



DRUGS AND CRIME PREVENTION COMMITTEE

# INQUIRY INTO THE INHALATION OF VOLATILE SUBSTANCES

DISCUSSION PAPER



**PARLIAMENT OF VICTORIA**  
**DRUGS AND CRIME PREVENTION COMMITTEE**

**Inquiry into the Inhalation  
of Volatile Substances**

**DISCUSSION PAPER**

**January 2002**

## **SUBMISSIONS ARE INVITED**

The Committee welcomes written submissions in response to the issues raised in this Discussion Paper or on any matter related to the Terms of Reference of the Inquiry.

To assist interested parties in making submissions a number of questions have been posed throughout the Discussion Paper.

Details of how to make a submission are included in the insert. Note that the Committee requires all submissions to be signed hard copy originals and would also appreciate an electronic copy.

**Please take this opportunity to make a written submission.**

Send all submission to:

Inquiry into Inhalation of Volatile Substances  
Drugs and Crime Prevention Committee  
Level 8, 35 Spring Street  
Melbourne Victoria 3000  
sandy.cook@parliament.vic.gov.au

THE CLOSING DATE FOR SUBMISSIONS IS

**Friday 22 February 2002**

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Drugs and Crime Prevention Committee  
Level 8, 35 Spring Street  
Melbourne Victoria 3000  
Phone: (03) 9651 3546  
Fax: (03) 9651 3603  
Email: sandy.cook@parliament.vic.gov.au  
Website: <http://www.parliament.vic.gov.au/dcpc>

## **Drugs and Crime Prevention Committee**

### ***Members***

The Hon. Cameron Boardman, M.L.C. – **Chairman**

Mr. Bruce Mildenhall, M.L.A. – **Deputy Chairman**

The Hon. Robin Cooper, M.L.A.

Mr. Kenneth Jasper, M.L.A.

Mr. Hurtle Lupton, M.L.A.

The Hon. Sang Minh Nguyen, M.L.C.

Mr. Richard Wynne, M.L.A.

### ***Committee Staff***

Ms Sandy Cook  
Executive Officer

Mr Peter Johnston  
Legal Research Officer

Dr James Rowe  
Research Officer

Ms Michelle Heane  
Office Manager

## Functions of the Drugs and Crime Prevention Committee

The Victorian Drugs and Crime Prevention Committee is constituted under the *Parliamentary Committees Act 1968*, as amended.

*Parliamentary Committees Act 1968*

### Section 4 EF.

To inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with the illicit use of drugs (including the manufacture, supply or distribution of drugs for such use) or the level or causes of crime or violent behaviour, if the Committee is required or permitted so to do by or under this Act.

## Terms of Reference

The Governor in Council, acting under section 4F (1) of the *Parliamentary Committees Act 1968* and on the recommendation of the Premier, by this Order requires the Drugs and Crime Prevention Committee to inquire into and report to Parliament on the issue of inhalation of volatile substances for the purpose of intoxication. In particular, the Committee is requested to:

1. examine factors contributing to the inhalation of volatile substances;
2. review the adequacy of existing strategies for dealing with the inhalation of volatile substances;
3. consider best practice strategies to address the issue of inhalation of volatile substances, including education and voluntary initiatives;
4. consider options to reduce the incidence of inhalation of volatile substances and identify factors in order to prevent first time inhalation of volatile substances.

In conducting the Inquiry the Committee is to have regard to:

- a. approaches taken to this issue in other Australian and overseas jurisdictions;
- b. such other legislation, reports and materials as are relevant to the Inquiry.

Under section 4F (3) of the *Parliamentary Committees Act 1968*, the Governor in Council specifies the first day of the Autumn 2002 Parliamentary session as the date by which the Committee is required to make its final report to Parliament on this matter.

18 April 2001

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# 1. Introduction

*My 16 year old daughter is slowly dying, her memory is fading, her sight, hearing, lungs, kidneys, bone marrow and liver are being damaged. Her blood oxygen is being depleted and this can directly induce heart failure. This can also cause death from suffocation by displacing oxygen in the lungs and then the central nervous system, causing breathing to cease. Her personality has changed.*

*Her system is slowly being poisoned.*

*She buys a can of paint legally from a store, sprays it into a plastic bag and breathes the fumes deeply into her lungs.*

*She doesn't notice the paint stains on her mouth and hands. I do.*

*My beautiful daughter is a "chromer".*

*The girl I gave birth to 16 years ago is killing herself.*

*And I cannot stop her, help is too far away, hands are tied, this practice is not illegal.*

*I can no longer sit back and allow this practice of our youth to continue.*

*I would like to have it made hard for these children to destroy their lives or kill themselves.*

*As the law stands at the moment it is not illegal for cans of paint to be sold to minors.*

*According to authorities, it is not a drug, BUT she has all the hallmarks of a drug addict, no longer at school, roams the streets day and night, is in trouble with the law, is destroying our family. Everything is locked up so it doesn't 'vanish'. She has no respect for herself, others or their property ... I have been on an endless merry-go-round for 18 months trying to find assistance for my daughter...<sup>1</sup>*

The above quote was received from 'Anne', a mother of a young woman who is a chromer. This letter was tendered as a Submission to this Inquiry. The desperate concern that this woman has about her daughter's condition is self-evident. During the course of this Inquiry the Committee has become aware that her concern is not an isolated case.

The deliberate inhalation of volatile substances to achieve an intoxicated state is a serious problem that is increasing throughout the world (World Health Organisation (WHO) 1992). It is by no means, however, a recent phenomenon:

Vapour inhalation [for pleasure] has a long history, dating back to the rituals at the Oracle of Delphi, where priestesses induced trance by inhaling the vapours from crevices in rocks. There is a distinct thread of mysticism, prophecy and 'worship' [connected to] vapour inhalation in all cultures, and incense and other aromatic materials are still used as part of worship in a number of religions (Re-Solv 2000, p. 6).

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1 Submission from 'Anne' to Drugs and Crime Prevention Committee, Inquiry into the inhalation of volatile substances, May 2001.

In the nineteenth century, nitrous oxide ('laughing gas') was commonly used for its intoxicating effects, often by prominent figures such as Coleridge and Roget. The inhalation of nitrous oxide became popular at genteel 'sniffing parties', particularly by women. By the early twentieth century, chloroform and ether were being inhaled for their intoxicating properties, the latter being used as a substitute for alcohol in Germany during the Second World War (Merill 1978; Birdling 1981).

In more recent times the deliberate sniffing of inhalants has become viewed as being almost exclusively associated with children and adolescents. Deliberate sniffing of glue from model airplane sets was being reported in the 1940s. In the 1950s children were arrested in the United States for the inhalation of gasoline (petrol). In the 1950s a wave of publicity followed an article on glue sniffing in a Denver newspaper, with subsequent warnings about the practice in other newspapers and on television. Ten months later it was reported that Denver had a huge problem with adolescent glue sniffing (Re-Solv 2000, p. 6). This incident raises an important issue that is still relevant. Does publicising the practice of inhalation, even with the positive intention of educating the public as to its dangers, in fact encourage the practice? This is a vexed issue that will be discussed in detail in a later chapter of this Report. By the 1960s the practice of glue and petrol sniffing had spread across the United States. By the 1970s these practices were evident in the United Kingdom, Europe, Australia and New Zealand.

Inhalation of volatile substances is now practised worldwide, although its manifestation varies between different countries and within them. For example, in Britain the problem is largely restricted to the inhalation of butane from gas lighter refills. In Australia, petrol inhalation is still a huge problem among Indigenous communities in remote parts of the country:

Historically, the use of petrol as an inhalant was largely confined to areas in the Northern Territory and in central Australian communities. Qualitative data suggests that petrol sniffing has occurred in some indigenous communities since the 1970s<sup>2</sup> ... The use of petrol and other solvents as inhalants has largely been documented to occur among young indigenous people in remote geographical locations. However, recent reports have documented localised petrol sniffing 'outbreaks' in certain rural areas in Queensland, New South Wales and Western Australia, where it has not previously occurred (Western Australian Drug Strategy Office 1998, p. 1).

In Victoria and the cities of Australia, however, the inhalation of vapours from spray paint, known as 'chroming', seems to be currently the most popular form of inhalation.<sup>3</sup>

- 
- 2 Although some research has documented inhalant abuse, particularly of petrol, as occurring as early as the 1950s in some Central Australian Indigenous communities, see for example, M. Brady, 'Petrol sniffing among Aborigines: Different social meanings', *International Journal of Drug Policy* vol. 2, no. 4, 1990, pp. 28–31.
  - 3 See S. MacLean, 'Social meanings of inhalant misuse in Victoria', *VicHealth newsletter*, 2001, p. 16. This information was also conveyed to the Committee in submissions from a variety of Victorian government, non-government and research organisations.

The method and type of inhalation also appears to vary over time. Glue sniffing was popular in Britain and some parts of Australia during the 1970s and early 1980s but now appears to be less favoured. These differences and variations and the reasons for them will be discussed in more detail in Chapter 2.

## **This Inquiry**

On 18 April 2001 the Governor in Council referred the following terms of reference concerning the inhalation of volatile substances and related issues to the Drugs and Crime Prevention Committee.

### ***Terms of Reference***

The Governor in Council, acting under section 4F (1) of the *Parliamentary Committees Act 1968* and on the recommendation of the Premier, by this Order requires the Drugs and Crime Prevention Committee to inquire into and report to Parliament on the issue of inhalation of volatile substances for the purpose of intoxication. In particular, the Committee is requested to:

1. examine factors contributing to the inhalation of volatile substances;
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## **Background to the Inquiry**

The background to the reference in part stems from concerns expressed to parliamentarians from members of both Indigenous and non-Indigenous community organisations and representations as to the extent and seriousness of chroming or inhalant abuse in their communities. In particular, the issue has been raised by the Victorian Regional Aboriginal Justice Advisory Committee with respect to the deleterious effect and impact 'chroming' is having on Koori (Aboriginal) youth in various areas of Victoria. It must be stressed from the outset, however, that the problem is by no means restricted to Indigenous youth. Indeed, at least in the non-rural areas, the inhalation of volatile substances is predominantly a practice of non-Indigenous youth.

These issues with regard to volatile substance abuse are present in each of the Australian states. Some of the major common concerns have been comprehensively expressed by the Western Australian Solvents Working Party in a recent strategy framework. Although this report does pertain to the situation in Western Australia, the same concerns have been expressed in various forums and by groups and individuals in Victoria:

### ***Concerns about solvent abuse***

Solvent abuse is of particular concern because:

- Solvent abuse primarily occurs amongst very young people as well as some older, disadvantaged adults;
- It is the fourth most abused substance by young people;
- The products containing solvents are inexpensive and available;
- Solvents are toxic;
- Accidents and regrettable behaviour occur while intoxicated on solvents;
- Sudden sniffing death can occur from first time abuse of solvents;
- Associated community problems include family and social disruption from theft, truancy, vandalism and other delinquent behaviour;
- In some Aboriginal communities, petrol sniffing has resulted in immense community, family and individual tragedy;
- Sexual abuse and other forms of exploitation of solvent abusers by adults, including through supply of solvents, is of special concern, particularly given the age and vulnerability of those being exploited; and
- Children of young parents who are abusing solvents are at high risk of neglect and abuse (Rose 2001, p. 2).

Following the announcement of this Inquiry, the Drugs and Crime Prevention Committee has been contacted by the Coroner, the Chief Magistrate of the Children's Court, the Victoria Police Drug Unit, shopkeepers and traders, youth and community workers and several concerned parents and individuals, such as the mother quoted above. All expressed their concerns and emphasised the necessity for information upon which to base urgent interventions.

### ***Some definitions***

Before this Paper discusses the issue of volatile substance abuse in depth it is useful to set some definitional parameters that will form the basis of this Discussion Paper.

### ***Volatile substance abuse (VSA)***

Following the lead of the British Home Office's Report by the Advisory Council on the Misuse of Drugs, *Volatile Substance Abuse*, the Committee has decided to use the term 'volatile substance abuse' or VSA throughout this Discussion Paper, unless a specific context warrants otherwise. Volatile substance abuse has in turn been defined as 'deliberate inhalation of a volatile substance to achieve a change in mental state' (Advisory Council on the Misuse of Drugs 1995, p. 14). The reason for the use of such a term is its inclusiveness and wide-ranging scope. More popular or specific terms such

as 'glue sniffing', 'solvent abuse', 'inhalant abuse' or 'chroming' do not completely capture the breadth of the substances used or the methods employed to use them. It also reflects the fact that VSA includes the use of substances which are not solvents, paint or glue. Where the context of the discussion requires the use of a specific term such as 'chroming' then such a term will be used. The term 'abuse' is used to distinguish intentional inhalation from accidental inhalation of fumes by legitimate users – usually in an industrial setting (Rose 2001, p. 6).<sup>4</sup>

### **Volatile substances**

Research to date has been hampered by arguments as to what precisely constitutes a volatile substance, and the numerous methodologies employed to record the extent and effects of their use. A simple and workable definition, however, is that volatile substances are those which give off vapours or gas at room temperature and are capable of producing an intoxicated or psychoactive effect.<sup>5</sup> A more detailed discussion of the types of products that contain volatile substances and their chemical properties is found in Chapter 2.<sup>6</sup>

## **Work of the Committee**

The Committee has embarked on an extensive research process in order to canvass the issues and receive input and information from a broad range of individuals, agencies and organisations with a stake or interest in the issues raised in the Terms of Reference.

To date the Committee has undertaken an extensive review of the literature on volatile substance abuse, has called for and received submissions from the community and spoken to some experts, key stakeholders and interested individuals in Victoria, the UK and the United States.

The Committee has also prepared this Discussion Paper to highlight the scope and complexity of issues to be addressed, provide an overview of the current law, regulations, policies and programs in Victoria and other Australian and overseas jurisdictions, and raise specific questions that need to be addressed.

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4 The Committee's brief is primarily to discuss intentional volatile substance abuse. Where appropriate, however, it will canvass the issue of inhalation of volatile substances in industrial or workplace settings (see Chapter 5).

5 A legal definition as to what counts as a volatile substance is given in Chapter 6.

6 A comprehensive list of volatile substances is also found in Appendix 1.

***Submissions are invited***

The Committee welcomes written submissions in response to the issues raised in this Discussion Paper or on any matter related to the Terms of Reference of the Inquiry.

To assist interested parties in making submissions a number of questions have been posed throughout the Discussion Paper.

Details of how to make a submission are included in the insert. Note that the Committee requires all submissions to be signed hard copy originals and would also appreciate an electronic copy.

Submissions should be sent by 22 February 2002 to:

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## 2. The nature of volatile substance abuse

### **What is volatile substance abuse?**

Volatile substance abuse is the deliberate inhalation of a gas, or of fumes released from a substance at room temperature, for the purpose of intoxication. These substances are lipophilic (fat-soluble), easily absorbed through the lungs and carried to the brain where they act to depress the central nervous system. Such rapid absorption results in the effects of the substance occurring within minutes. The term 'volatile substance abuse' (or use) is appropriate as it encompasses aerosol and gas fuel use in addition to glue sniffing and other forms of solvent inhalation (Rose, Daly & Midford 1992, p. 7). Volatile substance abuse has been observed as having a 'cyclical nature' or coming in 'waves'. This phenomenon will be discussed in more detail in Chapter 5.

### **What are volatile substances?**

Volatile substances produce chemical vapours that can be inhaled to induce a psychoactive, or mind-altering, effect. Although other abused substances can be inhaled, the term 'inhalants' is often used to describe volatile substances, given their main common characteristic: that they are rarely, if ever, taken by any method other than inhalation. This definition encompasses a broad range of chemicals found in hundreds of different household products that may have different pharmacological effects. Like alcohol, all volatile substances act as depressants, even if the initial effect is to lessen inhibitions or act as a stimulant.

