigenous health workers, mental health and health promotion officers and community support workers). Consideration should therefore be given to a partnership approach with non-government agencies such as community, private sector, education research centres and prevention programs.

A number of the subject children who formed part of my review identified as being Aboriginal or Torres Strait Islander. My research has also identified that the practice of VSM is a problem for some Indigenous communities. Accordingly, it is important that the cultural needs of these children are appropriately considered within the development of policies and procedures and the current whole of government framework. This process should involve appropriate consultation with relevant Recognised Entities.

It is also important to remember that the research provides that VSM is not isolated to any one particular socio-economic group in society and is generally associated with young people and vulnerable groups such as children who are homeless. Accordingly, I believe that consideration should be given to extending the areas currently targeted by the AVSMI.

4.4.3 Addressing Volatile Substance Misuse Initiative

While the AVSMI was introduced in 2006, the information provided to me does not reveal whether funding under this initiative was available to the communities where SC1 and SC2 were residing or whether referrals for SC1 and SC2 were made to

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151 In the development of this protocol, some guidance may be provided by the ‘Interagency Protocol between Victorian Police and nominated agencies’.
DOC under the AVSMI. Accordingly, I am unable to comment on the effectiveness of the AVSMI in the context of the service delivery to SC1 and SC2 for the period under review.
Chapter Five: Comment, opinions and recommendations

In this chapter I seek to address the following term of reference:

Make any necessary comment, opinions and recommendations to address these issues

Chroming is an emerging problem being increasingly linked to children in care. Its apparent attractiveness is in part due to the ready availability and wide variety of inhalant type substances, its inexpensiveness and the “quick high” that it gives. Removing inhalant substances from the market is clearly not an option, nor is it a long term solution to ‘stopping’ young people from chroming.

What has my research identified?
Research undertaken as part of my review has revealed a number of important considerations for those who are involved in providing care and support services to children in care who are chroming. These are summarised as follows:

- VSM is a very dangerous practice that can have adverse impacts on the users safety and wellbeing and can also lead to long term health issues
- VSM is generally associated with young people and vulnerable groups such as children who are homeless and Indigenous communities
- children who have not been involved in healthy and attached relationships and who are living in care have a very high risk of adopting dysfunctional and destructive coping strategies such as chroming and VSM
- many common and readily available household products may be used for inhalation purposes
- VSM may disproportionately impact negatively on the overall wellbeing of a community
- a large percentage of young people involved with VSM often present with a high rate of psychological disorders such as depression, anxiety, stress, and poor self esteem. This can lead to high risk behaviours and suicidal ideations
- young people involved with VSM are often disproportionately involved in crime and are more likely than those young people not involved in VSM, to be placed in detention, and
- inhalant intoxication can lead to a user being at risk to themselves and others.

Further, my research has revealed that significant events in a child’s life, such as living in dysfunctional home environments, neglect, exposure to substance abuse, domestic violence and sexual abuse are stressors that, if unaddressed, can have a long lasting and detrimental effect on a child’s wellbeing. Often children will respond by “acting out”, self-harming, displaying challenging behaviours and even later adopting those very same behaviours themselves. The following represents additional information that also requires careful consideration when considering how best to respond to the needs of a child in care who is chroming:

- whilst boredom and experimentation may account for a proportion of children and young people who chrome, it appears more likely that for many children and young people, chroming provides them with a perceived escape from the pain and trauma that they have suffered, and/or are continuing to suffer
- minimising the impact of domestic violence and placing a child in an environment where abuse is known to have previously occurred, are issues
that will potentially impact upon a child’s ability to appropriately develop future relationships

- appropriate management of high-risk behaviours commences with appropriate and up-to-date case planning and an accurate understanding of how to respond effectively to young people who continue to take part in chroming
- case planning should have a collaborative approach and be undertaken in consultation with relevant providers, health professionals, care providers and any other persons who may be involved in the provision of linked services, care and support to the young person
- research indicates that children who have not been involved in healthy and attached relationships and who are living in care have a very high risk of adopting dysfunctional and destructive coping strategies such as chroming and VSM
- the issues of attachment, relationship boundaries and sexual abuse significantly impact upon a child’s sense of stability and acceptance, and
- ‘attachment theory’ relates to how the development of relationships by young people, can impact upon their ability to develop future relationships. One research source provides: 152

“It can be useful in helping those who work with children in out-of-home care to think about both past and future. It can increase understanding about what children may bring in to the new relationships that care involves, and, looking forward, how one can build on the past, modify expectations and strategies that are no longer helpful, and help the development of new positive relationships.

The concepts derived from attachment theory have been widely embraced by those who work in child welfare as they offer a framework for understanding the developmental importance of close relationships. These concepts help to explain why children who have had a poor start to relationships with others, or who have experienced seriously disrupted care, often behave in very troubling ways in care. They are also used in making decisions about the arrangements for family visits and specific forms of therapy for children experiencing behavioral problems.”

5.1 Comment

In Chapter Four I made various comments in relation to the adequacy of the provision of service delivery to children in care who are chroming and how those services may be improved. As CSS has the primary care responsibilities for children placed in care, it is imperative that it has well informed policies and procedures to help guide its staff in adequately providing for the needs of children in care who are involved with chroming. I have also provided some comment in relation to a number of broad issues that were revealed by an analysis of the service delivery to SC1 and SC2.

In summary, my review revealed that:

152 NSW Department of Family Services. (2006). The importance of attachment in the lives of foster children: Key messages from research. Centre for Parenting and Research, NSW.

chroming is a form of volatile substance misuse (VSM). The needs of, and behaviours displayed by, many children in care who are chroming are generally a response to some deeper underlying concern(s)
chroming issues can take some time to rectify, and generally only with significant support and counselling by appropriately trained professionals and carers
QPS has a comprehensive suite of operating procedures, including the development of the ‘immediate response’ protocol with QAS, its online learning package for officers and the development of other information about VSM readily available on its intranet
many community based organisations and NGOs offer support and resources and this needs to be adequately utilised by government service providers
it is important that an adequately resourced placement option with appropriately trained and skilled worker(s) is sourced prior to placing children with challenging behaviours such as chroming, in care settings, and
in addressing the needs of children in care who are chroming, there needs to be a commitment to form genuine partnerships involving government, non-government and community sectors.

5.2 Opinions and recommendations

In formulating my opinions and recommendations I have relied on an analysis and review of the following:

- documentation received from CSS in respect of SC1 and SC2
- information received by the Commission through its complaints and community visitor functions in relation to five other subject children who were involved in chroming
- information provided by CSS, QH, DOC, DSQ, QPS and DET in relation to their agency’s systems, policies and practices for the delivery of services to children in care who are chroming, and
- research in relation to VSM.

5.2.1 Opinions

I have formed the following opinions:

**Opinion One:**
The current Queensland whole-of-government framework for responding to the needs of children in out of home care who are chroming (a form of VSM) consists of:

- an “immediate response” protocol between the Queensland Police Service (QPS) and the Queensland Ambulance Service (QAS) focused on protecting the immediate safety and wellbeing of children in care who are involved in chroming
- an interagency services program which provides therapeutic and behaviour support for children in care with complex needs, and
- an initiative known as the ‘Addressing Volatile Substance Misuse Initiative’ (AVSMI) which is co-ordinated by the Department of Communities (DOC) and works in conjunction with powers included in the Police Powers and Responsibilities Act 2000.
Opinion Two:  
There appears to be an absence of policies and procedures by DOC (both Child Safety Services and Disability Services), QH and DET to help guide and support the delivery of services to children in care who are involved with chroming.

Opinion Three:  
Service delivery by CSS to children in care who are chroming may be adversely impacted upon by a lack of available support programs to help address the needs of children and young people who chrome. To help counteract this, CSOs need to be provided with regularly updated advice and information about those support programs provided by both government, non-government and community based groups in their local areas and requirements for entry into these programs.

Opinion Four:  
CSS does not have a process/provision for recording:
- the number of children in care who are known to be involved with chroming, and
- service responses to those children so that learnings can be gained and improvements to service delivery made where appropriate.

Opinion Five:  
Case planning by CSS around the specific needs of children in care who are chroming requires a collaborative approach, in consultation with relevant government agencies, health professionals, care providers, NGOs and any other persons who may be involved in the provision of linked services and, where appropriate, family, the community and past carers/care providers. Case plans should be regularly reviewed to ensure they are still meeting the needs of the child.

Opinion Six:  
Whilst the immediate safety needs of the child are paramount, longer term planning is necessary to address the underlying issues impacting on a child’s involvement with chroming.

Opinion Seven:  
When responding to the issue of chroming, a primary focus should be on prevention and early intervention strategies.

Opinion Eight:  
There needs to be careful consideration of the cultural needs of a child who is in care and involved in chroming. Where the child identifies as being Aboriginal and/or Torres Strait Islander this should include involvement with a Recognised Entity.

Opinion Nine:  
There are many possible reasons why a child may be chroming. It is important therefore that the child receives therapeutic support and/or counselling on an ongoing basis to assist the child in addressing their involvement with chroming.

Opinion Ten:  
Children who are involved in chroming should be provided with information and education about the risks continued chroming misuse poses to their immediate and long term physical and psychological health and wellbeing.
Opinion Eleven:
Children who are, or who have been, involved with chroming need to receive an appropriate health assessment and have regular health check-ups.

Opinion Twelve:
Children who are living in care and who are involved in chroming will often present with a variety of high care needs which require a holistic and well coordinated approach to addressing these care needs.

Opinion Thirteen:
Moving children who are involved with chroming away from their family, community and/or society generally, may further increase feelings of marginalisation and low self esteem by the child.

Opinion Fourteen:
Children in care who are involved with chroming are predisposed to significant risk behaviours such as absconding, violence and sexualised behaviours. The appropriate management of these complex behaviours is therefore seen to be a fundamental component of addressing the child’s involvement with chroming.

Opinion Fifteen:
Children and young people in care require appropriate guidance and support to re-enter, or to continue attendance, at an appropriate educational facility. This process requires the commitment and cross-agency support by CSS, QPS, and DET to ensure the young person is attending school and is assisted in being able to take part in a meaningful way.

Opinion Sixteen:
The coordination of resources between the various government agencies the subject of this review is necessary to ensure that children and young people in care who are involved in chroming are receiving the best possible services and outcomes.

Opinion Seventeen:
That contact is made by the various government agencies the subject of this review with already established working parties and review committees such as the 'National Inhalant Abuse Coordinating Group'.

Opinion Eighteen:
The AVSMI is a valuable initiative in responding to the issue of VSM by children and young people and I encourage it to continue with the work currently being undertaken.
5.2.2 Recommendations
I have formed a number of recommendations to address the issues that I have identified during the course of my review. Having sought and considered the response of service providers to my proposed recommendations, I now make the following recommendations under section 50 of the CCYPCG Act:

Recommendation One
CSS develop a ‘practice resource’ that is readily available for frontline officers regarding the delivery of services to children in care who are chroming. The practice resource should be created in addition to existing CSS Practice Manual (CSPM) guidelines, as well as incorporating the following information (at a minimum):
- clear definitions and explanations of VSM related topics, such as what is VSM, methods of VSM, its affects and the possible signs of VSM
- the QPS and QAS immediate response protocol, and a synopsis of all relevant projects being conducted in this area by Government and Non-Government agencies
- a reference list of relevant community and government bodies offering support and assistance with referrals etc.
- clearly defined practice strategies and guidelines regarding the minimum duty of care responsibilities and expectations required of officers tasked with case management duties
- development of a direction that where a child or young person is suspected of, or is known to be involved with VSM, that this information is to be included in the child/young person’s Child Health Passport and that provision is made for regular health checks and referral to specialist agencies
- a list of useful community and government intervention programs and resources
- management strategy guidelines specific to out-of-home care settings
- issues to be considered when determining placement options (including the list of considerations identified under the heading 3.2.4 of my report), and
- examples of behaviour contracts and management plans designed for children and young people involved with chroming. Such contracts/plans must consider the underlying causal factors of the young person’s involvement with chroming/VSM.
- clearly defined guidelines around the provision of immediate and short term service delivery, as well as ongoing intervention and rehabilitation.

Recommendation Two
CSS to give consideration to the development of a suite of screening and assessment documents to be used by officers when working with children and young people involved with chroming, incorporating an assessment of:
- underlying factors such as past abuse, and
- risk factors such as sexualised behaviours, high risk behaviours and any intellectual and/or physical impairment.

153 Similar to information contained in the QPS Volatile Substance Misuse – Information Z Card: see Attachment 1 of this report
Recommendation Three
CSS to give consideration to the inclusion of information and training for officers around VSM in Child Safety Officer training, or as part of induction or other training provided to its officers.

Recommendation Four
CSS takes steps to develop an interagency working group made up of representatives from DOC (including Communities, Child Safety Services and Disability Services), QH, DET and QPS (or perhaps through the Child Safety Directors Network or as part of the AVSMI) charged with the following responsibilities:

- to develop a project to map service delivery and training needs and options for officers, non-government agencies and carers to improve responses to children who are involved with chroming
- to meet periodically to discuss any emerging issues in relation to the service delivery to children in care involved with chroming
- to share information in relation to each agency's service delivery to children in care who are chroming and training/education provided to staff
- to develop specific training program(s) for frontline child protection officers to assist them in the delivery of quality services to children in care involved with chroming
- to develop a partnership approach in relation to the development and delivery of tailored education strategies for young people and other professionals around VSM (e.g. social workers, doctors, nurses, Indigenous health workers, mental health and health promotion officers and community support workers)
- to strengthen partnerships involving government, non-government and community sectors in relation to the delivery of quality services to children in care who are chroming
- to establish contacts and possible networks with other interstate agencies which provide services to children in care who are chroming and research entities, and
- to create a central information source/database that identifies the resources and support programs available for addressing VSM.

Recommendation Five:
1) DOC to lead the development of a protocol which clearly defines the necessary processes to support the implementation of the AVSMI, including each of the program partners’ roles and responsibilities, and
2) DOC to provide the Commission with periodic advice as to the progress being made to develop this protocol, including a copy of the proposed protocol.

Recommendation Six:
CSS take into account the outcome of the department's current review of the AVSMI and determine the existing capacity of the department to present data that can effectively assist CSS improve its service delivery to those children in care who are known to be involved in chroming.

CSS to report to the Commission on the outcome of its determination.
Recommendation Seven:
DET in conjunction with CSS develops a broad strategy and relevant practice guidelines that assists service providers to support young people in care who are involved with chroming, to best engage with the education system in a co-ordinated manner that is tailored to meet the needs of the young person.

Timeframes and Reporting
Agencies are requested to provide an interim and final report to me on progress with implementation of recommendations within the following time frames:

- an interim progress report within three months of receipt of this report and,
- a final report on implementation action within six months of receipt of this report.
Attachment 1: Volatile Substance Misuse – Information Z Card
Queensland Police Service and Queensland Ambulance Service Immediate Response Protocol

Queensland Police Service

What Police Should Know About VSM

Under the Police Powers and Responsibilities Act 2000, police have the power to search for and remove a potentially harmful thing they suspect has been, is being or is about to be ingested or inhaled. The term potentially harmful thing is defined in Schedule 4 of the Police and Responsibilities Act 2000. If the incident occurs in a declared locality as defined in s37 of the Police Powers and Responsibilities Act 2000, the police officer may, if satisfied that a person is affected by the ingestion or inhalation of a potentially harmful thing, detain the person for the purpose of taking the person to a place of safety.

An appropriate place of safety will vary depending on the circumstances and location of the incident. A safe place may include:
- A hospital for a person who needs medical attention.
- A place other than a hospital that provides care to intoxicated persons.
- A vehicle used to transport persons to a place of safety and under the control of a police officer. (This includes an ambulance.
- The person’s home or the home of a relative or friend if there is no likelihood of domestic violence happening at the place.

Misusers of volatile substances may be at risk of further self-harm, or harm from other people or the environment in which they are misusing.

There are different levels of volatile substances misusers: experimental, regular and chronic misusers;

Reactions of misusers to police may vary and will be dependent on a range of factors including the level of experience the misuser has with the substance, possible poly-drug use, and the environment in which use is occurring.

Police involvement may cause the user to become agitated, they may try to run or react violently. This may cause a serious reaction due to their VSM usage and can lead to sudden death from cardiac irregularity if frightened or chased.

Police should have knowledge of referral pathways so that the reasons ‘why’ people misuse volatile substances can be addressed by appropriate agencies.