In Australia, around 250 products containing potentially intoxicating inhalable solvents have been identified in supermarkets, newsagencies and hardware stores. As a result, precise categorisation of inhalants is difficult. Different classification systems are used depending on the context (scientific, educational, legal etc). Indeed the classification of volatile substances has been an issue of some contention, particularly among scientists and medical officers. It has been argued that the inclusion of all forms of volatile substances under the one heading is problematic. Such an all-encompassing classification makes it difficult to plan education, prevention and treatment policy that differentiates between the different types of substances and the different reasons why (young) people may use them. For example, Beauvais and Oetting state:

The study of the nature and extent of the use of volatile, psychoactive substances has been hampered by a confusing terminology. Widely disparate substances such as glue, gasoline, anaesthetic gases, and nitrites have all been discussed under the single rubric of 'inhalant abuse'. A classification scheme is proposed which differentiates



users of substances such as volatile hydrocarbons (gasoline, glue, etc) from users of the anaesthetic gases and of the amyl and butyl nitrites. Since users of these three types of volatile chemicals differ on predisposing factors, level of dysfunction, and consequences of use, the former group should be classed generically as 'inhalant' users, while the latter should be diagnosed as users of a specific drug (Beauvais & Otting 1987, p. 779).

For example, the issues pertaining to paint chroming or glue sniffing of an emotionally distressed young person 'in care' will be very different to those who 'pop' nitrites for the enhancement of sexual pleasure.<sup>7</sup>

It is important to bear classificatory distinctions in mind in terms of developing policy. The strategies required to address these disparate 'client' groups will also need to be differentiated.<sup>8</sup> As the Youth Substance Abuse Service has stated '[m]ost educational material regarding the harmful effects [of volatile substance abuse] ignores the distinctions between solvents and attributes to each and every one of them the potential ill effects of them all'.<sup>9</sup> This issue of differentiation will be discussed at length in Chapter 5.

One classification system lists four general categories of inhalants: Volatile solvents, aerosols, gases and nitrites (NIDA 2000).

**Volatile Solvents** are liquids or semi-solids, such as glues, that vaporise at room temperature. They are found in a multitude of inexpensive, easily accessible products used for common household and industrial purposes. These include paint thinners and removers, dry-cleaning fluids, degreasers, petrol, glues, contact adhesives, plastic cement, correction fluids and felt-tip markers. Toluene and xylene are common compounds found in these products.<sup>10</sup>

**Aerosols** are sprays that contain propellants and solvents. These include spray paints, deodorant and hairsprays, insect sprays, vegetable oil sprays for cooking and fabric protector sprays. Pressurised aerosols can contain halons and freons (fluorocarbon propellants) but, increasingly, to protect the ozone layer butane may be used. Substances from fire extinguishers (bromochlorodifluoromethane – BCF) have also been inhaled and even the abuse of salbutamol (Ventolin) by those prescribed inhalers for asthma has been noted (Commonwealth Department of Health 1984, pp. 19–20).

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7 The term 'pops' refers to the snapping of the vial in which the nitrites were often contained. The user then inhales the subsequent fumes. It is not the intention of the Committee to discuss this form of inhalant abuse in detail, other than for a brief discussion in Chapter 5. For a discussion of 'popping' nitrites as a form of inhalant abuse, see T. Brouette and R. Anton, 'Clinical review of inhalants', *American Journal of Addictions*, vol. 10, no. 1, 2001, pp. 79–94; R. French and R. Power, 'Self reported effects of alkyl nitrite use: A qualitative study amongst target groups', *Addiction Research*, vol 5, no. 6, 1997, pp. 519–48.

8 Werry (1992) classifies the pharmacology of volatile solvents into three groups – Commercial source and function, Chemical compounds and Pharmacological effects (Therapeutic or Toxicological action). The first category is more useful for lay people and as a means of locating the source of supply for preventive programmes. The latter two categories are more useful for chemists, scientists and medical personnel.

9 Youth Substance Abuse Service, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 2.

10 See Appendix 2 for a description of the properties and effects of these compounds.

**Gases** include medical anaesthetics as well as gases used in household or commercial products, such as refrigerants. Medical anaesthetic gases include ether, chloroform, halothane, and nitrous oxide, commonly known as 'laughing gas'. Nitrous oxide is the most commonly abused of these gases and can be found in whipped cream dispensers.

Household Gases include commercial products containing gas fuels such as butane cigarette lighters, bottled domestic gas and cylinder propane gas.

**Nitrites** are often considered a special class of inhalant. Unlike most other inhalants that act directly on the central nervous system, nitrites act primarily to dilate blood vessels and relax the muscles. While other inhalants are used to alter mood, nitrites are used primarily as sexual enhancers. Nitrites include amyl nitrite and butyl nitrite.

Some chemical compounds in products, such as toluene, contain an almost pure volatile substance. Others, particularly in glues and adhesives, contain a combination of volatile substance in combination with other compounds. A comprehensive list of volatile substances classified according to both chemical properties and household name is attached in Appendix 2.

## **What is chroming?**

Chroming is one specific form of volatile substance abuse. It consists of spraying (chrome) paint from an aerosol can into a plastic bag and then breathing in the vapours from the bag. Although there is no hard data to verify this fact, it would seem in Melbourne and rural Victoria that 'chroming' is the most popular and frequently used form of volatile substance abuse (MacLean 2001, p. 16). Chrome paint is favoured because it is cheap and according to some youth workers young people also find it is less unpleasant in taste and has a higher degree of intoxicating substances than other products. A worker from MacKillop Family Services describes it thus:

It's called chroming because the chrome paint is meant to have less bad taste, but they use any paint. Lately the kids have been going through all the colours, and they have different colour days, and they say different colours give different effects.<sup>11</sup>

The community agency Berry Street Victoria state that among its residential clients gold and silver chrome paint is particularly popular as these paints contain more toluene than other colour mixtures.<sup>12</sup>

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11 MacKillop Family Services, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 4.

12 Berry Street Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p.5.

## How are volatile substances abused?

Vapours from the volatile compounds are commonly inhaled directly from the container or, as with chroming, placed in a plastic bag from which the concentrated vapours are inhaled. The re-breathing of exhaled air in the bag causes anoxia (oxygen deficiency) which intensifies the effect (WHO 1992, p. 3). They can also be sprayed directly into the mouth from the container. A 'unique' form of administration is to spray the aerosol propellant into a balloon and then allow the balloon to implode inside the mouth (WHO 1992, p. 3). Another form of administration is 'huffing'. Huffing consists of saturating a rag or cloth with the substance and holding it over the nose and mouth while inhaling.<sup>13</sup>

Whatever method is used, as an earlier report has noted it is of concern that most forms of administration are simple and do not require expensive equipment, (Commonwealth Department of Health 1984, p. 8).

## Why use volatile substances?

Sophie (15 years old) – *Chroming is like a 1000 heroin rushes.*

Michael (15 years old) – *It gets rid of boredom. Time disappears! ... what seems like 15 minutes, turns out to be half a day.*<sup>14</sup>

The above quotes are taken from a submission to this Inquiry by Berry Street Victoria and reflect the views of some of their young clients. The comments reflect the reality that for some young people inhalant use is a pleasurable activity. This section deals solely with the (pleasurable) effects of inhalation for users. The more complex issues pertaining to why (young) people may use volatile substances are discussed in detail in Chapter 5.

The 'pleasant' physical effects of inhalation of most volatile substances are euphoria and an initial and rapid 'high' or 'rush' that resembles alcohol intoxication. Light-headedness and an anaesthetic-type feeling may follow. The Youth Substance Abuse Service state:

Inhalants are depressants, but the lack of inhibition they produce creates a feeling of stimulation and excitement, delusions of grandeur and giddiness followed by a drowsy euphoria ([www.ysas.org.au/drugs/chroming.html](http://www.ysas.org.au/drugs/chroming.html)).

The added advantage is that most of these substances are inexpensive to purchase, can be easily stolen or are already accessible from the kitchen or bathroom cupboard.

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13 See Appendix 3 for a comparison of methods of use and their associated effects.

14 Quoted in Berry Street Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the inhalation of volatile substances. August 2001, p. 7. A representative example of case stories from other Berry Street Victoria clients is given in Chapter 5.

## The effects of inhaling volatile substances: Physiological and toxicological consequences

From the outset it is important to qualify the following discussion with some caveats.

First, as the Committee has noted, there are a huge and varied number of products that can be abused for inhalation purposes. Therefore the physiological effects of each substance will be by no means uniform. This is particularly the case given that some products may be chemically pure whereas others may have unknown formulations.

Second, 'A variation in the physiological effects may occur according to the nature of factors such as age, personality, physique, and the particular substance inhaled, the quantity inhaled, and the length of 'sniffing' history' (Commonwealth Department of Health 1984, p. 9). Other factors such as the duration of the episode or use, the gender of the user and the environment in which it is used will also need to be taken into account.

Third, the effects of volatile substance abuse and their severity will vary according to the method of administration used. It is generally agreed that direct spraying of substances into the mouth can result in the most serious physical consequences, while huffing (breathing the substance from a saturated rag) is relatively 'safe'.<sup>15</sup> Nonetheless, some common physiological and toxicological effects can be posited across a wide spectrum of products and substances, although as shall be discussed later in this chapter there is no uniform agreement among the scientific and medical community as to the severity or duration of these effects. It should be noted that clearly the most drastic consequence of volatile substance abuse – death, including the phenomenon known as 'sudden sniffing death' – is dealt with in Chapter 3.

### *Short-term effects*

Although the psychoactive effects of inhaling volatile substances occur rapidly, they are of relatively brief duration. They last from 5 to 45 minutes after cessation of 'sniffing.' The initial effect may fade after several minutes, depending on the method of inhalation.<sup>16</sup> Nonetheless, the fat soluble nature of the substances and the consequent storage of compounds in fat deposits, particularly in the brain, may 'lead to a prolonged effect on the level of consciousness even hours after the inhalation has stopped' (WADASO 1998, p. 11). Continued inhalation may lead to increased intoxication, a state in which confusion, perceptual distortion and hallucinations may cause accidents

15 See below and Appendix 3.

16 In Britain, where the predominant form of inhalation abuse is that of butane, the short-term effects of this form of volatile substance are very short-lived. In July 2001, the Committee met with Dr John Ramsay of St George's Hospital Medical School, London, and a leading expert on volatile substance abuse. He commented on the quick 'recovery period' for inhalers of butane products:

I think the prime advantage to a youngster with butane is that you can leave school at 3.30, you can be bombed out of your mind at 4 o'clock and stone cold sober again at 5, now you can't do that with any other intoxicant. So as teenage intoxicant, butane couldn't be better designed really. It is in these convenient packs, 250 mls packs for a pound that you can carry around with you. You can get the gas out by clenching the nozzle between your teeth; it is the absolute ideal intoxicant for a 15 year old. That is the problem we have, I think.

Dr John Ramsay, in conversation with the Drugs and Crime Prevention Committee, 10 July 2001, London.

or prompt aggressive behaviour (Cameron 1988). Recovery from the acute effects of intoxication is usually relatively rapid unless gross intoxication has been produced, but the rate of recovery depends on the volatility of the substance and the length of exposure. Petrol sniffers, in particular, have been documented as being subject to severe mood swings and extreme depression. Suicide attempts and suicidal ideation is not uncommon. These tendencies are compounded if petrol is used in association with alcohol (Ministry of Youth Affairs, New Zealand 1996, p. 7).

Other short-term effects of inhalation can include:

- ◆ Feeling of well-being
- ◆ Drowsiness
- ◆ Confusion
- ◆ Aggression
- ◆ Enhanced risk taking
- ◆ Loss of inhibition
- ◆ Loss of muscular coordination
- ◆ Incoherence
- ◆ Vomiting
- ◆ Slurred speech
- ◆ Blurred vision (Crompton, 1996)

Short-term effects can be grouped as occurring at the approximate stages as follows. These effects can be divided into four stages:

1. *Initial* – Excited, dizzy, exhilarated, visual and auditory hallucinations, nausea;
2. *Early central nervous system depression* – Dullness, disorientation, loss of self-control, blurred vision;
3. *Medium central nervous system depression* – Drowsiness, lack of muscular coordination, slurring;
4. *Late central nervous system depression* – Stupor, delirium, epileptic type seizures.

*One boy believed he got supernatural powers through chroming, that he could get under the white lines on the road and that if he looked at the moon and touched graffiti he became full of these powers and could do really frightening things.<sup>17</sup>*

One of the clear dangers associated with the use of volatile substances is the risk for accidents to occur while in an intoxicated state. Some volatile substances may cause hallucinations and/or make the user feel very relaxed or sleepy. It has been reported that whilst under the influence of volatile substances some people have acted out fantasies, feeling invincible or impregnable. Injury and death can result from accidents sustained

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17 Staff member, MacKillop Family Services, in MacKillop Family Services, Submission to the Drugs and Crime Prevention Committee, Inquiry into inhalation of volatile substances, October 2001, p. 9.

while in such a state.<sup>18</sup> Indirect causes of death may occur from injuries caused by falls or drowning when intoxicated, by fire or explosion when a highly flammable vapour ignites, or by asphyxia due to unsafe inhalation practices.<sup>19</sup>

One welfare agency has informed the Committee of its experiences with young people in its care who 'chrome':<sup>20</sup>

Fatal injury due to accidents associated with volatile substance abuse occurs in a variety of ways, such as road accidents, jumping off buildings or other structures, falling or jumping in front of moving vehicles such as trains, or drowning. The effects the chemicals produce upon the brain, and also the location and ways in which the substance is used, can lead to fatal injury from accidents. Young people often use volatile substances at train stations, near railway lines or freeways, or on the roofs of buildings. Such places may be appealing to young people because they are isolated and out of the way of authority.

There are other dangers associated with where they chrome: sometimes they do it on the roof or in train stations, and these are really dangerous places if they get spaced out.

Volatile substances can produce hallucinations, feelings of self-confidence and ataxia (lack of muscular coordination).

These can in turn lead to injuries or death to young people through falling off buildings, due to loss of coordination or hallucinating they can fly. Some may wander across roads and railway lines wanting to investigate something they can 'see' on the other side. Further to this, fatal injuries are also caused in road accidents involving drivers under the influence of volatile substances.

We had one person on the roof for four hours, up very high on the edge, and we had the fire brigade and police and it was very dangerous, and he was going to jump, and there was nothing we could do until he ran out of chrome and started to come to his senses.

### ***Long-term effects***

Long term use of volatile substances may result in

- ◆ Chronic headache
- ◆ Sinusitis
- ◆ Diminished cognitive function
- ◆ Ataxia (lack of muscle co-ordination)
- ◆ Chronic or frequent cough
- ◆ Tinnitus
- ◆ Chest pain or angina

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18 See Cameron 1988.

19 See Cameron 1988 and Appendix 3.

20 MacKillop Family Services, Submission to the Drugs and Crime Prevention Committee, Inquiry into Inhalation of Volatile Substances, October 2001, pp. 8–9.

- ◆ Nosebleeds
- ◆ Extreme tiredness or weakness
- ◆ Increased nasal secretions
- ◆ Red, watery eyes
- ◆ Depression and/or anxiety
- ◆ Shortness of breath
- ◆ Indigestion
- ◆ Dizziness
- ◆ Stomach ulcers (Commonwealth Department of Human Services and Health 1984).

Chronic users may also experience withdrawal symptoms and/or hangover effects. These may persist for several days and may be characterised by:

- ◆ Tremor
- ◆ Headache
- ◆ Nausea
- ◆ Vomiting
- ◆ Mild abdominal pain
- ◆ Loss of appetite
- ◆ Fatigue
- ◆ Muscular cramps
- ◆ Delirium (Commonwealth Department of Human Services and Health 1984).

It has been argued that perhaps the most significant toxic effect of chronic exposure to volatile substances is widespread and long-lasting damage to the brain and other parts of the nervous system. For example, human pathological studies indicate that chronic abuse of volatile solvents such as toluene damages the protective myelin sheath around nerve fibres in the brain and peripheral nervous system. Other research has disputed such findings.<sup>21</sup>

The neuro-toxic effects of prolonged inhalant abuse include neurological symptoms that reflect damage to parts of the brain involved in controlling cognition, movement, vision and hearing. Cognitive abnormalities can range from mild impairment to severe dementia. Other effects can include difficulty coordinating movement, and loss of feeling, hearing, and vision.