Police Dealing With a VSM Incident Should Remember:

The role of police is public safety and the keeping of public order.

The least Intrusive strategy should be the first response, this should be increased to more complex responses where necessary.

Local conditions and the age of the user may warrant different responses.

Police involvement may cause the user to become agitated, they may try to run or react violently. This may cause a serious reaction due to their VSM usage and can lead to sudden death from cardiac irregularity if frightened or chased.

Police Attending a VSM Incident Should Consider

The misuser’s condition whether conscious, altered level of consciousness, unconscious or any reported unconsciousness will determine action at this stage.

All suspected misusers with an altered level of consciousness, unconscious or any reported unconsciousness need to be clinically assessed by QAS.

If unconscious - render first aid and call for medical assistance from QAS.

At incidents, police should:

- Assess medical risk and contact QAS if necessary.
- Remove the product and all solvent-stained materials, especially from the nose and mouth.
- If indoors, open windows and doors to improve ventilation.
- Keep calm, speak quietly and discuss what substances have been used.
- Suggest safe place to recover and provide referral information.
- Contact parents if under 17 years old.

If VSM is suspected and there is reason to believe that the misuser has an immediate health risk or it is not safe for the misuser to be left or if the misuser is a danger to themselves and others, contact calling QAS for assistance.

When removing the misuser to a safe environment, QAS officers have powers to protect, treat and provide transport to a volatile substance misuser in accordance with the relevant provisions of the Ambulance Service Act 1991 as amended.

Avoid unnecessarily chancing or aggravating the affected person. In some cases, it may be necessary to chase a person affected by potentially harmful things, if for example the person is suspected of having committed a serious offense or where it is necessary to ensure the immediate safety of the person. Chasing or aggravating the affected person may cause a serious reaction due to their volatile substance misuse and can lead to unconsciousness and possibly death from cardiac irregularity.

For more information: Refer to the QPS Bulletin Board

Queensland Ambulance Service

Role Of The Ambulance Service

The QAS, on receipt of a call for assistance to a patient suspected of volatile substance misuse (VSM), will, as soon as possible, dispatch the most appropriate ambulance resource.

- The role of the paramedic when attending a patient suspected of VSM includes:

  - To exclude and/or treat other medical or injury causes of abnormal behavior, e.g. diabetes, head injury.
  - Confirm VSM, if the person is unconscious or has an altered level of consciousness, they need to be assessed by paramedics who will record blood oxygen levels and heart rhythm along with vital signs. If the person maintains an altered level of consciousness or remains unconscious following paramedic assessment, transport to hospital by ambulance is required.
  - If the person is conscious and his/her condition is stable, paramedics can be relied upon to control the patient's condition.
  - (Paramedics can be relied upon to control the patient's condition and can attend to the patient's condition. Paramedics can attend to the patient's condition with stability.)

  - Consider QAS assistance if patient is violent or non compliant.
  - Provision of advice regarding referral to Project Drug Overdose Victim (Project DOV) and other relevant support services.

  - The paramedic implements procedures and provides care in accordance with that prescribed in the QAS Clinical Practice Manual and other relevant QAS Codes of Practice.

  - In circumstances where a patient who is suspected of VSM expresses refusal to medical treatment, including transportation to a hospital emergency department, the paramedic must determine the validity of the patient’s refusal.
  - If the patient’s refusal is deemed to be invalid, the paramedic has a duty to care for the patient in accordance with recognized standards of ambulance practice.

  - When providing treatment to a patient in these circumstances, it is acceptable for the paramedic to reassure the patient, if he or she permanently resides in Queensland, that no fee will be charged for the provision of ambulance service, including any transportation to a hospital.

  - When attending a patient who is suspected of VSM, paramedics should consider Project DOV and the assistance that could be provided to the patient through the project. If the patient is fully conscious and alert paramedics should discuss the many advantages of the project with their patient, and seek to obtain the patient’s consent to refer the patient to a DOV Project Coordinator. The paramedic should consider leaving a Project DOV information card with the patient, or the patient’s family or significant other, so that the patient may consider self-referral at a later time.

For more information: Refer to the QAS VSM Fact Sheet
Attachment 2: Queensland Police Service and Queensland Ambulance Service – Response to Volatile Substance Misuse

QUEENSLAND POLICE SERVICE (QPS) AND QUEENSLAND AMBULANCE SERVICE (QAS) RESPONSE TO VOLATILE SUBSTANCE MISUSE

For Police and Ambulance Officers

- At all times, the primary concern of the police and ambulance officers should be their own safety and the immediate safety and the immediate safety and welfare of the misuser of volatile substances.
- Consider the safety of the immediate scene – location of product, no smoking in area, ventilated area (air circulating).
- If a large group of people are misusing, police and ambulance officers should take extra caution to ensure the safety of officers involved, all misusers and the public.

What police should know about VSM

- Under the Police Powers and Responsibility Act 2000, police have the power to search for and remove a potentially harmful thing they suspect has been, is being or is about to be, inhaled or ingested. The term potentially harmful thing is defined in Schedule 4 of the Police Powers and Responsibility Act 2000. If the incident occurs in a declared locality as defined in s.3715 of the Police Powers and Responsibility Act 2000 a police officer may, if satisfied that a person is affected by the ingestion or inhalation of a potentially harmful thing, detain the person for the purpose of taking the person to a place of safety.
- An appropriate place of safety will vary depending upon the circumstances and location of the incident. A safe place may include:
  - A hospital for a person who needs medical attention
  - A place other than a hospital that provides care to intoxicated persons
  - A vehicle used to transport persons to a place of safety and under the control of someone other than a police officer. (This includes an ambulance)
  - The person’s home or the home of a relative or friend if there is no likelihood of domestic violence happening at the place.
- Misusers of volatile substances may be at risk of further self-harm, or harm from other people or the environment in which they are misusing.
- There are different levels of volatile substances misusers – experimental, regular and chronic misusers.
- Reactions of misusers to police may vary and will be dependent on a range of factors including the level of experience the misuser has with the substance, possible poly-drug use, and the environment in which use is occurring.
- Police involvement may cause the user to become agitated, they may try to run or react violently. This may cause a serious reaction due to their VSM usage and can lead to sudden death from cardiac irregularity if frightened or chased.
- Police should have knowledge of referral pathways so that the reasons ‘why’ people misuse volatile substances can be addressed by appropriate agencies.
Police dealing with a VSM incident should remember:

- The role of police is public safety and the keeping of public order
- The least intrusive strategy should be the first response; this should be increased to more complex responses where necessary
- Local conditions may warrant different responses
- The age of the misuser may require different responses
- Police involvement may cause the user to become agitated, they may try to run or react violently. This may cause a serious reaction due to their VSM usage and can lead to sudden death from cardiac irregularity if frightened or chased.

Police attending a VSM incident should:

- The misuser’s condition whether conscious, altered level of consciousness, unconscious or any reported unconsciousness will determine action at this stage
- All suspected misusers with an altered level of consciousness, unconscious or any reported unconsciousness need to be clinically assessed by QAS.
- If unconscious – render first aid and call for medical assistance from QAS
- At all incidents, police should:
  - Assess medical risk and contact QAS if necessary
  - Remove the product and all solvent-stained materials, especially from the nose and mouth
  - If indoors, open windows and doors to improve ventilation
  - Keep calm and speak quietly
  - Discuss what substance/s has been used
  - Suggest safe place to recover and provide referral information
  - Contact parents if under 17 years old
- If VSM is suspected and there is reason to believe that the misuser has an immediate health risk or it is not safe for the misuser to be left or if the misuser is a danger to themselves and others, consider calling QAS for assistance or moving the misuser to a safe environment. QAS officers have powers to protect, treat and provide transport to a volatile substance misuser in accordance with the relevant provisions of the Ambulance Service Act 1991 as amended.
- Avoid unnecessarily chasing or aggravating the affected person. In some cases it may be necessary to chase a person affected by potentially harmful things, if for example the person is suspected of having committed a serious offence or where it is necessary to ensure the immediate safety of any person. Chasing or aggravating the affected person may cause a serious reaction due to their volatile substance misuse and can lead to unconsciousness and possibly death from cardiac irregularity.
Role of the Ambulance Service

- The QAS, on receipt of a call for assistance to a patient suspected of volatile substance misuse (VSM), will, as soon as possible, dispatch the most appropriate ambulance resource.

- The role of the paramedic when attending a patient suspected of VSM, includes:
  - To exclude and/or treat other medical or injury causes of abnormal behaviour, e.g. diabetes, head injury.
  - Confirm VSM, if the person is unconscious or has an altered level of consciousness; they need to be assessed by paramedics who will record blood oxygen levels and heart rhythm along with vital signs. If the person maintains an altered level of consciousness or remains unconscious following paramedic assessment, transport to hospital by ambulance is required.
  - If the person is conscious with normal vital signs following paramedic assessment, they can be left in the care of a responsible conscious adult or taken to/arrange for transport to a safe place. (Paramedics cannot leave a patient affected by VSM with abnormal vital signs or a Glasgow Coma Score less than 14).
  - Consider QPS assistance if patient is violent or non-compliant
  - Provision of advice regarding referral to Project Drug Overdose Visitations (Project DOV) and other relevant support services.

The paramedic implements procedures and provides care in accordance with those prescribed in the QAS Clinical Practice Manual and other relevant QAS Codes of Practice.

- In circumstances where a patient who is suspected of VSM expressly refuses recommended ambulance treatment, including transportation to a hospital emergency department, the paramedic must determine the validity of the patient’s refusal. If the patient’s refusal is deemed to be invalid, the paramedic has a duty to care for the patient in accordance with recognized standards of ambulance practice.

- When providing treatment to a patient in these circumstances, it is acceptable for the paramedic to reassure the patient, if he or she permanently resides in Queensland, that no fee will be charged for the cost of the ambulance service, including any transportation to a hospital.

- When attending a patient who is suspected of VSM, paramedics should consider Project DOV and the assistance that could be provided to the patient through the Project. If the patient is fully conscious and alert paramedics should discuss the many advantages of the Project with their patient, and seek to obtain the patient’s consent to refer the patient to a DOV Project Coordinator. The paramedic should consider leaving a Project DOV Information card with the patient, or the patient’s family or significant other, so that the patient may consider self-referral at a later time.
DIAGNOSTIC PATTERN

About Inhalants

Inhalants are chemicals (usually liquids or gases) that give off fumes. These fumes have
mind-altering qualities that can result in intoxication. Inhalants fit into four groups: volatile
solvents, aerosols, gases and nitrates. The term generally used for inhalant abuse is
Volatile Substance Misuse (VSM).

Psychological and Physiological Effects from Volatile Substance Misuse.

Inhalants have similar effects to other depressant drugs such as alcohol and cannabis. The
effect depends on how much is taken, how it is taken, the tolerance level, the mood of the
person and other factors.

Short-Term Use

The psychological symptoms of short-term use of inhalants include the following:
- Exhilaration and euphoria,
- Agitation and irritability,
- Disinhibition,
- Mental state alterations, involving transient psychotic symptoms such as delusions,
hallucinations and self-reference ideation (true paranoia).

This is often followed by:
- Drowsiness, slurred speech, ataxia, confusion and disorientation.

Other physiological effects include the following:
- Cardiac arrhythmia & chest pain,
- Nausea and vomiting (first-time users),
  Diffuse abdominal pain, & loss of appetite,
- Sneezing, coughing, glazed eyes or a runny nose, like having a cold or the flu,
- Lethargy and decreased reflexes,
- Headaches,
- Nosebleeds, bloodshot eyes, and sores around the mouth and nose,
- Dilated pupils.

Overdose and Risk to User

Very high doses can result in convulsions, seizures and coma. Solvents induce respiratory
depression and cardiac arrhythmia. These can be fatal.
GUIDING PRINCIPLES

Types of Users

Inhalants are mostly abused by young adolescents and disadvantaged groups of the population. The most likely age for experimentation is 13 years.

Death has also been caused by suffocation by inhaling from a plastic bag or from aspiration of vomit. Some users have also died as a result of accidents, or doing dangerous things, while affected by inhalants. Accidents from drowning, falling, or traffic collisions, are more likely to occur in inhalant users. In addition, death from burns as a result of an accidental explosion may occur, as inhalants are highly flammable. Poisoning and chronic organ failure are also common causes of death following long-term or intense volatile substance abuse.

Pharmacological Properties

Acute intoxication for most solvents occurs three to five minutes after inhalation (10 to 15 breaths are sufficient) and peak plasma concentrations occurring 15-30 minutes later. Their half-lives may vary from hours to days and the euphoric effect may last between three and six hours. The metabolism of most solvents occurs in both the kidneys and the liver. The very high lipid solubility of the solvents is responsible for the rapid absorption from the lungs. They are also likely to accumulate in fat rich organs such as the liver and the brain.

Chroming

Chroming is one specific form of volatile substance abuse. It consists of spraying paint from an aerosol can into a plastic bag or other container such as soft drink bottle and then breathing in the vapours.

Sudden Sniffing Death

Deaths that result from the direct toxic effect of the substances inhaled are known as ‘sudden sniffing death’ (SSD). Immediate causes can include cardiac arrhythmia which may lead to ventricular fibrillation. It is thought that certain substances sensitize the heart to adrenaline and that this sensitivity, in combination with stress, physical exertion or anxiety, may lead to death within minutes. Our aim is to contain rather than restrain or chase the volatile substance user.

Ensure normal breathing and cardiac rhythm.
Transport to hospital if patient needs further medical care.
Leave in a safe place or with a responsible adult only if they have normal vital signs and GCS 14 or 15 after basic cares.
REFERENCES:

Custodial Drug Guide:
Victoria Police 2002

About Inhalant Abuse
For health and community workers.
Department of Human Services
State Government of Victoria 2002

Inquiry into the inhalation of Volatile Substances
Drugs and Crime Prevention Committee
Attachment 3: Volatile Substance Misuse: evidence-based recommendations for enhancing Queensland Police Service response

Volatile Substance Misuse: evidence-based recommendations for enhancing Queensland Police Service response

Kate Foot, Adrian Kelly, Paul Mazerolle, Chris Bond, and Adrian Chemey

Executive Summary

The overall aim of the project was to improve knowledge about how inhalant abuse and associated problems vary across communities, and to provide recommendations for training that highlight strategies reflective to the problems of particular communities.

In Australia, there are a vast range of readily accessible volatile substances available for misuse, and volatile substance misuse (VSM) is associated with a range of negative acute and long-term consequences. Studies show that levels of misuse can fluctuate widely over relatively short time periods (Gray, 2006b) making it difficult to establish reliable prevalence levels. Our best estimates are that between 0.3 and 6.4% of adolescents report having engaged in inhalant use over the week prior to survey (Australian Institute of Health and Welfare, 2005; White & Hayman, 2006). Adolescents engaging in VSM are often young and from marginalised and/or Indigenous backgrounds.

It is not an offence to possess or misuse volatile substances, and Queensland police officers have had very limited powers to intervene where VSM is evident. In Queensland, legislation is available to police in seven locations, which builds on foundation legislation allowing police to search a person who they reasonably suspect is (or is about to) engage in VSM, and to seize any inhalant found. The additional powers further enable police to transport an affected youth to a ‘safe place’ for the purpose of recovery. The Department of Communities is responsible for overseeing responses to VSM in Queensland, however, police commonly report challenges in the coordination of services in this area.

In the present project, two policing districts were chosen for inclusion, one with the additional police powers (Rockhampton), and the other without these powers (Ipswich). The district of Rockhampton incorporates the Indigenous community of Woorabinda, where petrol sniffing has been reported to be a longstanding problem. The project involved the administration of a police officer questionnaire (n=149) and face-to-face interviews with police in these districts (n=25). Some of the key findings were that:

- Approximately half of police reported observing people engaging in VSM at least once a week.
- Levels of observed misuse varied substantially from one station to another.
- While the majority of people reported to be engaging in VSM were identified as Indigenous, VSM among non-Indigenous youth was also perceived as a significant problem.
- There was significant variability in perceived levels of Indigenous misusers across the central and outlying stations in each district.

1. School of Social Science, the University of Queensland. 2. Key Centre for Ethics, Law, Justice and Governance, Griffith University. 3. School of Justice, Queensland University of Technology.
• Across all respondents, police reported receiving low levels of VSM training, and the perceived quality of most forms of training was modest.
• Police articulated the need for greater awareness of available training, and the need for networking across agencies.
• Across all respondents, police reported low levels of awareness of VSM via operational guidelines. A substantial number of VSM-related resources are already potentially available to police, but systems for improving availability and consumption of these resources are needed.