Inhalants may also be toxic to other organs. Chronic exposure can produce significant damage to the heart, lungs, liver and kidneys. Although some inhalant-induced damage to the nervous system and other organs may be at least partially reversible when inhalant abuse is stopped, many syndromes caused by repeated or prolonged abuse can be irreversible, although again there are conflicting views with regard to such findings. (See discussion later in this chapter.)

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21 See discussion later in this chapter.

## Psychological and behavioural effects

*Chroming's addictive behaviour in the sense that a kid who wants to hide or run away from an emotional issue can do it instantly. They need it to mask the pain. It's not just social, like say marijuana.*<sup>22</sup>

Only a small percentage of young people ever try volatile substances. For example, a comprehensive survey done by the Western Australia Research Institute for Child Health conducted in 1994 found that of Perth's 12–16-year-olds, about 2.4 per cent of the sample had ever used solvents in the last year. At the national level, the 1993 National Household Survey showed 6 per cent of males and 5 per cent of females (14–19 years of age) had ever tried solvents (quoted in Dear & Helfgott 1997, p. 3).<sup>23</sup> Of those who do inhale volatile substances it is a short-term or experimental form of behaviour for most.<sup>24</sup> For those who do use chronically there is the possibility of psychological complications. Although volatile substances are not thought to be physically addictive, evidence suggests that chronic users may develop a strong psychological dependence (Gorny 1994, cited in MacKillop Family Services 2001). An earlier report has noted:

Some research has indicated that while the substances inhaled in solvent abuse are not in themselves addictive, the practice of solvent inhalation is self-reinforcing and tends to become habitual. It remains to be determined whether in cases of solvent inhalation there are physiological factors underlying the psychological needs of habitual users. Little is known about the patterns of use which would characterise the dependent user as opposed to other users or describe their relative numbers; nor is there information on the variations in response to the different solvents by different individuals (Commonwealth Department of Health 1984, p.19).

Those who work with young substance abusers in the field have little doubt that there is a link between (chronic) volatile substance abuse and psychological dependence. In a submission to this Inquiry, MacKillop Family Services states:

Volatile substances are generally not regarded as resulting in physical dependency. In some cases there are minor withdrawal symptoms such as headaches and irritability, but there are no symptoms on the same level as suffered when withdrawing from other drugs such as alcohol or heroin. However, research has established that psychological dependence upon volatile substances is possible. Psychological dependence usually occurs among chronic users, but not experimental users. This is likely to be linked to the chronic user's reasons for using inhalants, which are often long term emotional and family problems. Our workers report that volatile substances provide the user with a way of masking the reality of their problems and pain.

The submission from Berry Street Victoria makes similar claims stating:

22 Staff member, MacKillop Family Services, in MacKillop Family Services, Submission to the Drugs and Crime Prevention Committee, Inquiry into Inhalation of Volatile Substances, October 2001, p. 9.

23 Further information on prevalence is given in Chapter 3.

24 See discussion later in this chapter.



A strong need to continue using inhalants has been reported among many individuals, particularly those who abuse inhalants for prolonged periods over many days, as many of Berry Street's young people do.<sup>25</sup>

The link between inhalation of volatile substances and the manifestation of antisocial and criminal behaviour is far more tenuous. Werry has argued that as with other forms of intoxication that depress the central nervous system, the inhalation of volatile substances can facilitate a number of undesirable antisocial behaviours such as violent and sexual crimes. He does acknowledge, however, that there is no hard data to support this proposition in the case of solvents (Werry 1992, p. 8). The links have been drawn much more starkly in Britain. Warren Hawksley, Director of Re-Solv, the British society for the prevention of solvent and volatile substance abuse, made the following comments during a meeting with this Committee in London in July 2001:

We get a lot of crimes – not as in drugs where it is stealing to fund it [solvent abuse] because the products are easily available and fairly cheap – it is unusual, although we do occasionally get that. But I should think without checking the statistics we get something like five murders a year that are connected [to solvent abuse]. We had an 80-year-old Roman Catholic priest befriended and tried to help a solvent abuser and he murdered him in Albury last year. I think the most horrific was the case, in Belfast, of a 3-year-old girl, who was raped by a gang high on solvents. You can't imagine anything more horrific ...

[Solvent related offences] are nearly all public-order offences that are committed by people, but there is a terrific amount of it going on. I would say in the three years I have been there we are getting an increasing level of crimes being reported.<sup>26</sup>

In a recent Background Paper written for the Western Australian Working Party on Solvents Abuse, Rose (2001) makes the following observations on the links between delinquency and volatile substance abuse, drawing from the American experience:

A study from the USA<sup>27</sup> showed people who abused volatile substances who were on probation had more neighbourhood gang activity, peer and parental substance abuse, intentions to engage in illegal behaviour, substance-related criminality and substance abuse than did their non-using peers on probation. In another study<sup>28</sup> from the USA which compared incarcerated adolescents with and without a history of VSA, higher rates of delinquent behaviour was noted in those with a history of VSA. Delinquent behaviour included earlier use of drugs, buying and selling illegal drugs, committing crimes while under the influence, committing crimes to get money to buy drugs, and

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25 Berry Street Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 6.

26 Warren Hawksley, Director, Re-Solv in conversation with the Drugs and Crime Prevention Committee, 10 July 2001, London.

27 M.O. Howard & J.M. Jenson, Inhalant use among antisocial youth: Prevalence and correlates, *Addictive Behaviors*, vol. 24, no. 1, 1999, pp. 59–74.

28 E. McGarvey, R. Canterbury & D. Waite, 'Delinquency and family problems in incarcerated adolescents with and without a history of inhalant use', *Addictive Behaviours*, vol. 21, no. 4, 1996, p. 537–42.

threatening to hurt people. In addition they had more family problems such as running away from home, breaking rules, and fighting with parents.

While one does not want to dismiss claims such as these, in the Australian context, at least, there is simply insufficient evidence or research to be able to confidently posit a firm nexus between inhalation of volatile substances and criminal or antisocial behaviour.<sup>29</sup>

On balance, one needs to be careful about drawing firm conclusions about the nexus between volatile substance abuse and psychological aspects. It is possible that some of the manifestations of behavioural disturbance among users are cause rather than effect. In other words, the chronic user may have a behavioural disposition to use the substances rather than antisocial behaviour being a manifestation of such use:

The picture of the adolescent inhalant-abuser drawn from the data shows that the inhalant-abuser appears to be an individual under pressure of many stresses, both psychological and environmental. While this form of drug abuse may temporarily reduce stress, undoubtedly the same form of drug abuse behaviours further alienate these individuals from society, leading to even more stressful situations (Commonwealth Department of Health 1984, p. 18).

### ***Debates over the consequences of inhalation of volatile substances***

The physical and psychological sequelae of volatile substance abuse outlined above are by no means universally accepted by those professionals and others, including medical personnel, working in the area. This is particularly true with regard to the long-term effects of such abuse.<sup>30</sup> The Commonwealth Department of Health has written:

Much of the concern aroused by solvent abuse is centred around the effects the practice may have on health. A good deal of what is written on the harmful effects tends to ignore distinctions between solvents and to attribute to each and every one of them the combined total of possible effects of them all. ... [For example] The general belief that glue sniffing causes permanent brain damage appears to stem from isolated case reports. A study conducted into the medical implications of solvent abuse in brain impairment found no evidence of this. The researchers recorded that while some users showed temporarily abnormal electroencephalogram tracings, these reverted to normal when the solvent's effects had worn off (Commonwealth Department of Health 1984, pp. 11, 13).

The findings over long-term damage to the brain have been particularly contentious. One comprehensive review of the literature that formed part of a submission to this Inquiry states:

There is much debate as to whether or not the abuse of volatile substances results in irreversible brain damage. Some studies have reported that brain damage does not

29 Of interest, however, is a manslaughter trial currently before the Supreme Court of Victoria. In this case the young defendants pleaded guilty to the manslaughter of an elderly woman. They have pleaded in mitigation that their judgement was impaired by their chroming practices. The presiding judge has requested background information pertaining to chroming from the Committee.

30 One medical researcher has gone as far as saying that when it comes to toxicology the 'mythology' about solvent abuse reaches its 'hysterical crescendo' (Werry 1992, p. 7).

occur, others report that it occurs in chronic users but reverses after a period of non-use, others again report cases of irreversible brain damage occurring in long term and chronic users.<sup>31</sup>

Australian researchers have described evidence of long-term harm resulting from solvent abuse as 'controversial'. Mechanisms by which individual solvents damage organs and organ systems are not well understood. Studies have concentrated largely on industrial settings in which workers are exposed to small amounts of volatile substances over an extended period of time (Chen, Wang et al. 1997; White & Proctor, 1997). The results from such studies cannot be extrapolated to young solvent abusers whose use is characterised by inhalation of concentrated amounts of volatile substances over short periods of time. In 1995 the British Advisory Council on the Misuse of Drugs noted:

Long-term studies of young people who have engaged in VSA are comparatively rare ... there is a scarcity of reliable information on the long-term damage which young people may be doing to themselves through VSA (Advisory Council on the Misuse of Drugs (UK) 1995, p. 49).

An earlier British study conducted in 1986 – The Strathclyde Study – found that there was no significant risk of long-term impairment as a result of solvent sniffing. What is significant is the fact that this is one of the most comprehensive studies of its kind ever undertaken worldwide. Dr Joyce Watson, the chief researcher, interviewed 788 individual solvent users and examined their medical histories. She noted:

From [the author's] study of 788 individual glue users, it is clear that the risk of developing any impairment due to solvent abuse is small. When it does occur, there are many factors such as lack of oxygen or individual susceptibility which might act singly or in combination making it impossible to predict who might be at risk (Watson 1986, pp. 147–48).

The difficulty in ascribing medical pathology to certain substances is further compounded by the fact that many products contain more than one solvent. The effects of solvent combinations are little understood. Certainly it would seem that glue sniffing in relative terms is a 'safer' substance to inhale than petrol or chrome paint:

[Glue's] relative safety probably arises from the fact that its vapours are made up of various hydrocarbons lacking the complicated chlorine and fluorine compounds (fluorocarbons) which are found in some other products, which do seem to be more immediately toxic, and also from the fact that being solid, glue is not generally directly ingested in the way that aerosols tend to be. For this reason only the solvent vapours find their way into the air passages and lungs, not the substances meant to be left behind after these solvents have evaporated. Nor is glue a severe fire risk, as petrol can be (Institute for the Study of Drug Dependence 1981, p .2).

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31 Submission by MacKillop Family Services to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 6, citing S. W. Gorny, 'Inhalant abuse as an adolescent drug problem: An overview', *Child and Youth Care Forum*, 23 March 1994.

Although the above comments are fairly dated, more recent Australian research makes similar conclusions. A study conducted in Western Australia with regard to the sniffing of 'Kwikgrip' resulted in some interesting findings:

There have been case studies, typically of heavy users, which provide clinical indications of the toxic effects of contact adhesives and toluene (a principal component). However, other large scale studies of glue sniffers have failed to show any significant difference between sniffers and non sniffers, once social and economic variables are taken into account. The researchers involved have concluded that long-term neurological impairment from glue sniffing is rare and, when it does occur, is often reversible (Midford et al. 1993, p. 634).

The reason postulated as to why this might be the case centres on the chemical make-up of adhesive products. Kwikgrip, for example, was made up of 53% toluene, 35% N-Heptane and 12% methyl ethyl ketone (MEK). Although toluene is more toxic than the other compounds, tests showed it to leak from the polythene bag at a far greater rate than n-Heptane or MEK. Toluene at no time accounted for more than 40% of the vapour cocktail.<sup>32</sup> Its concentration after a few minutes falls rapidly whereas the concentrations of the other less toxic compounds rose steeply:

These findings demonstrate that toluene, the principal component in liquid Kwikgrip, is not necessarily the principal volatile substance inhaled under typical sniffing conditions. This information may go some way towards explaining why toxic effects associated with long term exposure to toluene have not been demonstrated in the majority of glue sniffers (Midford et al. 1993, p. 635).

Despite these difficulties and the academic differences of opinion, there are valid reasons for concern. Experimental and industrial toxicological research indicates that, in some circumstances, several of the commonly misused substances can cause damage to tissues of the body including, as has been noted above, the brain (Rosenberg & Sharp 1992; Grasso 1998), sense organs (Pryor et.al. 1991; Hollo & Varga 1992), the peripheral nerves (Lolin 1989), liver (Ungvary et.al. 1982), kidneys (Gupta, Van Der Meulen & Johny 1991), and the bone marrow (Tunek, Hogstedt & Olofsson 1982). It is probable that although some types of damage are recoverable, others, to a degree, will be cumulative with increased exposure and, *perhaps*, irreversible. Those substances which stay in the body for a long time may pose greater dangers of tissue damage than substances which are rapidly eliminated in the breath. For example, one report has noted:

A further danger with volatile substance misuse is that some substances known to be abused contain chemicals which are more toxic than the solvent itself. A real and less visible danger may lie in the lingering and long-term effects from ingested chemicals or metals which the body is incapable of excreting, such as copper, lead, zinc or vinyl chloride. These chemicals may remain in the body, possibly to cause harm in later life, with such effects as cancer, chronic zinc or copper poisoning or gradual brain damage (Commonwealth Department of Health 1984, pp. 12-13).

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32 However, Toluene has been noted to make significant contributions to renal toxicity and renal complications. See Brouette and Anton 2001.

The long-term effects of exposure to lead are clearly of concern when applied to the sniffing or inhaling of petrol and petrol based products that include lead.

The Committee thus recognises that there is much academic and scientific debate as to the precise medical and social consequences of inhaling volatile substances. The Committee also acknowledges, however, that for many workers in the field, for the many individuals, parents and communities who know or love a young person who abuses volatile substances, such debates, if not irrelevant, are a diversion from their most pressing concerns – assisting young people to stop harming themselves by inhaling these substances. For example, the Committee has received a submission from the Victorian Regional Council of ATSIC expressing its concerns over the way in which chroming is affecting Indigenous youth in Victoria. It states:

Though chroming is not addictive, it is particularly detrimental to people because of the immediate and serious nature of the damage it causes. It does not have to be addictive as even mild use damages the brain irreparably.<sup>33</sup>

While the assertion in this quote is probably not correct as a statement reflecting current medical knowledge, the Committee does appreciate and sympathise with the sense of frustration and anguish felt by Indigenous agencies with regard to the issue of inhalation of volatile substances. It will be covering the issue of volatile substance abuse amongst Indigenous youth both in this Discussion Paper and in its Final Report after further deliberations and consultations with members of the Victorian and Australian Indigenous community and Indigenous agencies.

### **Questions to consider**

- ◆ What are the distinctions that are being made between solvents and other drugs?
- ◆ How do these distinctions impact on policy and practice?
- ◆ Should solvents be classified as drugs at all?
- ◆ Is there any evidence to suggest that petrol sniffing is a problem in Victoria?

#### ***For medical, scientific and health professionals***

- ◆ Are there any further medical consequences of volatile substance abuse other than those hitherto mentioned in this chapter?
- ◆ If you work in the field of (volatile) substance abuse, from your observations what are the medical and psychological consequences of volatile substance abuse?
- ◆ The literature on the medical impact of volatile substance abuse is divided. What further evidence is there that you are aware of to support either side of the argument as to the consequences of volatile substance abuse?

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33 Submission by the Binjirru and Tumbukka Regional Councils (ATSIC, Victoria) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 2.

# 3. The extent of the problem: Prevalence, mortality and morbidity

## Introduction

Whilst the prevalence and magnitude of volatile substance abuse (VSA) should not be over-estimated neither should it be viewed as insignificant. The issue of volatile substance abuse has been overshadowed in recent years by justifiable concerns surrounding a rapid increase in the availability and use of heroin and by accompanying debate as to the merits of various policy responses. However, the Committee has been made aware of growing concern that the use of these volatile substances is increasing and, as such, is an issue in urgent need of address. The following chapter examines the extent of the problem in Victoria by reference to available prevalence, mortality and morbidity data.

Levels of inhalant-related mortality and morbidity are the primary indicators of the human costs of volatile substance abuse. Mortality rates are based upon data gathered through the Victorian Coroner's Court and the Victorian Institute of Forensic Medicine. Morbidity information is derived from ambulance data collected by the Metropolitan Ambulance Service and Turning Point Drug and Alcohol Centre.<sup>34</sup>

It is important to emphasise the necessity for caution when interpreting the figures cited in this chapter. The accurate measurement of drug use, and of volatile substances in particular, is compromised by a number of methodological obstacles that are addressed below.

## Prevalence data

The use of volatile substances by school-age youth has been recorded in Australia since the 1970s. In 1974 a Queensland survey found that 6.5 per cent of school children reported use of inhalants. Solvents were used by 8.1 per cent of males and 4.9 per cent of females. Primary students reported a higher incidence of use than secondary students (Australian Royal Commission of Inquiry Into Drugs 1980). In contrast, a 1983 survey of 4,165 NSW students in Years 7–11 found inhalant use to be highest amongst adolescent girls. Thirteen-year-old girls were the most likely to be 'sniffing' on a regular basis (Commonwealth Department of Health 1984). Other results have indicated that levels of use varied from school to school (Commonwealth Department of Health 1984).

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34 In addition to ambulance data, the Committee is in the process of obtaining information on inhalant-related admissions to public hospitals and Emergency Departments. An analysis of this data will be provided in the Committee's Final Report.

Researchers have consistently found the use of volatile substances to be concentrated among adolescents (Rose 2001; Mundy 1995; Dear 1995; Rose, Daly & Midford 1992; Walker 1992; Chalmers 1991). However, it is important that the nature and extent of this use is addressed before figures are discussed. A further consistency of past research has been the finding that most young people will never use inhalants and of those who do, the greater majority will be experimental users of whom very few will develop a dependency (Department of Human Services (DHS) 2001c; Rose 2001; Mundy 1995; Rose Daly & Midford 1992; Werry 1992). Anecdotal evidence in the UK suggests that only one in ten experimenters carry on with sniffing for even a few months; and possibly as few as one in 50 become dependent users (Ives 1994). However, this is not to trivialise what, for a significant number of persons, may develop into a pattern of problematic inhalant abuse.

### ***Measuring prevalence in Victoria – Population surveys***

Prevalence data is primarily based upon population surveys. Three surveys have been used in order to establish the prevalence of volatile substance use in Victoria:

- ◆ The National Drug Strategy Household Survey is the largest drug-related survey conducted in Australia. It has been repeated in a similar format every 2–3 years since 1985. In 1998 the survey was conducted by the Australian Institute of Health and Welfare and involved interviews with 3,500 people aged 14 years and over (ABS 2001). It is anticipated that there will be approximately 20,000 respondents to the 2001 questionnaire (ABS 2001).
- ◆ The Australian School Students Alcohol and Drugs (ASSAD) Survey conducted in 1996 was the first national survey of students to obtain data about illicit drugs. It was coordinated by Anti-Cancer Council of Victoria and asked questions of approximately 31,000 school students aged 12–17 years who were selected randomly from government and independent schools. A second survey was conducted in 1999, with results to be published in late 2001 (ABS 2001).
- ◆ The Victorian School Students and Drug Use Surveys record Victorian students use of over-the-counter and illicit drugs. In 1996 and 1999 surveys were conducted by the Centre for Behavioural Research in Cancer, funded by the Anti-Cancer Council of Victoria and the Victorian Department of Human Services. Previous surveys in 1992, 1989 and 1985 were conducted by the Department of Human Services. In 1996, this involved 4,700 students who also took part in the 1996 ASSAD survey. In 1999, 4,286 students from Years 7–12 took part. These students were drawn from a representative sample of 67 secondary schools across Victoria (DHS 2001b).

### **Limitations of survey data**

#### *The measurement of drug activity*

The measurement of drug activity will always present significant research difficulties. The use of population surveys as the primary means of measurement inevitably raises questions of validity and reliability. Such problems may arise as a consequence of false

reporting or through respondents' misinterpretation of questions asked. Gaining access to a representative sample of the population presents further problems, particularly when active drug users are more liable to escape the attention of traditional surveys. Each of these issues, elaborated upon below, must be taken into consideration when interpreting the survey data reported within this section.

Illicit drug users often go to elaborate lengths to keep their illegal activities hidden. They may, consequently, be unwilling to reveal the extent of these activities to an unknown researcher. Suspicion as to the identity and motives of researchers may further impact upon the accuracy of the research findings. In this respect, the researcher must be prepared to acknowledge that surveys record what respondents *say* about their drug use, and not what they actually *do* (Moore 1992). It would be naïve to expect population surveys to generate data that is accurate beyond question (Bourgois, Lettiere & Quesada 1997).

This issue has arisen in the case of Victorian school based surveys conducted in 1996 and 1999. As Year 7 students in 1996 would be Year 10 students in 1999, it would be expected that a similar proportion or higher of Year 10 students would report having ever used inhalants in 1999 than the number of Year 7 students reporting having used inhalants in 1996. However, while 33 per cent of Year 7 students reported inhalant use in 1996, only 24 per cent of Year 10 students did so in 1999 (DHS 2001b). One reason could be false reporting. Year 7 respondents may have reported sniffing when they had not taken part in such activity (perhaps a desire to boast of dangerous exploits). Or, conversely, respondents may have later sought to deny their experimentation (perhaps later seen as 'childish'). Regardless of the reasons, such variance demonstrates the necessity for caution when interpreting survey results.

An alternative explanation for the disparity between survey results may be the potential for misinterpretation of questions. Questions relating to volatile substances and inhalants are particularly susceptible to such problems, as the following examples demonstrate. Is nitrous oxide or amyl nitrate to be included in a question regarding the use of inhalants? Is the use of glue included in a question about 'chroming'? Is 'sniffing' taken to mean having smelt a substance or, rather, having used it for the purposes of intoxication? Such questions can cast doubt on survey findings, particularly those that target younger children who may not be so clear about what is meant (Ives 1994). In the instance of the 1999 *Victorian School Students and Drug Use Survey*, students were asked if they had ever used inhalants. This was defined as having:

Deliberately sniffed (inhaled) from spray cans or sniffed things like glue, petrol or thinners in order to get high or for the way it makes you feel (DHS 2001b, p. 4).

The potential for misinterpretation here is considerable. The authors of this study noted that younger age groups could have been more liberal in their definition of inhalants, probably including items such as liquid paper and felt-tip pens (DHS 2001a).

A further concern is the serious doubt as to whether surveys are able to reach a representative sample of the population. Surveys are unlikely to reach those in the community who might be characterised as 'hidden.' The most active drug users and those



most likely to suffer from a broad range of health problems would be included within this group (Hopkins & Frank 1991; Jacobs & Miller 1998). Ives (1994), for example, states that there are good reasons for believing that those young people who are more likely to use drugs are the same young people who will be more likely to be absent from school and consequently missed by school based surveys. Likewise, the homeless, the incarcerated, and those in special accommodation are all populations with disproportionately high reported rates of illicit drug use, and yet they will not be 'captured' by national household surveys, the traditional measure of illicit drug use in Australia.

In addition, the capacity for national surveys to provide regional data is restricted by the sample size of the sample population in any category. The base population used by National Household Surveys, for example, is not of a size that might allow state-wide distinctions to be drawn. Similarly, the small number of respondents in categories that address issues of ethnicity or self-identification as an Indigenous person limits the use of resulting data.

An additional problem with survey techniques is that they are only able to provide a snapshot of drug use. They provide little information on patterns of use over time, an issue of particular importance when considering the cyclical nature of solvent abuse.<sup>35</sup>

#### *The measurement of volatile substance abuse*

A constant observation made by researchers, teachers and community workers with whom the Committee has met and in the submissions that the Committee has received is the lack of quantitative and qualitative data with regard to volatile substance abuse. For example the submission of the Wyndham City Council states:

Presently there is very little statistical information available regarding the prevalence and patterns of use regarding the inhalation of volatile substances on a State and a local government level. The absence of this information has made it difficult to develop targeted and strategic responses to volatile substance misuse.<sup>36</sup>

The issue of age is also of particular importance when considering survey data related to volatile substance use. As noted above, young adolescents comprise the greater proportion of individuals engaging in the inhalation of volatile substances. However, the largest drug-related survey conducted in Australia, the National Drug Strategy Household Survey, limits questions to those aged 14 years and over, effectively omitting a sizable number of those who use volatile substances. School based surveys, such as the Victorian School Students and Drug Use Surveys, concentrate solely upon the

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35 This issue is addressed in detail in Chapter 5 of the Discussion Paper.

36 Submission of Wyndham City Council to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3. In this submission Wyndham Council made the following recommendation:

Further research needs to be conducted regarding the prevalence and patterns of use amongst youth that inhale volatile substances. This research needs to be responsive and relevant to local communities.

A coordinated response to the volatile substance misuse is required. Including the development of a data collection and monitoring system to map patterns of volatile substance misuse to target interventions. Local level data on volatile substance misuse should be recorded and distributed to the key stakeholders. (Wyndham City Council Submission, p. 6)

activities of secondary school students, potentially excluding inhalant users in primary school. The limited reach of these surveys results in a limited understanding of the prevalence of volatile substance use in Victoria.

As noted above, issues of definition present particular difficulties to researchers engaged in the measurement of volatile substance use. As the Drugs Policy and Service Branch of the Victorian Department of Human Services (DHS) noted in a submission to the Committee:

Inhalant abuse is not only 'hidden' in terms of the covert nature of use, but equally 'hidden' in the broader collection of data on causes of death,<sup>37</sup> in police statistics (given that inhalant abuse is not illegal) and in national and international classification of diseases. Additionally the various definitions (and therefore individual understandings) of 'sniffing' provided in drug surveys and data collection add to the inconsistencies with reported rates of inhalant abuse. It is not surprising therefore that reported rates on inhalant abuse vary from around 5 per cent to 25 per cent (DHS 2001).

In addition, the very fact that volatile solvents are not illegal restricts the amount of information available as to their use. A number of the largest and most comprehensive national drug use surveys are concerned solely with illicit drugs. The Illicit Drug Reporting System (IDRS), for example, identifies emerging trends in illicit markets, information that proves vital in the formulation of preventative strategies. However, volatile substance use is not an illegal activity and, consequently, it is not analysed by such research tools as the IDRS.

It is perhaps a consequence of such difficulties that volatile substance abuse remains an under-researched form of drug use. There is currently little known about the dynamics of VSA in Victoria, a situation that appears unlikely to improve until consistent and uniform data gathering techniques are developed and employed.

## **What does the data say?**

The following section draws upon the surveys mentioned above, before addressing a range of additional evidence, both statistical and anecdotal, so as to appreciate the extent of volatile substance abuse. It is important to contextualise the Victorian situation by first examining national prevalence data.

### ***Survey evidence***

#### **The national context**

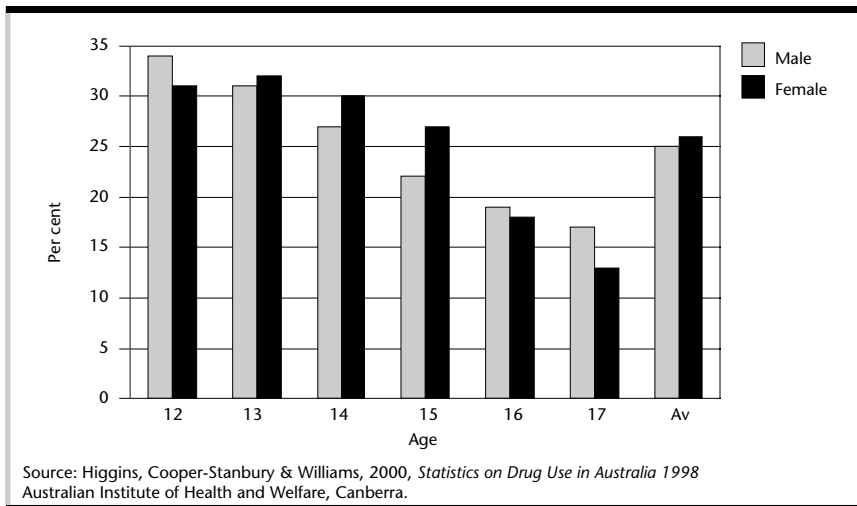
The prevalence of volatile substance abuse in Australia appears relatively low. Of 3,500 people aged 14 and over who were interviewed in 1998 for the Australian National Drug Strategy Household Survey, 3.9 per cent reported having used inhalants at some time (Australian Institute of Health and Welfare 1999). This represented an increase from the 2.4 per cent of persons who reported having used inhalants in the 1995 Household Survey (Australian Institute of Health and Welfare 1999).

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37 The 'hidden' nature of inhalant abuse in the collection of data on related mortality will be further addressed below.

Although such figures appear low, it is important to reiterate that the population base of Australian Household Surveys greatly compromises the resulting data as an indicator of youth drug use. As Carroll et al. (1998) note, volatile substance abuse is generally confined to those between the ages of 10 and 16 years, with most use occurring between the ages of 12 to 14. Because of their low cost, easy availability, ease of concealment and (for many volatile substances) the difficulty of having legislative control over possession and purchase, volatile substances may, for many, be the first psychoactive substances used. However, as noted above, Household Surveys are restricted to those aged 14 years and over, potentially excluding a significant proportion of volatile substance users.

**Figure 3.1: Lifetime inhalant use by Australian secondary school children, 1996**



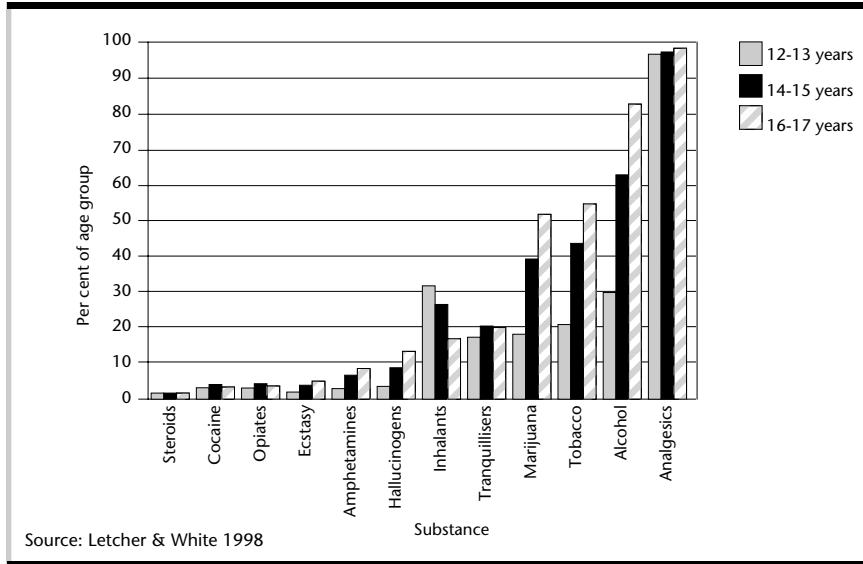
In contrast to general population surveys, the Australian School Students Alcohol and Drugs Survey 1996 recorded much higher rates of volatile substance use amongst its target population of students aged 12–17 years.<sup>38</sup> Eighteen per cent of males in this age group self-reported using inhalants over the past 12 months, as did 19 per cent of females (Higgins, Cooper-Stanbury & Williams 2000). As Figure 3.1 shows, the highest rates of lifetime inhalant use (those who reported having ever used inhalants) were recorded by 12 year olds (34 per cent of males and 31 per cent of females). Rates steadily declined in each subsequent year.<sup>39</sup>

38 It is important to draw attention to the exclusion of those aged under 12 years from survey data. Currently, there is almost no information available on the use of volatile substances by those aged under 12 years. The Committee would welcome submissions of any nature in respect to volatile substance use within this age group.

39 These figures were used by the United Nations to demonstrate that Australia had the highest lifetime prevalence of inhalant use (25.5 per cent). The next highest was the United Kingdom at 20 per cent. However, the figures used by the UN were not comparable. New Zealand, for example, reported a lifetime prevalence rate of just 1.5 per cent, but this figure was based on a 1990 survey of persons aged 15–24, missing the peak age for solvent use and using data so old as to be obsolete.