Based on these findings, and research in the field, a number of recommendations to QPS are made:

• Conduct an audit of available QPS VSM training and information resources.
• From this audit, develop or identify the need for any additional resources.
• Renew marketing of available training and information resources.
• Including VSM training and information in induction packages as necessary.
• Including VSM training and information in the Cultural Appreciation Packages as necessary.
• Include VSM training and information resources in any on-line centralised training portal that the QPS should implement in the future.
• Advocate for a funded ‘place of safety’ in the Ipswich district.
• Conduct further research that focuses on other Indigenous communities in Queensland where VSM is an identified problem. The present study found unique VSM-related issues in Woorabinda, but the sample of police stationed at Woorabinda was small, and there is little base for generalising the findings for this community to other Indigenous communities.

This project was funded by the National Drug Strategy Law Enforcement Funding Committee.
Attachment 4: Evolve Interagency Services – Information Sheet

Evolve Interagency Services

Queensland cross-government collaboration in the provision of services to children and young people in care

Background
The Evolve Interagency Services (Evolve) were introduced specifically to cater for the therapeutic and behavior support needs of children and young people in the care of the Department of Child Safety, with severe and complex support needs.

The 2004 Crime and Misconduct Commission’s Report: Protecting Children: An Inquiry Into Abuse of Children in Foster Care, recommended “…that more therapeutic treatment programs be made available for children in care with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated.”

A cross-sector response was instigated for the development and implementation of an interagency collaborative approach to the delivery of therapeutic and behaviour support services. A key focus of the program was to provide planned and coordinated clinical supports to children and young people in care, aimed at improving their emotional wellbeing and the development of skills to enhance their participation in school and community. This program has been established in seven locations across Queensland.

About the target group
The target group for referrals to Evolve is children and young people in care with severe psychological and behavioural problems. Severe psychological and behaviour problems are defined as those which significantly impact on daily functioning and developmental needs.

Depending on the child or young person’s age, their developmental stage, history of abuse and neglect and whether they have a disability, problems can manifest in a range of ways including severe depression, self harming, violence to others and property, and sexual acting out. Often these young people have experienced the most serious abuse and neglect and some may have a significant disability. These children need proactive and intense support services over a lengthy period. More traditional counseling and other support services have had limited success with this group of children and young people.

Key partners
The key partners in this initiative are the Department of Child Safety, Queensland Health, Disability Services Queensland and the Department of Education, Training and the Arts.

The Department of Child Safety holds either custody or guardianship of the child and young person referred to Evolve and has case management responsibility. The Department of Child Safety funds the therapeutic and behaviour support services provided by Evolve Therapeutic Services teams (Queensland Health) and the Evolve Behaviour Support teams (Disability Services Queensland).

Queensland Health, through the Evolve Therapeutic Services teams, provide intensive mental health therapeutic interventions to children and young people who experience trauma related psychological and behavioural problems as a result of abuse and neglect.

Disability Services Queensland, through the Evolve Behaviour Support teams, provide behaviour support services to children and young people with a disability who have psychological and behavioural problems that have resulted from trauma from abuse and neglect and/or from having a disability.
The Department of Education, Training and the Arts supports the collaborative model of service through linking therapeutic and behaviour support services with the Education Support Planning services which has been established to provide school based support and educational services to children and young people in care.

Principles of the interagency model
- Service responses are based on the goal of the best outcomes for the child or young person rather than the capacity or responsibility of each service system or department;
- The team will embrace a culture of shared responsibility and ‘owning’ solutions through the development of networks and relationships, not just systems and processes;
- A balance of ‘ground-up’ expertise regarding the particular needs and situations of the child or young person, with ‘top-down’ authority and expertise to consider and implement options and strategies;
- Effective communication between service providers across all departments/ agencies and all levels, the child or young person and their support system is essential;
- Children who have been maltreated require specialized, sensitive and consistent care;
- The child or young person is considered in their social and cultural context and, whenever possible, interventions will focus on developing supportive social environments rather than on the child or young person in isolation; and
- The views of the child or young person and their support system must be considered (including obtaining consent for information sharing and participation in care or treatment planning wherever possible).

Queensland Health – Evolve Therapeutic Services
These teams are made up of a range of mental health professionals including psychologists, occupational therapists, social workers, nursing clinicians, indigenous mental health workers and child and youth psychiatrists. The Queensland Health teams have evaluation, research and professional development coordinators who undertake research, training and practice supervision. Each team is managed by a team leader who is Queensland Health’s representative on the Evolve Panel.

The therapeutic services provided by the Evolve Therapeutic Services team encompass a range of interventions which are child-focused and intervene with significant others in the child’s support network (e.g. foster carers, biological parents and teachers.) Interventions will be based on the ‘severity’ of the child or young person’s problems and the capacity for change.

The interventions may include all or some of the approaches as outlined.
- A comprehensive assessment of the bio/psycho/social/cultural aspects of the child or young person and their significant others;
- Crisis response aimed at restoring equilibrium through promotion of appropriate coping strategies;
- Short-term intervention, e.g. cognitive-behavioural therapy to promote effective coping strategies for dealing with short-term stressors;
- Medium to long-term therapy aimed at reducing the child or young person’s maladaptive emotional and behavioural responses e.g. dynamic play therapy to increase the child’s self understanding and self esteem; cognitive behavioural therapy to correct maladaptive beliefs and attributions in relation to the abuse experience;
- Carer support, e.g. foster carer training regarding behavioural interventions; and
- Specialist consultation services and professional development and training provided internally to Queensland Health and externally across the government, non-government and private sector.
Disability Services Queensland - Evolve Behaviour Support
The Evolve Behaviour Support teams are made up of psychologists, speech and language pathologists and occupational therapists. Each team is managed by a team leader who is Disability Services Queensland’s representative on the Evolve Panel.

The Evolve Behaviour Support teams work in partnership with the child or young person, their carers and service providers to provide the following services. Behaviour support services based on “positive behaviour support” as per the model of support taught by the Institute of Applied Behaviour Analysis, USA. Positive behaviour support is a strengths based approach focusing on development of functional life skills and coping strategies to manage complex situations, makes appropriate environmental changes, enhances participation in community activities and improves overall quality of life.

The children and young people referred to the Evolve Behaviour Support Services are involved in a comprehensive assessment process which leads to the development positive behaviour support strategies, embodied in the behaviour support plan.

- An Initial Assessment is undertaken to obtain a holistic profile of the child or young person, their current needs and support systems. This assessment is multimodal, multidisciplinary and dynamic and includes a review of existing reports and letters, observations of the child or young person in multiple contexts, interviews with the child, carers, family, teachers and significant others.
- A Functional Assessment is conducted in order to understand the events happening around the behaviour/s, the nature of the behaviour including its intensity, frequency and duration, and the function or purpose of the behaviour to the child or young person. This enables the clinicians and key stakeholders to obtain greater understanding of the level at which the child or young person is functioning and the true impact on their disability/ies.
- From information provided in initial and functional assessments, a positive behaviour support plan is developed. The behavior support plans contain a number of strategies that seek to address a range of both immediate and long term behaviour support needs of the child or young person. Information, training and ongoing support is provided to the child or young person and key stakeholders as part of the implementation of the behaviour support strategies.

Evolve Interagency Services Panels and Stakeholder Meetings
The Evolve Panels are the mechanism which ensures the therapeutic and behaviour support needs of children and young people are addressed in each location. The Panel’s core functions include: intake and prioritisation, allocation of primary service provider (Mental Health or Disability Services), therapeutic and behaviour support services planning, quarterly progress reviews and case closure.

In addition to the Evolve Panels, a formalised Stakeholder Meeting process also operates to bring together the key stakeholders involved in the child or young person’s life and may include: the child or young person, carers, teachers and teachers aides, biological parents, therapists, other health care professionals and the Evolve clinicians. The Stakeholder Meetings occur regularly throughout the engagement of Evolve and are essential in maintaining communication, information sharing and commitment to a collaborative interagency approach to service provision for the child or young person.

Governance arrangements
A number of governance arrangements have been established to provide formal mechanisms for the ongoing development, implementation, reporting, monitoring and evaluation of the therapeutic and behaviour support services delivered by Evolve.