The decline in the use of inhalants by secondary school students follows a markedly different pattern to the use of other drugs. Figures from the 1996 Australian School Students Alcohol and Drugs (ASSAD) Survey show that both licit and illicit drug use amongst those aged 12–17 years increases with age. The most dramatic increases, as noted in Figure 3.2 below, were the consistent increases in the use of marijuana and alcohol.

**Figure 3.2: Lifetime use of licit and illicit substances by secondary school students in Australia, 1996**



That fact that the use of alcohol and tobacco increased at a similar rate to the rate at which the use of inhalants decreased is particularly interesting. In effect, this correlation supports the argument, raised further in Chapter 5, that the use of volatile substances declines as access to alternatives such as marijuana and alcohol increases. The financial and legal constraints that make these latter drugs difficult to access for younger age groups may fall away as they grow older, diminishing the attraction of cheap and easily accessible volatile substances.

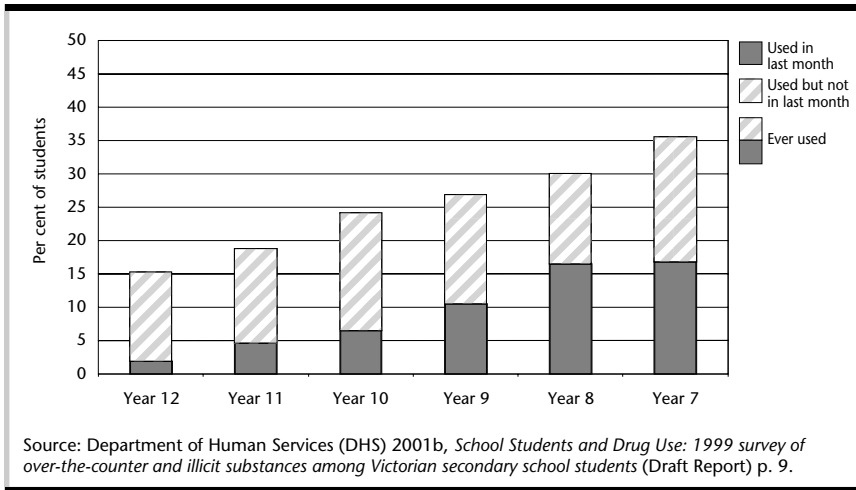
### **Volatile substance abuse in Victoria – Age of users**

The 1996 Victorian *School Students and Drug Use* survey reported that 24 per cent of students had deliberately sniffed inhalants at least once during their lives. It reflected national findings by recording a considerable difference in the proportions of younger and older students reporting use of inhalants (DHS 1999). Year 7 students were nine times more likely than those in Year 12 to report having used inhalants in the last month (18 per cent compared to 2 per cent) and nearly three times more likely to report ever having used inhalants (DHS 1999).

Similar trends were observed in the Victorian 1999 *School Students & Drug Use Survey*. Again there was little discernable gender difference but a noticeable age difference.

Reported use of inhalants was more common among younger students than among older students. Lifetime use of inhalants decreased from 35 per cent (Year 7 students) to 15 per cent (Year 12 students) (DHS 2001b). Recent use of inhalants also decreased with age. While 16.8 per cent of Year 7 students reporting having used inhalants in the past month, this gradually declined to just 1.9 per cent of Year 12 students reporting inhalant use in the past month. (DHS, 2001a).<sup>40</sup>

**Figure 3.3 Inhalant use by year level and frequency, Victorian secondary school students, 1999**



This consistent pattern of inhalant use declining with age differs from all other substances where use becomes more prevalent as students progress through secondary school (DHS 2001b). This pattern may suggest that older students see inhalant use as immature behaviour. However, it also says much about the accessibility of inhalants and offers some evidence for the likelihood that the use of inhalants is decreasing as substances such as alcohol and marijuana become either more accessible or more affordable.

### Volatile substance abuse in Victoria – Gender

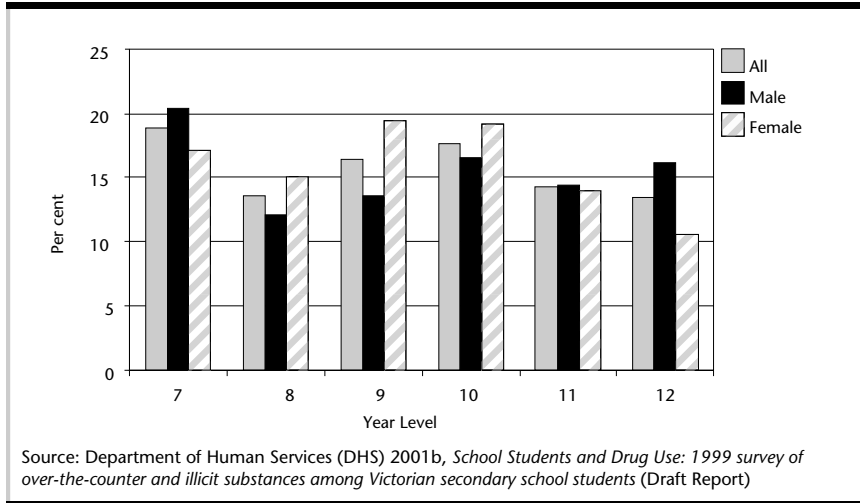
When the above survey data is analysed according to gender, there appears to be no major significant difference reported in either lifetime or regular use of inhalants (DHS 2001b). The similarity between the numbers of adolescent males and females who self-report the use of inhalants is of some interest, particularly given significantly higher

40 The DHS adds some reservations in relation to these figures, noting:

The decline in rates of reported use with age may be due to a misinterpretation of the question by younger age groups such that they probably included smelling items such as liquid paper and felt-tip pens as use of inhalants. Older students may have realised the question only referred to deliberate sniffing with the intention of getting 'high'. Alternatively, it could also be that older students regard sniffing as an immature behaviour and so under-reported past use of inhalants. It appears that further clarification of questions regarding inhalant use is needed to gain an accurate picture of inhalant use among secondary school students (DHS 2001a).

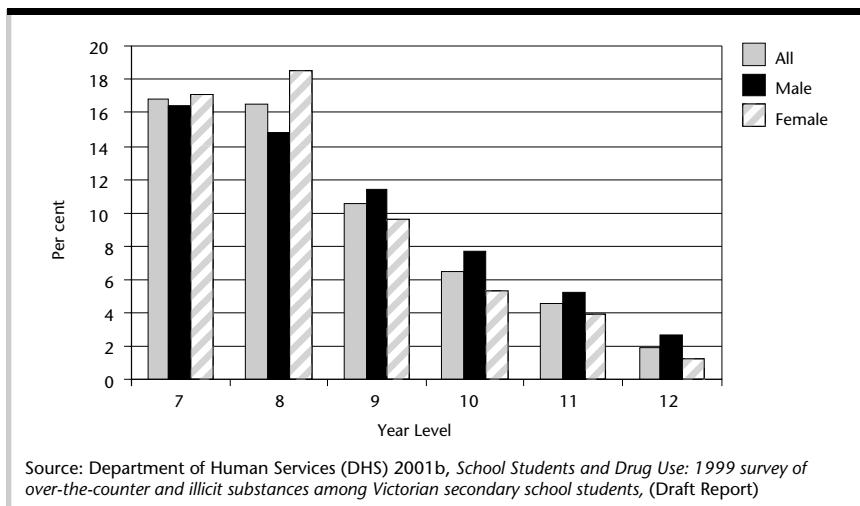
rates of mortality and morbidity among male inhalant users. Werry (1992) has suggested that a higher rate of 'heavy' or 'habitual' use exists among male users, perhaps distorting the statistics in this manner.

**Figure 3.4 Lifetime use of inhalants by Victorian secondary school students, 1999**



While Figure 3.4 demonstrates higher overall rates of lifetime use by adolescent girls in Years 8, 9 and 10, Figure 3.5 below illustrates more frequent use of inhalants by young males from Year 9 on. This gives some support for Werry's contention of higher rates of inhalant use by males.

**Figure 3.5 Use of inhalants in past month by Victorian secondary school students, 1999**

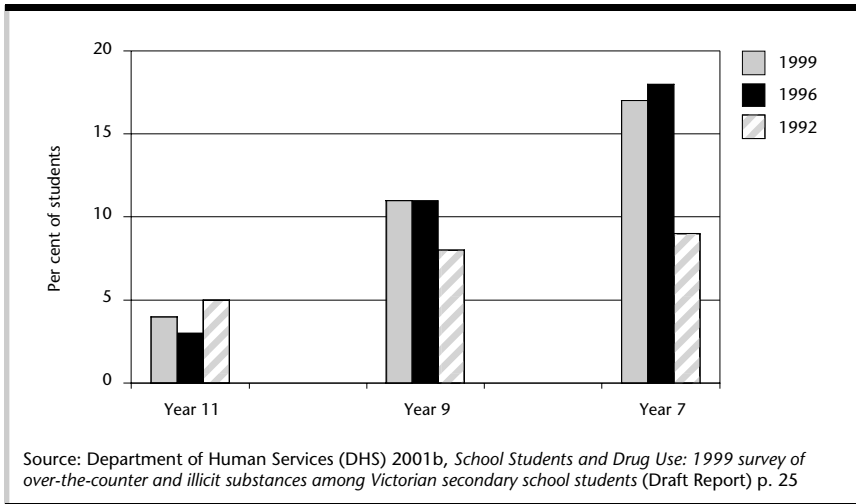


The limitations of survey based research means that the above analysis of survey data should be viewed cautiously. Attempts by the Committee to access further information concerning the relationship of gender to volatile substance use revealed a lack of any such research in an Australian context.

**Volatile substance abuse in Victoria – Longitudinal trends**

In respect of changes over time, it appears that between 1992 and 1999 the ‘recent (monthly) use’ of inhalants increased among younger students. However, the levels of inhalant use among older students, such as those in Year 11 for example, did not differ in 1999 from levels seen in 1996 or 1992. Trends over this period are seen in Figure 3.6 below.

**Figure 3.6 Monthly use of inhalants by Victorian secondary school students 1992, 1996 and 1999**



**Anecdotal evidence**

Anecdotal evidence suggests that there has been a recent rise in the incidence of inhalant abuse in the past two to three years. Drug treatment statistics, derived from 80 drug treatment agencies funded by the DHS, have charted a rise in treatment for inhalant use from 61 clients in 1999 to 134 in 2001 (DHS 2001). Given that young people do not easily access drug treatment services (the 9–15 year age group accounting for just 7 per cent of drug treatment clients) this number could be indicative of a much larger number of young people using inhalants (DHS 2001). In 2000, the Youth Substance Abuse Service presented a submission to the House of Representatives Standing Committee on Family and Community Affairs in which it warned of an epidemic of inhalant abuse among 13 and 14-year-olds.

Areas of concern include La Trobe Valley, Northern region of Melbourne and Northern Victoria. Currently Melbourne is in the wave of a mini epidemic of inhalant abuse among 14 year olds (Youth Substance Abuse Service 2000).

Further evidence from service providers suggests that young people who have come into care through the Child Protection System are much more likely to use inhalants than national survey figures indicate (MacKillop Family Services 2001). Indeed, given the potential for those in care to be missed by national and school based surveys, the extent of the problem within this population group could be underrepresented. Estimates from MacKillop Family Services are that approximately 30–50 per cent of those within their services use inhalants, 'and some chronically so' (MacKillop Family Services 2001, p. 2). Similar figures were reported by Berry Street Victoria (2001).

Calls to DIRECT Line (the 24-hour drug counselling and referral line) over the 2001/2001 period, record that inhalants accounted for 0.5 per cent of all drugs used. This translates to approximately 100 calls in which specific details regarding inhalant using scenarios were identified. Of the inhalant users, 68 per cent were males and 32 per cent were female. Thirty-nine per cent of cases related to inhalant use by 11–15 year olds, 28 per cent to 16–18 year olds and 13 per cent related to 19–21 year olds (DHS 2001).

The DHS noted a considerable variation in the prevalence of inhalant abuse across the state:

Prevalence of inhalant abuse appears to vary across the nine regions in Victoria. Current anecdotal reports indicate that chroming is more prevalent in the Western region, Loddon, and Gippsland. Victorian Drug Treatment figures for 2000-2001 support the anecdotal evidence. Most clients (for whom inhalants were the primary drug) were concentrated in the Gippsland region (23 per cent) Western Metro (19 per cent) Southern (19 per cent) and Northern (15 per cent) (ADIS data 2000/1). Certain towns and regional centres appear to have greater problems from time to time. Most regions experience inhalant abuse happening in 'waves', and a possible reason for this may be when a new person or persons moves into the local area. The areas of Swan Hill, Mildura, Tarralgon, Horsham, Bendigo, Euroa, Echuca, Stawell, Kerang (rural) and Sunshine, Werribee, Kensington and Darebin (metro) have all been reported (from workers in the areas) as recently experiencing increased rates of inhalant abuse.

The suggestion that local incidence of VSA may be very different from state averages is supported by Rose (2001). He notes that the use of inhalants may be localised to a particular group of people, even a single class in a school. Rose pinpoints Aboriginal people in the Western Australian location of Albany to demonstrate the point. Variation within this group was enormous – from 2 per cent of those aged 11–12 to 48 per cent of those aged 15–17 (Rose 2001, p. 22). The DHS in Victoria has reported similarly high rates of inhalant abuse among Aboriginal communities, noting:

Prevalence of inhalant abuse is higher in the Koori population (in 2000/1 25 per cent of inhalant treatment clients were from Aboriginal backgrounds) and reported anecdotally to be higher with the statutory clients of child protection and juvenile justice when compared with the general population. Unlike some of the northern states of Australia, 'chroming' with Victorian Aboriginal young people is generally seen to be more common than petrol sniffing (DHS 2001).



## **Mortality data**

Before examining the data of inhalant-related mortality, it is necessary to discuss the way in which volatile substances can cause or contribute to an unexpected death. Deaths attributed to the inhalation of volatile substances can be classified under two broad headings: Sudden sniffing death and Accidental death.

### ***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. This is an irregularity in the rhythm of the heartbeat which may lead to ventricular fibrillation, when the heart does not effectively pump blood. Severe cardiac arrhythmia can occur unpredictably during the abuse of several volatile substances (Advisory Council on the Misuse of Drugs (ACMD) 1995). It is thought that certain substances sensitise the heart to adrenaline and that this sensitivity, in combination with stress, physical exertion or anxiety, may lead to death within minutes. Because death is very rapid, the precise type of arrhythmia has only been recorded in very few cases, but notably after the abuse of toluene, chlorofluorocarbons and butane. Volatile substances can also cause depression of breathing and the blocking of oxygen supply (anoxia) (ACMD 1995).

The practice of spraying volatile substances directly into one's mouth is also potentially fatal. In a number of cases the cooling agents in aerosol propellants have frozen the larynx or throat of the user, leading to death by asphyxiation (Chalmers 1991).

Whatever the underlying medical technicalities, volatile substances have the direct capacity to suddenly and unpredictably kill. There is no agreed or recommended dose and the margin of safety which defines the difference between wanted and toxic effects can be easily exceeded. Some modes of misuse can be more risky than others but, there can be no 'safe' misuse of volatile substances (Walker 1992).

The following case from the Victorian State Coroner's files illustrates the unpredictable nature of a sudden sniffing death.

#### **State Coroner of Victoria**

The deceased was a 14 year old boy and a student in Year 9 at Greensborough Secondary College.

On 29 May 1991, the deceased purchased an aerosol can of lighter fluid on his way to school with some of his friends and was observed to sniff some of the gas as he walked.

At recess the deceased and his friends went to the far side of the College oval where the deceased took the can from his bag and sucked the gas from it for some minutes. A couple of the other boys each had a brief suck of the can before they all returned to class.

At lunch the deceased and some of his friends again went to the far side of the oval and again the deceased sucked gas from the can, this time for approximately 10 minutes. The deceased then appeared to hallucinate, ran a short distance and

collapsed. One of the boys present attempted to resuscitate the deceased, another ran to get a teacher and a third went to the nearest home to ring an ambulance. The teacher and the library technician alternated in giving mouth to mouth resuscitation and heart massage to the deceased but were unable to get any response. Ambulance officers attended shortly afterwards but were unable to revive him.

Case No: 1754/91

### ***Accidental death***

The second general heading refers to accidental deaths that would not have occurred had volatile substances not been used. Death may be caused by injuries sustained in falls when intoxicated, by fire or explosion when a highly flammable vapour ignites, or by asphyxia due to unsafe inhalation practices. An example of the latter includes placing one's head within a plastic bag containing glue. The following three cases illustrate the manner in which volatile substances can contribute to an accidental death.

#### **State Coroner of Victoria**

On 13.12.99 the deceased was struck by a car travelling on the North-West bound lane of Griffen St. Warrnambool, 12.2 metres North-West of the intersection of Clyde Cres. The deceased was observed by the driver of the vehicle to come out from behind a tree and put her hands up before being struck by the car. The vehicle was unable to stop and passed over the deceased, pulling up 35.2 metres from the point of impact. The body of the deceased came to rest 12.2 metres from the point of impact. Found under a tree beside the road adjacent to the point of impact was a plastic shopping bag with a glue like substance inside and a jumper that the deceased had been carrying when she left the house. .55 metres from the deceased on the road was a tube of 'Kwik Grip'. At the time of the accident it was daylight and the road was dry.

Case No: 3783/99

The deceased in this case was a 17 years old male who died in the following circumstances:

On 27/6/99 the deceased attended on the roof of the abandoned Sunshine Secondary College. This building is a 3 storey building. It appears the deceased was 'chroming' on the roof of the building. The deceased has accidentally fallen from the roof while chroming. Located on the roof was a can of paint and on the ground next to the deceased was the plastic chroming bag

Case No: 1936/99

The deceased, aged 18, was discovered dead in his flat at about 4pm on 13th May 1996 by Ms R\_\_\_\_ C\_\_\_\_, the deceased's social worker. He had a plastic bag over his head. A number of cans of spray paint were discovered in the flat.

Case No: 1377/96

### **Problems with data collection**

One problem in identifying the number of deaths caused by the inhalation of volatile substances is the practice of listing the medical explanation for death as opposed to the volatile substances that led to it. The death of a chronic petrol abuser, for example, might be recorded as 'end stage renal failure', not 'petrol sniffing'. This practice has doubtless resulted in the underestimation of VSA mortality and morbidity rates.

The practical difficulties that arise as a consequence of these problems were explained to the Committee by Graeme Johnstone, the Victorian State Coroner. Mr Johnstone noted:

If you are looking at volatile substances, then you are looking at toxins. You are looking at potentially a problematic area, which I think needs to be addressed, because realistically if you are looking at the broader picture, then we are not investigating these types of cases thoroughly – We are not seeing what's happened in the past in causing death.<sup>41</sup>

Indeed, the Committee discovered a number of deaths in which volatile substances were involved, but that had been classified according to other criteria. One such case involved the deaths of four young persons who died after inhaling butane and losing control of the car in which they were travelling. The case of death was listed as 'multiple injuries sustained in a motor vehicle accident' (State Coroner Victoria, Cases 1787/94, 178/94, 1789/94 and 1790/94).

### **Researching deaths attributed to the inhalation of volatile substances**

Dr John Ramsay, a toxicologist at the St George Medical School in London, is recognised as having established the benchmark for research into deaths attributed to the inhalation of volatile substances. Since 1983, Dr Ramsay and colleagues have been collecting data from a wide variety of sources (AMCD 1995).<sup>42</sup> In addition to the breadth of the research, its major success has been the consistency of definitions applied throughout the course of this research. The St George's team defines a VSA death as, 'one that would not have occurred if the deceased had not abused volatile substances, regardless of what was the terminal event' (ACMD 1995, p. 38). The continued application of this definition has provided the resulting data with a degree of uniformity currently lacking in Australia.

Between 1971 and 1992 the total number of VSA deaths recorded in the UK was 1,317. Eighty-eight per cent of deaths were male, 60.7 per cent of all deaths occurred in the 14–18 age group, and 72.6 per cent of those who died were under the age of 20 (AMCD 1005, p. 39).

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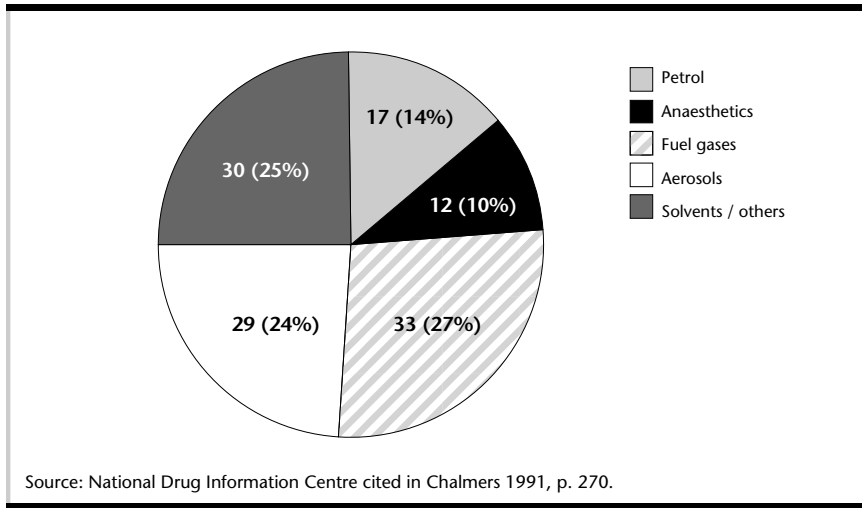
41 Mr Graeme Johnstone, in conversation with the Committee, 28 August, 2001

42 Sources consulted include press clippings agencies; HM Coroners; the Crown Office in Scotland; the Lord Chancellor's Office in Northern Ireland; the Deputy Viscount of Jersey; HM Greffier of Guernsey; the High Bailiff of the Isle of Man, the Office of Population, Census and Surveys (OPCS); the National Poisons Unit, the Home Office Forensic Science Laboratories; the Health and Safety Executive; the Railways Inspectorate; and from ad hoc notifications.

### Australian research

The Committee is only aware of one national study of mortality from volatile substance abuse undertaken in Australia. This study, conducted by the National Drug Abuse Information Centre, revealed that 121 deaths occurred between 1980 and 1987 (National Drug Abuse Information Centre 1988). Figure 3.7 below shows the volatile substance associated with the death.

**Figure 3.7 Deaths from volatile substance abuse in Australia 1980–1987, according to substance used**



In Western Australia, Rose (2001) compiled data relating to the number of deaths due to volatile substance use in that state in 1999. However, this data relied on hospital records alone and was therefore unlikely to provide an accurate reflection of deaths. In addition to the lack of alternative sources of information, the figures compiled by Rose were likely to incorporate deaths associated with suicide by carbon monoxide poisoning, accidental poisoning and industrial accident (Rose 2001).

### Volatile Substance Mortality in Victoria

The Committee's inquiry to the Victorian Coroner's Court and the Victorian Institute of Forensic Medicine revealed 44 deaths associated with inhalants between 1991–2000. These cases fell within the following categories:

- ◆ 17 deaths occurred as a consequence of either suicides or 'likely' suicides in which volatile substances had played a role. All victims were male;
- ◆ 13 deaths were directly attributable to the toxicity of volatile substances that had been deliberately inhaled. Of these 13 deaths, 9 were of males, all but one involving youths aged 18 years or less. Butane and/or propane was implicated in the greater majority of these cases;
- ◆ 2 deaths involved the accidental inhalation or ingestion of volatile substances;

- ◆ 8 deaths involved fatal accidents suffered by individuals who had been inhaling volatile substances immediately prior to their deaths. Of these deaths, four occurred in a single road fatality, two involved persons who died after being hit by cars, one following a fall from a roof and one case of plastic bag asphyxia (See cases 3783/99, 1936/99 and 1377/96 above).
- ◆ Four deaths were of individuals whose files indicated a history of VSA. Two of these deaths involved mixed drug toxicity and one was the consequence of a pulmonary embolism. Of note was the death of a male caused by meningoencephalitis.<sup>43</sup>

The Committee intends to examine the above cases in greater detail and will further report on the nature and causes of volatile substance related mortality in its Final Report.

## **Morbidity**

### ***Researching morbidity associated with the inhalation of volatile substances***

Australian researchers have described evidence of long-term harm resulting from solvent abuse as 'controversial' (Mundy 1995). Mechanisms by which individual solvents damage organs and organ systems are not well understood. Studies have largely concentrated upon industrial settings in which workers are exposed to small amounts of volatile substances over an extended period of time (Chen et al. 1997; White & Proctor 1997). The results from such studies cannot be extrapolated to young solvent abusers whose use is characterised by inhalation of concentrated amounts of volatile substances over short periods of time. In 1995 the British Advisory Council on the Misuse of Drugs noted:

Long term studies of young people who have engaged in VSA are comparatively rare ... there is a scarcity of reliable information on the long-term damage which young people may be doing to themselves through VSA (Advisory Council on the Misuse of Drugs 1995).

The difficulty in ascribing medical pathology to certain substances is further compounded by the fact that many products contain more than one solvent. The effects of solvent combinations are little understood.

Despite these difficulties, there are valid reasons for concern.<sup>44</sup> Experimental and industrial toxicological research indicates that in some circumstances several of the commonly misused substances can cause damage to tissues of the body, including the brain (Rosenberg & Sharp 1992; Grasso 1998), sense organs (Pryor et.al. 1991; Hollo & Varga 1992), the peripheral nerves (Lolin 1989), liver (Ungvary et al. 1983), kidneys (Gupta, Van Der Meulen & Johnny 1991), and the bone marrow (Tunek, Hogstedt & Olofsson 1982). Although some types of damage are recoverable, it is probable that others may be

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<sup>43</sup> Rose (2001) lists meningoencephalitis as one of 'the more common chronic effects of VSA.'

<sup>44</sup> The following is drawn from the Advisory Council on the Misuse of Drugs (1995).

cumulative and, perhaps, irreversible. Those substances which stay in the body for a long time may pose greater dangers of tissue damage than substances which are rapidly eliminated in the breath, with obvious implications for users of petrol containing lead.

### **Morbidity in Victoria**

In order to gain an understanding of the impact of volatile substance use on morbidity, the Committee sought data from two primary sources. The first was data collated by the Melbourne Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre. The second was hospital admission data. At the time of writing, the latter data set was being compiled. The Committee hopes to report the findings that emerge from this data in its Final Report. At present, however, the Committee is able to report that there were 18 (72 per cent male) inhalant-related hospitalisations in Victoria in 1999/2000 (DHS 2001a).

Despite the relatively low mortality rate attributed to volatile substances in Victoria, ambulance data collected in the metropolitan Melbourne area confirms that the use of these substances presents a health problem of some concern. As Table 3.1 details, from August 1998 to March 2001<sup>45</sup> ambulances attended at 337 volatile substance-related cases (Turning Point 2001).<sup>46</sup> Interestingly, there appears a concentration of activity in Council areas such as Frankston and Darebin.

**Table 3.1: Number of volatile substance-related cases attended by ambulances in selected local government areas, August 1998–March 2001\***

LGA Name	Volatile substance-related cases	% Melb
Frankston (C)	52	15.40
Darebin (C)	47	13.95
Melbourne (C)	27	8.09
Moreland (C)	24	7.14
Port Phillip (C)	22	6.50
Stonnington (C)	14	4.07
Yarra (C)	13	3.80
Brimbank (C)	12	3.61
Moonee Valley (C)	12	3.60
Maribyrnong (C)	12	3.57
Melbourne Metro Area	337	

\* June 1999 data were excluded because of incompleteness.

Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre 2001.

45 Excluding June 1999 data due to incompleteness.

46 These cases were all non-fatal. The majority of volatile substance-related cases attended by the Metropolitan Ambulance Service involved individuals displaying signs of acute intoxication (such as disorientation, incoherence, blurred vision). The remaining cases involved non-fatal accidents that occurred whilst intoxicated by volatile substances. Although volatile substances were used in these cases, this is not to discount the possibility that other drugs were used. The nature of the data is such that definite conclusions cannot be drawn.

The greater majority of cases attended by ambulances involved males (251 cases, 74.7 per cent). Given that the most recent Victorian surveys reported no gender differences in either regular or lifetime use of inhalants (DHS 2001b), this disparity provides further evidence of male youth being engaged in more harmful inhalation practices than females.

**Table 3.2: Sex distribution of volatile substance-related cases attended by ambulances in the Melbourne metropolitan area, August 1998–March 2001\***

	Sex	Frequency	Per cent
Valid	Males	251	74.5
	Females	85	25.2
	Total	336	99.7
Missing		1	.3
<b>Total</b>		<b>337</b>	<b>100.0</b>

\* June 1999 data were excluded because of incompleteness.

Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre 2001

Table 3.3 shows that 63.8 per cent of those attended to by ambulance were under 20 years of age. While this supports the consensus that the use of volatile substances is mainly confined to younger age groups, it suggests that a number of individuals are continuing use into later life.

**Table 3.3: Age category distribution of volatile substance-related cases attended by ambulances in the Melbourne metropolitan area, August 1998–March 2001\***

	Age category	Frequency	Per cent
Valid	Under 20	215	63.8
	20 - 24	40	11.9
	25 - 29	15	4.5
	30 - 34	18	5.3
	Over 34	32	9.5
	Total	320	95.0
Missing		17	5.0
<b>Total</b>		<b>337</b>	<b>100.0</b>

\* June 1999 data were excluded because of incompleteness.

Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre 2001

The greater proportion of incidents involving volatile substances attended by the Melbourne Metropolitan Ambulance Service occurred in public space. Again this is supportive evidence of volatile substance use occurring among young people who are unable to engage in such activity within the parental home. Only 77 attendances took

place at private property, while 239 incidents occurred in public space, with 146 of these occurring in outdoor public space.

**Table 3.4: Location of volatile substance-related ambulance attendances (where stated) in the Melbourne metropolitan area, August 1998–March 2001\***

Volatile substance-related attendances	Private Space	Public Space	Total
<b>Indoors</b>	64 (40.8%)	93 (59.2%)	157
<b>Outdoors</b>	13 (8.2%)	146 (91.8%)	159
<b>Total</b>	77 (24.4%)	239 (75.6%)	316

\* June 1999 data were excluded because of incompleteness.

Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre 2001.

## Conclusion

Volatile substance abuse is a problem of significant proportions in Victoria. Despite the limitations of current data collection techniques, anecdotal evidence from a variety of sources consistently warns of increasing prevalence among young Victorians. Although mortality figures are relatively low, these figures represent young lives cut short, often unexpectedly. In any case, the considerable number of cases attended by the ambulance service over a short period of time is an indication of the morbidity associated with volatile substance abuse.

Perhaps the issue of most importance that emerged throughout the course of the above chapter, however, is the necessity of establishing uniform research methodologies and ensuring that those authorities engaged in the collection of relative data are consistent in their application. It is only once such actions are undertaken that the full extent of the problem posed by volatile substance abuse in Victoria, and indeed Australia, will be understood.



### **Questions to consider**

- ◆ What statistics and other data should be collected pertaining to volatile substance abuse?
- ◆ How can such data be better coordinated and most efficiently disseminated?
- ◆ What research questions and projects should be developed with regard to volatile substance abuse?
- ◆ What can explain the discrepancy between the fairly equal level of use of volatile substances between the sexes and the greater proportion of deaths among males?
- ◆ What evidence or information is available relating to the *deliberate* inhalation of volatile substances by workers in industrial settings or in the course of their work?
- ◆ How does the workplace deal with this problem?
- ◆ Do specific strategies need to be developed to target this group?