Evolve reports quarterly to the Child Safety Directors Network which is made up of the Child Safety Directors from each of the nine human services departments in the Queensland State Government and a representative of the Commission for Children and Young People and the Child Guardian.
A State-Wide Evolve Steering Committee meets monthly and is comprised of senior officers of the Department of Child Safety from a central office and zonal level, a senior officer from each of the partner agencies and members of the Evolve Program Management team. The steering committee’s role includes the reporting, monitoring and reviewing of the implementation of these therapeutic and behaviour support services, raising and problem solving issues of local and statewide concern, and ensuring the incorporation of the Evolve as a core part of child safety services in Queensland.

Local Evolve Steering Committees are comprised of members from the four key agencies and oversee the implementation of the initiative at the local level. Their role includes ensuring services are being delivered to the target group, identification of issues in service delivery and the development of local solutions to address these issues, in particular problems that occur in relation to interagency collaboration for the delivery of services to individual children and young people referred to Evolve.

Evaluation
A recent review of the Evolve program has found positive outcomes, including significant decrease of challenging behaviours, a reduction of self harm and harm to others, greater placement stability and increased participation and engagement in school.

Children and young people have commented how they feel happier, valued and more confident to make friends and motivated to achieve personal goals. Caregivers have noticed significant improvements in the child or young person gaining insight into their behaviours and their ability to manage their own behaviours.

Key challenges
There are increasing numbers of children and young people entering the child protection system. In 2004 when the CMC report was released, it was reported that there were 3,600 children in care, whereas in June 2008 there are now in excess of 7,000 children in the child protection system. This doubling of the numbers of children in care represents an exponential increase in the demand for services which are usually accessed by children in the child protection system, including Evolve.

Recruitment of suitably qualified and experienced clinical staff has been a significant challenge for both Disability Services and Queensland Health. Despite continuous recruitment drives, 100% operating capacity of the teams has been unachievable to date with an average of 75% recruitment rate. The shortage of available skilled professional staff is a problem currently faced by health and welfare agencies throughout Australia and overseas.

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Attachment 5: Child Health Passport – Information Sheet

The Child Health Passport: A passport to better health care

Sadly, many children who come into the care of the Department of Child Safety have health problems. This may be due to neglect, poor understanding of a child’s developmental health needs, unaddressed genetic, disability or general health issues.

The Child Health Passport (CHP) is a Queensland Department of Child Safety initiative and was introduced to meet the health needs of children in out-of-home care. A health assessment is completed for a child when they have remained in out-of-home care for 30 days or more and where the Department has custody or guardianship of the child. The CHP process is outlined in the flow chart.

The health assessment is an age appropriate health check that covers a number of domains assessed by the health professional. These domains include:

- Physical and developmental assessments
- Nutritional assessment
- Immunisation status
- Vision, hearing and dental screenings
- Psychosocial and behavioural issues
- Mental health assessment.

Essentially, the health assessment process is a standard age appropriate health check and the method that the health professional would usually employ for children in the general community is acceptable. For example Well Child Health Checks or Healthy Kids Check for 4 year olds.

The Department has named the process Child Health Passport, because for our purposes, it becomes a compilation of health documents to ensure an accurate and comprehensive health history is available.

The health assessment is undertaken by health professionals in the primary health sector and to ensure continuity of a child’s health care the child’s General Practitioner (GP) should complete the health assessment where possible. Where a child is already engaged with a Paediatrician or other health professional, it may be appropriate that they undertake the assessment. Where the child does not have their own GP, consideration will be given to the child’s age, Indigenous status and cultural background, current living arrangements and any significant matters relating to their case plan when deciding who will complete the assessment.

Involvement of the child, carer and the child’s family is essential when planning the assessment. Other health professionals who can complete health assessments include Child Health Nurses, Royal Flying Doctor Service and other outreach paediatric services and Indigenous Health Services.

Children already engaged with a health professional for ongoing management and monitoring of health issues may not require a health assessment as the health professional may regularly review these domains. Advice is sought from the health professional to determine this. If a health assessment is not necessary for these children, copies of all relevant health information are collated and placed in the CHP folder, held by the carer.

The outcome of the health assessment and required follow up is integrated into a child’s case plan to enable ongoing monitoring of the child’s health needs by the Department and other significant people involved with the child.
The Child Health Passport process:

1. **Child/young person enters out-of-home care**
   - Essential health information is collected and provided to the carer in the CHP folder

2. **Eligibility and need for a health assessment is determined and carried out**
   - a. For children regularly seeing a health professional who advises an assessment is not required, ensure the actions necessary for managing the child’s health are articulated in the case plan document
   - b. Arrange a health assessment for children who require one and meet eligibility criteria

3. **Health assessment occurs**
   - Health professional provides written summary, outcome of assessment and recommended follow up to the Department to be integrated into the child’s case plan and regularly reviewed

4. **Health follow up occurs**
   - More comprehensive child and family health history is collected for children who remain in care for more than 12 months

5. **Annual health check occurs**
   - The management of a child’s health record occurs throughout the process so a complete and accurate health history is available

For more information please call the Program Management Branch (07) 3405 6741.

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“Living in a remote area, and serving the needs of children in care over such a wide area as we do here in Charleville, I have found that the Child Health Passport Initiative has improved health outcomes for our indigenous clients and other children in care. The provision of appropriate and timely health care for children provides a positive message to both parents and carers that the Department of Child Safety and Queensland Health are working collaboratively in regards to the assessment and treatment of the health of the children in care in Queensland.”

Wendy Christiansen, Acting Team Leader, Charleville Child Safety Service Centre

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“...The CHP process allowed me to acknowledge and demonstrate the importance of extended family members to gather information when parents are unwilling or unable to do so. It also highlights that the process can be empowering for parents by allowing them to share their knowledge during this emotional time.”

- René Nurse, Child Safety Officer, Fortitude Valley Child Safety Service Centre

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“The assessments have helped identify medical issues that may not otherwise have been picked up. Both the natural parents and carers really appreciate the service because they have contact with the child’s health practitioner. It has also been really valuable in terms of deepening our working relationship with other colleagues at Queensland Health. Ultimately it means the children in care are getting better medical treatment.”

Veronica Taylor, Senior Practitioner, Bundaberg Child Safety Service Centre

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“The feedback from carers has been positive as they have a clear health plan to follow and an awareness of any health requirements for the child. A common goal is to ensure that the health care needs of the child have been attended to and that the child has a record to refer to if they are moved from their placement. It has been a positive experience for health staff and has seen positive outcomes for the children who have attended the clinic.”

Danette Smale, Child Protection Liaison Officer, Redcliffe-Coastal Health Services District, Queensland Health
Attachment 6: Addressing Volatile Substance Misuse Initiative (AVSMI) - Information Sheet

Addressing Volatile Substance Misuse (VSM) Initiative

This information sheet summarises key aspects of the service delivery model for the Addressing Volatile Substance Misuse (VSM) Initiative.

Purpose of the Funding

The purpose of the funding is to assist the service to provide comprehensive responses to young people with complex needs in public spaces. The service model responds to the needs of young people:
- who misuse, or are at risk of misusing, volatile substances;
- who may be homeless; and
- with complex needs, including youth justice and child protection needs.

Key elements of the Service Delivery Model

Service delivery encompasses the following aspects:

- Support and supervision for rest and recovery
  This includes the provision of a safe, monitored environment to assist young people affected by VSM to recover. This may occur in a variety of settings including a public place, a hospital waiting room or a service premises. In particular, rest and recovery support is provided to enable the release of young people detained by Queensland Police under Police Powers Act 2000 (sec.604) due to being affected by the ingestion or inhalation of potentially harmful substances. However, rest and recovery support may be provided to any young person requiring support to recover from the effects of VSM.

- Outreach
  Outreach will ideally be responsive to the mobility of the target group and will be for the purpose of engagement with the target group to facilitate and enable access to other elements of service delivery. Outreach may occur in a variety of settings, including public space, and will forge links between young people and support services.

- Case management
  Services will provide ongoing support to young people to help address issues that put them at risk of misusing volatile substances, including enhancing their resilience and coping mechanisms, improving their capacity to achieve personal milestones, and developing or re-establishing support networks. Underlying issues may include grief and loss, child protection issues and/or youth justice issues.

- Diversionary activities
  Participation in diversionary activities will promote healthy lifestyle choices and provide alternatives to volatile substance misuse for young people.

- Links with other services:
  The service will build strong relationships with Queensland Police, youth justice services, child protection services and other relevant human services such as Supported Accommodation and Assistance Program (SAAP) services, youth services and Indigenous services. These links will enable access for the target population and facilitate referrals to services who can assist young people. Relationships with referral agencies may be facilitated through development of formal protocols.
Addressing Volatile Substance Misuse Services
Locations, Organisations and Contact Details

Logan
Youth and Family Services (YFS) Logan
2-4 Rowan Street
Slacks Creek Q 4127
Ph: 07 3626 1500

Brisbane
Indigenous Youth Health Service / AICHS
60 Ferry Street
West End 4101
Ph: 07 3240 8964

Sunshine Coast
Kidz Youth Community
Units 5 & 6, 7-9 Industry Drive,
Caboilure, QLD, 4510
Ph: 07 5428 3589 or 07 5495 8281

Rockhampton
Darumbal Community Youth Service Inc
14 Fitzroy St
Rockhampton Qld 4700
Mobile: 0409090998

Townsville
Townsville Aboriginal and Islanders Health Services Ltd
57-59 Gorden Street
GARBUTT QLD 4814
Ph: 07 4772 7850

Cairns
Anglicare
Youth Substance Misuse Service
1 Warrego St
PARRAMATTA PARK QLD 4870
Ph: 07 4083 1082

Mount Isa
Young People Ahead
45 Deighton Street
MOUNT ISA QLD 4825
Ph: 07 47438450
Attachment 7: Significant elements of the Victorian Government’s, Department of Human Services Management response to inhalant use

Management response to inhalant use: guidelines for the community care and drug and alcohol sector

In 2002, the Victorian Government developed a ‘chroming policy’, specifically aimed at providing clear and consistent guidance regarding the delivery of services to children living in out of home care. The are six primary and overarching aspects of this policy include:

- “No illicit drugs are allowed on premises.
- All children and young people with substance use issues must be referred to drug and alcohol treatment services.
- Children and young people are not permitted to have any non-prescribed inhalants in their possession or use such inhalants in their possession or use such inhalants in residential care facilities. Items that are essential to the day-to-day operation of the residential care service and which clients could use as inhalants are to be securely stored.
- Strategies relying on passive observation of clients using substances are not permitted.
- CSOs are expected to do everything reasonable and consistent within safe work practices to stop young people from using non-prescribed inhalants, to remove inhaling implements as soon as possible, and to reinforce that using prescribed inhalants is not permitted.
- In situations where children and young people present to the residential care facility in a substance affected state our duty of care remains to ensure that they are appropriately assisted.”

In 2003, the Victorian Government developed a number of operational guidelines in order to further enhance the capacity ‘front-line’ officers who are working with people who use inhalants. The Victorian government outlines on its ‘Drug related services in Victoria’ web page, that:

- “These operational guidelines were developed to underpin the management by front line workers employed in DHS funded services of people using inhalants. They cover assessment, clinical management and follow up of people using inhalants”, and
- That the guidelines aim to:
  - Clarify minimum expectation regarding duty of care responsibilities
  - Clarify minimum expectation regarding strategies to respond to inhalant use
  - Promote consistent and high quality interventions for people abusing inhalants
  - Broaden the menu of options available to workers
  - Be used as a learning tool for workers new to the field or those with little experience or knowledge of interventions for inhalant use

Due to copyright provisions, I have not included a copy of this document with my review. I would however recommend that agencies:

- refer to the said document at the following website http://www.health.vic.gov.au/drugservices/pubs/inhaleguide.htm, and
- make appropriate enquiries with the Victorian Government should they wish to consult further regarding the content of the document.

In summary, the document covers a number of key topics regarding children in out-of-home care settings who are involved with chroming, including (in part):

- Chapter one: background information
- Chapter two: detection and assessment
- Chapter three: management strategies for out-of-home care settings
  - Includes a pathway for choosing appropriate intervention strategies.
- Chapter four: Management strategies for specialist alcohol and drug settings
- Chapter five: Inhalant use and brain injury
- Chapter six: special groups of inhalant users
- Chapter seven: Other important community interventions.
- Appendices which include (in part):
  - A suite of screening and assessment documents to be used when working with young people involved with chroming
  - A series of steps to follow for emergency workers when assessing and responding to the needs of a person who is affected by substance misuses.
  - Examples of behaviour contracts and management plans
  - Retailer information, and
  - A list of useful resources.
Attachment 8: Interagency Protocol between Victoria Police and nominated agencies (Drugs Poisons and Controlled Substances (Volatile Substances) Act 2003

In September 2002, the Victorian Government’s Parliamentary Drugs and Crime Prevention Committee tabled its report titled Inquiry into the Inhalation of Volatile Substances. The report resulted from an eighteen month inquiry into volatile substance misuse in Victoria and included in it a number of recommendations.

One such recommendation targeted the development of legislation, effectively providing police with the power to ‘search and seize’ with regards to young people involved with VSM. The Victorian Government supported this proposal and subsequently “The Drugs Poisons and Controlled Substances Act 1981 (the ‘DPCS Act’) was amended to include The Drugs Poisons and Controlled Substances (Volatile Substances) Act 2003.” The amended Act commenced operating on 1 July 2004.

Overall, the Interagency Protocol between Victoria Police and nominated agencies (Drugs Poisons and Controlled Substances (Volatile Substances) Act 2003 was developed in order to:

- Encourage “an integrated police and health response, which will take into consideration the best interests of the young person.”
- Map “the interaction between departments and agencies to ensure a unified and consistent response to young people detained under the provisions of the Act.”
- “support the implementation of” the amended Act.

Due to copyright provisions, I have not included a copy of the Victorian Interagency Protocol with my review. I would however recommend that agencies:

- refer to the said document at the following website http://www.health.vic.gov.au/drugservices/pubs/inhaleguide.htm, and make appropriate enquiries with the Victorian Government should they wish to consult further regarding the content of the document.

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## Attachment 9: Issues for consideration prior to the development of a ‘service delivery framework’

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<thead>
<tr>
<th>Issues</th>
<th>Factors for consideration</th>
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| Marginalisation and social stigma                | • Research indicates that many of the young people involved with chroming are often aware of society’s perception of chroming as a ‘dirty’ habit, hence perpetuating the concepts of ‘low social status’ and marginalisation.\(^{158}\)  
  • Terms such as ‘the lowest people on earth’ are sometimes expressed by young people themselves who are chroming.\(^{159}\) These ‘words’ are often accompanied with feelings of shame and guilt about the person’s chroming addiction.\(^{160}\)  
  • It is suggested that images of death and fear surrounding chroming has impacted upon the ability of agencies and individuals to develop ‘purposeful and compassionate policy responses to this issue’.\(^{161}\) |
| Family dynamics and attachment issues            | • The opinion of one author is expressed on page 89 of his research article stating, “the world of attachment-disordered children is a frightened, frightening and troubled one. They see themselves as unlovable and unworthy but capable of evoking anger, rejection and violence in others. As a consequence they feel both powerful and evil...the confusion evoked by this conflicting range of emotions leaves them feeling out of control, helpless and vulnerable, and as a result, it is hard to focus or concentrate on anything around them from social relationships to cognitive development.”\(^{162}\) |


\(^{159}\) MacLean, S. 2003. ‘Just a dirty kind of drug: young people’s perceptions of chroming’. The University of Melbourne. Paper presented at the Inhalant Use and Disorder Conference convened by the Australian Institute of Criminology and held in Townsville 7-8 July 2003. p7


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| Conflicting emotions experienced by subject children | - There may be a degree of relief experienced when the SC eventually exits a neglectful, chaotic, abusive and unpredictable home environment, however this may also be coupled with feelings of guilt and anxiety about having ‘left’ their parents/carers, family and community. ¹⁶³  
- This mixture of emotions is one of the many factors impacting on a child’s ability to settle into out-of-home care placements, which in turn may see the young person relying on behaviours such as chroming to ease their emotional pain and distress. |
| Mental health concerns and VSM | - Certain research suggests that undiagnosed personality disorders, avoidant coping strategies and attachment concerns are some of the risk factors underpinning a young person’s involvement with VSM. ¹⁶⁴  
- Adolescents with a mental illness and who are involved with substance misuse often present with unique challenges for service providers; many of which are exacerbated when a young person is either homeless or living in out-of-home care. ¹⁶⁵  
- One of the many challenges faced by these young people, is the need for them to access a multitude of care agencies in order to seek accommodation (if the young person is currently homeless), to arrange Centrelink benefits and to gain access to medical treatment, training and education. ¹⁶⁶  
- Due to the challenges faced by this vulnerable group of young people, it is essential that a nominated person works with the young person to liaise with the various support agencies. ¹⁶⁷ Also, there needs to be a focus on providing the young person with a flexible and adaptable strategy to meet their unique and individual needs. ¹⁶⁸ |