## 4. Causes of volatile substance abuse

David (17 years old) – *“A total buzz! ... Escaping to another world ... you can escape to an imaginary preferred world.”*

Jane (15 years old) – *“It’s my life. I can do what I like.”*

Jamie (14 years old) – *“I do it when I am bored.”*

Judy (16 years old) – *“You can straighten out, and have a bunch of papers in your pocket of police charges, and not remember how you got them.”*

Adam (16 years old) – *“Let’s me pass the day inside my head, watching others watching me.”*

John (16 years old) – *“It takes away the pain.”<sup>47</sup>*

Why do young people choose to use volatile substances? The greater majority of young people who use volatile substances are simply experimenting. For them it will be an issue of curiosity that will often be quickly satisfied (Rose, 2001). Access presents few obstacles. The Berry Street Organisation, in a submission to the Committee, noted:

Inhalants – volatile solvents, gases and aerosols – are often among the first substances that young people use. This may be attributable to many factors, some of which include its low price, accessibility, that there is no ‘dealer’ required, it is simple to use and is easier than most other substances (including tobacco) for younger adolescents to access.<sup>48</sup>

This is supported by Werry (1992) and Rose (2001), who suggest that volatile substances present a more easily accessible alternative to alcohol and marijuana. As access to and experimentation with these other drugs increases the level of volatile substance misuse declines. Indeed, surveys record a steady increase in marijuana use with age at the same time as use of inhalants is decreasing (Higgins, Cooper-Stanbury & Williams 2000).

Rose argues that the reason ‘experimenters’ may grow out of the behaviour are complex but include some naturally occurring ‘protective factors’ that ‘need to be maintained or enhanced particularly given the ease of availability of solvents’ (Rose 2001, p. 19). Some of these protective factors include:

- ◆ solvents are seen as ‘gutter drugs’ by most youth;
- ◆ societal disapproval including disapproval by peers (positive peer influence);

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47 Quotes taken from clients of Berry Street Victoria in its submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 7.

48 Berry Street Victoria, submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 5.

- ◆ solvents are generally not advertised or glamorised by media;
- ◆ fear of harm of VSA, particularly brain and organ damage;
- ◆ short-term effects mimic permanent brain damage which may reinforce this fear;
- ◆ unpleasant smell which is also easily detectable for many (but not all) products;
- ◆ effects can be frightening and disorientating;
- ◆ headaches, nausea and irritation to eyes, nose and mouth; and
- ◆ other drugs such as alcohol, tobacco and marijuana tend to displace solvents as young people grow older (Rose 2001, p. 19).

Rose argues that any interventions which diminish the power of the above factors 'may unwittingly do more harm than good' (Rose 2001, p. 19).

However, what of those individuals who go on to develop a dependence or problematic use pattern? Dear (1995) has found:

Of the few [young persons] who become regular or dependent users [of inhalants], many have major problems. These may precede use and could include environmental, psychological, family, or education problems. Regular or dependent users also tend to lack the support networks needed to deal with these problems.

Paul Hogan, Manager of Residential Services for the Victorian Youth Substance Abuse Service, explained the development of problematic drug use in the following terms:

The majority of young people go through adolescence relatively unscathed and their families and the local community come out relatively unscathed. There is a small group – these young people are a part of that group – that have significant difficulties. Sometimes drug use is a symptom of the difficulties that they have already got. So I do not believe that when somebody who has a significant drug problem had their first drink or their first puff or their first injection they were making the choice to become a drug user. It is something that overtakes them and it is something that actually offers them something – perhaps a bit of a break from what they are running away from.

MacKillop Family Services makes similar observations with regard to the young 'chromers' in their care:

Personal factors contributing to chroming are difficult to determine and deal with. Anecdotal evidence compiled in our study indicates that young people turn to chrome partly under peer pressure and, when chronic users, to mask pain.

You could look at a young person's file and see how deterioration in family history leads to placement changes and a sense of abandonment and exposure to other kids who are chroming and it's been a part of his life ever since. In residential care there's always an element of kids introducing behaviours to kids who haven't done it before. A real chronic chromer with a strong personality will get other kids doing it, and the kids will drop off when that person moves on.<sup>49</sup>

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49 MacKillop Family Services, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 14.

Rose too associates higher rates of volatile substance abuse with family and personal dysfunction. He also states that 'There is a significantly higher risk of associated antisocial behaviour with those who engage with VSA as compared to non-abusers' ((2001, p. 8). Rose cites Howard et al. (1999) who found that those who engaged in VSA reported a lack of family support and cohesiveness, low self-esteem, suicidal thoughts and lower perceived school ability as compared to non-users. This is supported by Dinwiddie (1994, p. 930) who states:

Whether from impoverished families or not, the family backgrounds of inhalant users have repeatedly been noted to be chaotic and disrupted, with absent or emotionally distant parents, physical abuse and antisocial behaviour by other family members being prominent findings.

These factors are particularly relevant to children who are in residential care. A submission from the Juvenile Justice Branch of the Victorian Department of Human Services makes the following pertinent comments:

The complexity in working with children and young people who have drug and substance abuse problems and who have also experienced abuse and neglect, cannot be understated. These children and young people present with increasingly troubled and multiple problems requiring intensive interventions that are youth specific, operating with a multi disciplinary approach in order to ensure more consistent, comprehensive and integrated interventions.

Research findings have noted the high prevalence of young people and adults with substance abuse problems who have also experienced abuse and neglect. Other research indicates a self medication theory of substance abuse. Biopsychosocial risk factors that may influence young people to abuse substances have been well documented. These include previous experiences of maltreatment, social disadvantage, impulsivity, low social conformity, influence and association of substance abusing peers or family, and a lack of family and school connectedness.<sup>50</sup>

Such research suggests volatile substances are used as a way to escape emotional and/or social pain or, as Rose (2001, p. 17) notes, 'It may be a way of showing adults and others that they have pain – *'I don't care if it kills me, my life isn't worth living anyway'*.

The association of drug misuse with dysfunction and deep-seated psychological issues is not to deny the influence of adolescent curiosity and rebellion in drug-taking activities of an experimental nature. Rose (2001) notes that the reasons young people engage in VSA will often be the same reasons they will later use other substances: Out of curiosity, for fun, to be part of a peer group and to challenge authority figures. He also notes that, because volatile substances are perceived as dangerous, the social status associated with risk-taking behaviour is attributed to their use. At a recent forum on volatile substance abuse organised by and for the Indigenous community of Victoria, one participant, a doctor, formerly with the Aboriginal Medical Service, observed:

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50 Department of Human Services (Juvenile Justice Branch) Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001c, p. 3.

Why do people do it? They do it because they like it. It feels good, they have this feeling of euphoria, they feel intoxicated, they get excited, they feel part of a group, they are sharing something together. It is something shared like a cigarette. They can hand it around, that is part of the substance abuse ritual thing, it is a bonding thing for the peer group. They do it to shock adults.<sup>51</sup>

A study by Houghton, Odgers and Carroll (1998) found that reputation enhancement was more strongly associated with VSA than self-esteem or coping strategies. Users of volatile substances identified themselves as both having and wanting to have a more non-conforming reputation, and as admiring drug-related activities. In this respect, the 'self-presentation' of the volatile substance user was seen to offer the individual the means by which to induce others to credit them with a particular social identity (Houghton, Odgers, & Carroll 1998). Further research by these authors (1998) found chronic users had a higher status within the group.<sup>52</sup>

Earlier research with regard to volatile substance abuse found that while the experience of poverty and powerlessness may be one of the contributing factors, the practice cuts across social classes. Some admittedly dated findings from New South Wales school surveys indicated that:

[L]evels of sniffing vary from school to school and regardless of social class, area or system of the school. Children who often go out at night and who are inclined to be truant from school are more likely to be involved in sniffing, and those students who receive a large amount of money ... from their parents – as opposed to having a job – are more likely to be sniffers.

However, the single most important factor in the use of solvents, is the child's perception of the danger of the practice. A student who is sceptical or unaware of the risks of injury or death from sniffing solvents or aerosols is more inclined to be a sniffer. This may imply a preparedness to accept the risks of sniffing as part of the activity. It may reflect bravado or ignorance or both (Commonwealth Department of Health 1984, pp. 6–7).

The question of 'ignorance' is an interesting one. Beauvais (1997) states, for example, that solvents are not considered by many young people to be a form of drug abuse. He states: 'In our work we have often heard young people say, "No, I don't use drugs, but I do sniff once in a while"' (Beauvais 1997, p. 104). In February 2000 a series of focused discussion groups with young people who chrome and their families was conducted by the Gippsland based La Trobe Valley Drug Reference Group (LVDRG). One of the facts that emerged was that for some young people who chromed ignorance was indeed 'bliss'. The lack of knowledge of young people with regard to the deleterious effects of chroming was summed up in the words of one respondent: 'If it

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51 Dr Malcolm Dobbin, Indigenous Forum on volatile substance abuse, 17 August 2001, Transcript, p. 17.

52 The comprehensive Strathclyde Study conducted by Dr Joyce Watson has been referred to previously. As a result of her extensive interviews she concluded that peer group pressure was the single most important factor leading to volatile substance abuse (Watson 1986, p. 2). Other academics, although not necessarily rejecting her findings, have placed less emphasis on the significance given to peer-group pressure.

is harmful then it would be illegal'.<sup>53</sup> While the views expressed in the LVDRG discussion groups cannot be generalised or extrapolated to other communities, Indigenous or non-Indigenous, this survey is instructive for its insight into the reasons why one group of Koori adolescents may use volatile substances:

Young people reported that they took up Chroming as a drug of choice. That is, it was seen to be a drug that was not illegal, was very cheap to purchase, and was very accessible and available to the young people.

The young people commented about the drugs that if it is harmful, then it would be illegal. It made the young people feel great, and relieved their sense of boredom. Ultimately, it was felt that this helped to remove some of the sense of isolation, dispossession and rejection as a result of stolen generation issues (passed down within families).

For family members and professionals it was felt that a lack of connectedness to family, lack of supervision of young people, as well as positive peer pressure, brought about a positive response to being involved with chroming. It was also observed that a need for positive, older role models was an important aspect of resolving the crisis, especially male role models.<sup>54</sup>

A survey of young people by the Sunshine Chroming Awareness Program (SCAP) based in Sunshine in the western suburbs of Melbourne found that boredom and a lack of activities for young people in Sunshine was the overwhelming reason given for why the respondents chromed (Sunshine Chroming Awareness Program 2001a, p. 3). In a separate report SCAP stated that while these findings are skewed towards young people 'with a range of identified issues', other anecdotal evidence supports these findings. The report argues that:

Understanding the underlying factors and real meaning of the term 'boredom' could assist in developing strategies. Boredom may arise from a range of factors including:

- lack of employment (or employment prospects)
- poor self esteem
- lack of appropriate alternative activities
- relationship difficulties
- homelessness
- loneliness
- sense of disconnection/alienation (Sunshine Chroming Awareness Programme 2001b, p. 16).

While there may be commonalities of cause (family dysfunction, boredom, poverty etc) across various substances there will be some substances that are abused for quite discrete reasons and that are apposite to a particular context in which they are used. For example, anthropologist Maggie Brady writes that the 'meanings' of petrol sniffing

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53 Submission of Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3.

54 *ibid.*

among outback Aboriginals are not necessarily the same as those non-Indigenous substance users, particularly in the cities. She writes that for some young Aboriginal people petrol sniffing is 'an expression of power and control in an otherwise powerless situation' (Brady 1992, p. 31).

Therefore an important caveat with which to conclude this chapter is to note that any discussion pertaining to cause must recognise that an analysis of contributing factors must be adapted to the substance in question. As with all drugs, Rose states the experience of volatile substance abuse is dependent on three key interacting factors:

- *Individual factors* (age, gender, beliefs, previous experience, mood, psychological factors, etc)
- *Drug factors* (dose, type of substance, method of administration)
- *Environmental factors* (family, friends, cultural context, etc) (Rose 2001, p. 13).

Any policy development with regard to volatile substance abuse should thus recognise and take into account these variables.

### **Questions to consider**

- ◆ What are the environmental factors that may contribute to volatile substance abuse?
- ◆ What are the psycho-social factors associated with volatile substance abuse?
- ◆ What are the sociocultural, psychological and/or environmental conditions that give rise to *adult patterns* of volatile substance abuse?
- ◆ Are there any other causes or contributing factors that can be posited for volatile substance abuse, that have not been mentioned in this chapter?
- ◆ What are the major risk factors associated with volatile substance abuse?

## 5. Volatile substance abuse: User profiles, patterns and culture of use

### Who uses volatile substances?

Defining a 'typical' volatile substance 'user' is as problematic as classifying exactly what volatile substances are and what is meant by volatile substance abuse. To do so is simplistic and reductionist given that inhalant use takes on different forms and manifests different behaviours depending on the context in which it is placed. Culturally there is a great difference between a young person who chomes on a railway line and a carpet fitter who deliberately inhales industrial fluids to get 'high'.

In previous chapters this Discussion Paper has almost exclusively concentrated upon children and adolescents when discussing inhalant use. This is with good reason, as it is this population who predominantly misuse inhalants deliberately for the purpose of intoxication. Within this group we have noted there are distinct types of users – the *experimenter*, the *social user* and the *long-term dependent user* (Australian Drug Foundation 1999, p. 2). While the experimenter and the social user often use volatile substances in the context of group activity, the long-term dependent user may be inclined to use alone and in isolated circumstances and often has had family, psychological and social problems associated with the substance use (Western Australia Drug Strategy Office (WADASO) 1998, p. 11. See also six case stories at the end of this chapter). A recently published Background Paper written by Rose (2001) states:

Volatile substance abuse occurs in association with a number of different situations, each of which require a range of categorically different interventions:

- 'Average' young people who experiment with VSA.
- VSA associated with delinquent behaviour and low socio-economic status.
- VSA in urban and rural Aboriginal communities.
- Petrol inhalation in remote Aboriginal communities.
- VSA amongst disadvantaged and homeless adults.
- Abuse of anaesthetic gases by professional groups.
- Abuse of amyl and butyl nitrites by those in gay community.

Rather than treating VSA per se, understanding the social context and associated behaviours may provide insights into the provision of more holistic interventions (Rose 2001, p. 7).



Using Rose's classification, where appropriate, the remainder of this chapter will outline discrete groups of volatile substance users and their patterns of using behaviour, noting both the commonalities and the differences of inhalation practices between the groups. Acknowledging that there is no one 'type' of volatile substance user is important in tailoring future prevention and intervention strategies to the needs of particular 'communities of use'.

### ***Adolescents from lower socioeconomic backgrounds***

As has been previously noted, volatile substance abuse is not confined to people from a particular social class. Nonetheless, as Rose (2001) observes, those engaged in volatile substance abuse are more likely to come from impoverished backgrounds. Richard Ives, a British expert on volatile substance abuse, has recently undertaken a comprehensive review of volatile substance abuse in Britain. He concludes that 'those living in households with the lowest income category were twice as likely as those in the highest category to have tried volatile substances' (quoted in Rose 2001, p. 8). In general terms volatile substance abuse has been found to be more common across the board in economically depressed areas than in affluent areas (Rose 2001, p. 8)<sup>55</sup>

### ***Adolescents from troubled backgrounds***

Rose (2001) drawing from Howard's (1999) research notes that:

[t]hose engaged in VSA reported significantly less family support and cohesiveness and lower self-esteem, and significantly more lifetime thoughts of suicide and suicide attempts and lower perceived school ability as compared to non-users. In clinical groups and those within the justice system, solvent abusers had higher rates of emotional symptoms (mostly depressive) and abundance of adverse life events, family dysfunction and higher rates of relatives who had attempted suicide (Rose 2001, p. 8).