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<td>○ These challenges are particularly relevant for young people who are involved with chroming, and who are preparing to transition from the care of CSS.</td>
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<td>○ In response to the nominated concerns, strategies such as developing an improved coping ‘repertoire’ and managing personality traits that are a potential barrier to developing appropriate social relationships, may be incorporated into the care/treatment plan.(^{169})</td>
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| Factors impacting upon on a young person’s identify and their ‘place’ in society | ○ The results from one study suggests that out of twenty-eight young people (aged between 13 and 24 years old) interviewed:\(^{170}\) |
| | ○ all of the participants had current or previous involvement with substance misuse |
| | ○ none of the participants were regularly attending school |
| | ○ no one had regular employment |
| | ○ many young people had little contact with their families, and |
| | ○ just under half of the participants had lived in out-of-home care. |
| ○ While many young people find they are able to experience their environment in new and exciting ways while they are affected by VSM, there is very little positive impact on their life when they are not intoxicated.\(^{171}\) |

| Ineffective diversion strategies | ○ It’s interesting to note that marginalised youth (including young people living in out-of-home care) are regularly offered videos, television and electronic games as a strategy to divert the young person from engaging in VSM.\(^{172}\) Research suggests however that, “it is ironic that providing young people with opportunities to play electronic games is so ingeniously put to maximising the pleasures of drug use.”\(^{173}\) |


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<tr>
<td>Political sensitivity of VSM</td>
<td>• An article that discusses whether information about inhalants should be included in Australian School Based Education outlines that “inhalant use is very politically sensitive. It often involves very young people of whom a disproportionate number are under the legal guardianship of the state and living in “out-of-home care” or involved with the juvenile justice system. It is also a form of drug use with particular power to distress and disturb adults.”</td>
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<td>• Research suggests that there are a number of factors that influence the ways in which government agencies respond to issues such as sniffing, some of which include:</td>
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<td>o “The underlying assumptions of people that inform policy-making.”</td>
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<td>o “A number of structural factors combine to marginalise petrol sniffing as an issue and to encourage reliance on short-term, one-off interventions in place of a sustained policy commitment.”</td>
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<td>Availability of support services to the SC and the SC’s family</td>
<td>• Children are sometimes indirectly involved with chroming due to their parent’s/carer’s involvement with VSM. This is particularly relevant in cases where reunification of a child with their family is the planned outcome, but the child’s parents remain involved with VSM. This issue is concerning from an ‘inter-generational’ perspective.</td>
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<td>• Whilst research suggests it is imperative that children receive the support of the ‘family’ following the completion of drug and alcohol rehabilitation programs, it is important to recognise that for many families, adult carers who are involved with VSM may be unable to provide appropriate ongoing care to children. 176 This issue also needs to be factored into case planning and reunification planning.</td>
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<td>• It is also vital that carers are aware of who they are able to contact in situations where a child is suspected of being involved with VSM.</td>
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<td>• One of the difficulties for carers and guardians is that often there is no one central agency that is able to provide support where a child is involved with VSM, leaving many carers in situations where a child is placed into care with a human service department. 177</td>
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## Worker’s skills

The CMC outlines a number of skills that it believed to be requisite, not necessarily of one individual, but rather collectively of a group of people who are delivering services to VSM clients including:

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

## Education

- Education for children and young people living in out of home care is a key outcome indicator that is monitored by the Commission. It is vital that education services are involved with the development and delivery of service delivery frameworks to children involved with VSM.
- Research is divided over whether or not children in schools should be educated regarding VSM. One report suggests that specific education strategies should be developed to target children from the general population, children who are considered to be at risk of chroming and VSM and those children and young people who are involved with VSM.\(^{179}\)
- When children depart from the education system due to VSM, this can have significant flow on effects such as difficulties finding employment later in life.\(^{180}\) It is for this reason that many suggested service delivery networks to address VSM include the combined services of Child Protection, Juvenile Justice System, Health (including mental health) and Drug and Alcohol Services, but also education and accommodation services.\(^{181}\)

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## Attachment 10: Demand reduction strategies

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<tr>
<th>Intervention</th>
<th>Actions involved/required</th>
<th>Key elements for success</th>
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<tbody>
<tr>
<td>Community based programs</td>
<td>• promoting advocacy and service provision at a local community level</td>
<td>• a range of people from the community and agencies within the community are involved</td>
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<td>• dedicated staff in regional and remote areas who are able to visit children and young people and provide education, support, and information about VSM</td>
<td>• research and consultation with the community to identify the specific needs of the people involved</td>
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<td>• providing the specialist staff with support and resources that will enable them to appropriately and effectively work with young people involved with VSM</td>
<td>• improved communication between agencies providing services at a local level and agencies such as the police and CSS</td>
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<td>• for interventions in more remote areas, it is important that agencies such as the police, schools and health clinics are supportive of the community-based efforts.</td>
<td>• educating the community so that all people including staff, children and adults/parents are aware of the VSM issue and its associated risks</td>
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<td>Involvement of schools and education</td>
<td>• educating young people about the impact of VSM on activities such as sport, as opposed to education campaigns that use scare tactics are shown to be more effective</td>
<td>• the use of innovative educational programs that specifically target the needs of the children and young people involved</td>
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<td>• appropriate education, training, employment and skill development have been shown to help reduce the incidence of VSM</td>
<td>• an example of this is the use of story telling and art and the reestablishment of caring relationships in Indigenous communities</td>
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<tr>
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| Recreation and youth programs    | • the availability of activities (including out of school hours) have been shown to help reduce the incident of VSM  
• it is reported however that this intervention is not likely to address the needs of a ‘chronic chromer’. | • ensure people involved with drugs are not stigmatised nor marginalised  
• ensure the focus is on developing skills and ability  
• ensure there is a wide range of activities available, some of which involve risk taking in a safe environment  
• activities make good use of resources available locally within the community  
• are sustainable and need to be run during the day, night and on weekends and during holiday periods |
| Clinical management              | • the outcomes for the clinical management of VSM are reported as being generally ‘poor’ and there is limited information available regarding clinical management strategies.  
• it is argued by certain researchers that interventions for VSM should address the often broad range of factors that have lead to or stemmed from the person’s involvement with VSM, as opposed to focusing only on the VSM. | • ensure a thorough assessment is completed including poly drug use, family functioning, mental health disorders, medical screening and examination including screening for mental health disorders that may impact on the effectiveness of treatment strategies.  
• assess the person’s social and family situation – (this is particularly relevant to children being placed in out-of-home care settings). |
| Counselling, family intervention and after-care | • as with clinical interventions, there is limited research or evidence available that helps guide this type of intervention  
• needs to be delivered in conjunction with other activities that divert the young person away from VSM | • the Australian Government recommends that for Indigenous and Non-indigenous people, it is recommended that families are also involved in the counselling process – (again particularly relevant to consider this aspect of intervention when delivering services to children in out-of-home care).  
• use of outreach service providers to assist the young person with support and reinforcement of strategies learnt during initial rehabilitation. |
### Intervention | Actions involved/required | Key elements for success
--- | --- | ---
Homeland centres and outstations | - Children in Indigenous Communities are sometimes taken to outstations and ‘homelands’ in order to address in a ‘cultural’ manner the young person’s involvement with VSM and to also provide some relief to the community to which they belong.  
- The application of this strategy needs to also be considered for children who are placed in out-of-home care settings. | - The outstations and homelands need to be well resourced and their intervention strategies need to be sustainable with regards to the actual program and the required follow up care  
- It is important that young people are still encouraged to appropriately socialise with the broader society and that the medical and psychological needs of the young person are also able to be met. (Again this is particularly important for children living in out-of-home care settings such as residential facilities).