Volatile substance abuse has also been found to be disproportionately high amongst children and adolescents 'in care' or involved in the juvenile justice system (McGarvey, Canterbury & Waite 1996). It has also been associated with significantly higher levels of antisocial and delinquent behaviour (Houghton, Odgers & Carroll 1998). This is generally true of most forms of substance abuse. In its submission to this Inquiry the Juvenile Justice section of the Victorian Department of Human Services stated:

Chroming behaviour has been identified as a problem for a number of young people for whom the Child Protection and Juvenile Justice program has responsibility. An increasing number of young people are coming to the attention of Child Protection and Juvenile Justice as a result of escalating family conflict, due to the young person's substance abuse and resultant parental/carer inability to manage the young person's behaviour. It is common that even where strong family/carer relationships have existed the additional stressors of caring for a child with a substance abuse problem cause significant impact on the capacity of parents/carers to manage. Child Protection and Juvenile Justice often has to locate alternative accommodation and

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55 For other studies that discuss the nexus between volatile substance abuse and economic disadvantage, see Jacobs and Ghodse 1988; Chadwick 1991; Dinwiddie 1991.

support services for young people with substance abuse problems who may have been rejected, are homeless or refuse to reside in the family home any more.

Currently 80% of all children and young people's case management services are contracted to DHS Placement and Support funded Community Service Organisations, these non government agencies provide a range of services to children and young people, including out of home care services such as foster care, residential care, high risk adolescent services, family support services and counselling. While it is difficult to identify the exact numbers of children and young people participating in chroming, regional Child Protection, Juvenile Justice and CSO's continue to report that this is significant problem being exhibited particularly by young people who reside in residential out of home care services.<sup>56</sup>

These comments are echoed by Berry Street Victoria, a leading provider of residential care for child protection and juvenile justice clients:

Berry Street's experience suggests that inhalant use is present in both rural and urban areas. As with some research coming from the United States and the United Kingdom, Victorian young people using inhalants are typically effected by poverty, a history of child abuse, low school engagement and disconnection from family. It is Berry Street's experience that young people in care are a high risk group for inhalant use. Furthermore, for this group, inhalant use is usually a transitional drug, which may be later replaced with harder, illicit substances.<sup>57</sup>

### ***Indigenous communities***

A constant comment made by Indigenous Victorians with whom this Committee has met is that the problem of volatile substance abuse is not a new phenomenon for Indigenous communities in this state. The following comment is representative of these concerns:

This is not a new subject to our community. I can remember talking about the drug and alcohol issue back in 1981 when I first came to work with the Victorian aboriginal community. I have been associated with this issue between 1981 and 1989. Chroming was a part of that issue. I can see faces in this forum today that were involved in these conferences, meetings, and forums. You name it; we did it. We were talking about it 20 years ago and we are still talking about it today. One of the visions that many of us had back then was to form our own youth detox and rehabilitation centre for these young people. Today, we are still waiting.<sup>58</sup>

Despite these long-held concerns there is very little documentation or data on volatile substance abuse among Victorian Aboriginals. Most of the literature on volatile substance abuse that pertains to Indigenous (young) people and Indigenous communities relates to petrol sniffing and or communities located in states other than Victoria.

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56 See Submission of the Department of Human Services (Child Protection and Juvenile Justice Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001d, pp. 2-3.

57 Submission of Berry Street Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 6.

58 Ms Barb Honeysett, Indigenous forum on volatile substance abuse, 17 August, Melbourne.

Petrol inhalation will be discussed briefly in this Discussion Paper, although the Paper's predominant focus is the issue of chroming. It is believed that chroming is a far more prevalent form of volatile substance abuse, including amongst Victorian Aboriginals, than petrol sniffing. It may be that this is an erroneous assumption. The Committee welcomes any information by way of submission that may provide evidence to the contrary.

Rose (2001) comments that volatile substance abuse in Aboriginal communities and among Aboriginal young people differs from non-Aboriginal communities: 'by way of cultural heritage, patterns of use and some intervention strategies as compared with non-Aboriginal communities' (p. 9). While Rose's research refers specifically to the Western Australian context, the above statement is generally applicable to other Australian states, including Victoria. Rose argues further that differences in inhalation practices and culture apply to Aboriginal people in the cities, large rural towns, small rural centres and remote outback communities. Such differences include the:

- ◆ Degree of community cohesion
- ◆ Local traditions, customs and degree of cultural [identification]
- ◆ Number of those engaged in VSA
- ◆ Local methods and types of volatile substances abused
- ◆ Access to resources and supports
- ◆ Other local factors.

Studies have found Aboriginal youth are more likely to use inhalants more intensively and for a longer duration than non-Aboriginal urban youth (Rose, Daly & Midford 1992, p. 29).<sup>59</sup> One study on petrol inhalation reported a mean duration of eight years of petrol sniffing, a considerably longer period of usage than that found among urban adolescent inhalers of volatile substances, the greater majority of whom engage in no more than a brief period of experimentation (Burns, d'Abbs & Currie 1995, pp. 159–69).

Estimates of petrol sniffing are imprecise and often conflicting. This is partly because in some communities it is a clandestine activity carried out at night. It is also because its prevalence fluctuates widely – even within a period of a few weeks – in most communities in which it occurs (d'Abbs & MacLean 2000).

Petrol sniffing occurs in some Aboriginal communities and not others.<sup>60</sup> In 1989 it was reported as occurring mainly in Arnhem Land, in Central Australia among desert Aboriginals, and in the Riverina region of New South Wales. However, it did not occur

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59 However, Aboriginal youth are also more likely to use drugs and other substances including petrol in the open. It is possible therefore that any analysis of the proportion of Indigenous to non-Indigenous users 'may indicate sampling bias towards those more visible' (Rose, Daly & Midford 1992, p. 29).

60 Petrol is a mixture of C4 to C12 hydrocarbons, the relative amounts of the various constituents depending on the origin and preparation of the petrol. The unsaturated hydrocarbons have mild anaesthetic properties while the saturated hydrocarbons have a narcotic effect. The principal additive is tetraethyl lead which also has intoxicant properties. Tetraethyl lead and its metabolites are highly neurotoxic.

Fifteen to 20 inhalations of petrol will cause euphoria and intoxication for three to six hours. Prolonged inhalation or rapid inhalation of a highly concentrated vapour, such as when a petrol-

in the Kimberleys or the Pilbara region of Western Australia, or in the Barkly Tablelands, Northern Territory (Brady 1989). In 1994, Brady and Torzillo argued that patterns had changed:

It appears that the intensity of sniffing has increased over the past 20 years, with more users sniffing over longer periods, which has resulted in an increase in reported morbidity and mortality from the 1980s onward (Brady & Torzillo 1994, p. 176).

However, since 1994 a further shift in patterns and prevalence of petrol sniffing seems to have occurred. A little-publicised but positive development of recent years has been the move by many Aboriginal communities to use aviation fuel (WA Task Force on Drug Abuse 1995, p. 238). In several communities where a long and established history of petrol sniffing has existed, sniffing has been reduced or even stopped (d'Abbs & MacLean 2000, p. 8).

Conversely, some communities which had previously been free of petrol sniffing are now reporting the practice. It has been reported in the Katherine region of the NT, Cape York in Queensland, south-west Queensland, western NSW and Northern Victoria.<sup>61</sup>

There is also evidence that Aboriginal children are turning to the use of other volatile substances. Although petrol sniffing remains the primary form of volatile substance misuse among young Aboriginal children, there are increasing reports of other forms (particularly glue and aerosol paint sniffing) in urban areas, as noted above.<sup>62</sup>

Overall, it appears that since 1994 there has been a reduction in intensity of sniffing in some of the areas where it has been prevalent for a long time, particularly in Central Australia, although some communities still experience high levels. This has occurred at the same time as Aboriginal volatile substance misuse has begun in new localities in Australia. There also appears to have been an increase in prevalence within some urban communities.<sup>63</sup>

As stated, this Discussion Paper is not predominantly concerned with petrol inhalation. Nonetheless, it would seem crucial that in addressing petrol sniffing, as with any form of drug or substance abuse, any initiatives or strategies devised to combat it must be culturally appropriate and sensitive to the needs of the target population.<sup>64</sup>

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soaked cloth is held to the nose, may lead to violent excitement followed by a loss of consciousness, coma or death. Organic lead toxicity is regarded as the major long-term health hazard of petrol sniffing although some other components (toulene, n-hexane) may contribute to neurological damage.

The syndrome of ataxia, tremor and encephalopathy seen in chronic sniffers is attributed to tetraethyl lead toxicity. Other long-term sequelae of chronic sniffing include nutritional disturbances, anaemia, and cardiac, liver and renal effects. Cognitive functioning may also be impaired and there is evidence that some of these changes are irreversible (Western Australian Task Force on Drug Abuse 1995; d'Abbs & MacLean 2000).

61 There is very little Victorian research literature on such practices. The Committee welcomes submissions from organisations and individuals who may be able to provide information outlining such a trend or development.

62 *ibid.*, p. 6.

63 *ibid.*, p. 8.

64 Submissions to this Inquiry have noted that the few strategies in place to address volatile substance abuse are *not* 'culturally accepted or appropriate for the Aboriginal people'. Submission of Indigenous Health and Drug Worker, Robert Johnson to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, July 2001, p. 1.

### ***Gender profile***

The gender profile of volatile substance abuse is another contentious area of research. VSA is often perceived to be an activity engaged in by young males (National Drug and Alcohol Statistics Unit 1994; Mundy 2001). Walker (1992) noted that this perception was largely based on the significantly higher rate of inhalant-related mortality among young males. However, although the VSA mortality rate is certainly higher for males, this could be as a consequence of differences in sniffing behaviour, as opposed to a gender imbalance in the use of inhalants.<sup>65</sup>

Despite a paucity of both quantitative and qualitative data and research with regard to gender profiles of volatile substance abuse, it has been argued that strategies developed to address volatile substance abuse must take into account the gender of the targeted users. Women's Health Victoria, a health information service, clearing house and advocacy group for Victorian women, argues that a gendered analysis of volatile substance abuse is extremely important:

When analysing the health impacts of volatile substance inhalation on women and men, differences relating to gender, in addition to biological sex, need to be considered because women and men experience health differently. In reviewing the literature for this submission, it was noted that sex differences have only been analysed in terms of incidence and prevalence rates for substance inhalation and that little attention has been paid to the differential impacts of gender.

In examining factors which contribute to the inhalation of volatile substances, Women's Health Victoria therefore advocates that the Committee gives due recognition to

- the biological sex differences in order to determine the different ways that women and men react to such substances (for example, women's bodies have been found to react differently to insulin, cardiac drugs, dietary treatments for heart disease and alcohol consumption);
- gender and how social roles, attitudes and behaviours contribute to differential effects of women's and men's experience of volatile substance inhalation. Applying a gendered analysis enables a focus on the sexual specificity of experience or intervention that will assist in understanding the symptoms, aetiology, and management of the health issue.<sup>66</sup>

### ***Users from non-English-speaking backgrounds***

There is very little quantitative or qualitative research that the Committee is aware of that comprehensively discusses the ethnic and cultural backgrounds of people who use volatile substances. Neither is there readily available information on how to develop intervention strategies that will effectively target these groups. Any issues pertaining to

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65 See Chapter 3 for discussion of mortality related to VSA.

66 Submission of Women's Health Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 2.

For a discussion of the impact of drug abuse on young Vietnamese women, see the submission of Buoyancy to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001.

the ethnicity of particular groups of inhalers that have come to the Committee's attention are anecdotal and unsubstantiated.<sup>67</sup> It would therefore be inappropriate to repeat them at this stage. The Committee welcomes receiving any information from the community that might inform them about volatile substance abuse among non-English-speaking communities.

### ***Differences between city users and rural users***

Similarly, there seems to be very little research available, other than some very rudimentary empirical data, that differentiates between patterns of inhalation abuse in rural and regional areas as opposed to city and metropolitan districts. Again, the Committee welcomes any information that may provide some insight into volatile substance abuse patterns and practice in rural and regional Victoria.

### ***Professional groups***

There is some evidence that some members of the medical and health professions (doctors, nurses and dentists) or people studying for those professions have used certain anaesthetic substances such as nitrous oxide deliberately for the purpose of intoxication (Beauvais & Oetting 1987; Rose 2001).

While this is a disturbing phenomenon, this form of inhalant abuse is not a focus of this Inquiry. It may be that the relevant bodies accountable for regulating and administering these professions are the best bodies to take responsibility for investigating these claims.

### ***Industrial settings***

There are some documented studies of accidental or inadvertent inhalation of volatile substances in the workplace and the toxicological effects on the worker (Grasso 1985; Lolin 1989; Rosenberg & Sharp 1992; Advisory Council on the Misuse of Drugs 1995). However, there has been little, if any, research undertaken on the deliberate inhalation of volatile substances by workers in industrial settings for the purpose of intoxication, although anecdotal evidence suggests that such a phenomenon does exist.

The Committee met recently with Dr Jane Maxwell, Chief of Research at the Texas Commission on Alcohol and Drug Abuse. She informed the Committee that her data has suggested that there may be a link between the deaths of mechanics, air-conditioning technicians and other industrial workers and deliberate attempts to inhale freon gas for the purpose of intoxication. She stated that the deliberate use of inhalants by those who had access to them through the workplace was only just starting to be looked at as a discrete phenomenon. However at this stage the evidence is speculative:

One of the fascinating things I found when I was looking at occupations was a relationship between the freon deaths — half were students and about an equal number were mechanics who had access to freon on the job. They were air-

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67 Local data produced by the Sunshine Chroming Awareness Program indicates that in that area at least it is predominantly Anglo-Australians who use chrome and 'other ethnic groups are not largely represented' (Sunshine Chroming Awareness Program 2001, p. 15).

conditioning technicians and maintenance mechanics, people who had freon on the truck. I had not seen this before.

Responding to a question from the Committee Chairman as to whether these deaths were deliberate or accidental, Dr Maxwell stated:

You cannot tell. In other words, suicide was not necessarily mentioned. In some instances suicide was indicated and in some instances it was not, but it was that relationship with air-conditioning technicians who had access to it [which is fascinating]. None of those certificates indicated it was accidental in the sense that occasionally someone cleaning out a railroad tank car will die from lack of oxygen. Those will clearly say the death was due to accident.

None of these had that kind of description. There was a relationship between toluene and blue collar workers, particularly the building trades and the fact a lot of those people who spray paint with lacquers and varnishes are at risk, so it gave me a different picture... There is some literature about it as an occupational hazard exposure, but nothing in the sense of perhaps it is Friday night and there is a tank of freon on the back of the truck. Instead of getting a case of beer they get into the freon. That gives you a different picture and another area to look at.<sup>68</sup>

The inhalation of volatile substances as an occupational hazard or health and safety issue is not the focus of this Inquiry. This by no means discounts the seriousness of accidental or inadvertent exposure to toxic substances.

The Committee is, however, interested in receiving any information about the *deliberate* inhalation of volatile substances by workers in industrial settings or in the course of their work, whatever the workplace. It would also be useful to know whether particular and focused strategies may need to be developed to target this group.

### ***The use of nitrites in the gay men's community***

The practice of inhaling or 'popping' amyl and butyl nitrites as muscle relaxants for the enhancement of sexual pleasure has been briefly mentioned in a previous chapter. The inhalation of these substances acts primarily to dilate blood vessels, which may intensify sexual intercourse. This is a practice identified mostly, but not exclusively, with the gay men's scene (French & Power 1997; Beauvais & Oetting 1987; Brouette & Anton 2001).

Again it is not the intention of the Committee to focus upon this very discrete and confined area of volatile substance abuse. As has been previously discussed, questions arise as to whether practices such as this or indeed inhalation of anaesthetic gases by professional groups can be even included under the category of volatile substance abuse. Again we hasten to add that this does not mean that such practices are not viewed with concern. The fact that amyl and butyl nitrites have been associated with involvement in casual and high risk sex and the consequent risk of HIV infection is of concern. Nonetheless, we believe that such concerns and the issues pertaining to this

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68 Dr Jane Maxwell, Chief of Research at the Texas Commission on Alcohol and Drug Abuse, in conversation with the Drugs and Crime Prevention Committee, 23 October 2001.

particular form of inhalation are better dealt with by those health workers and researchers in the field more appropriately qualified to address them.

## **The patterns and culture of volatile substance abuse**

It is in a sense reductionist to speak of *one* pattern or *one* culture of volatile substance abuse, just as it is a generalisation to speak of *a* user profile of substance abuse. Rather, it would seem that different practices or cultures of use are observable depending on the particular type of user. In this section, however, it is salutary to make some general comments pertaining to the ways in which young people may engage in a defined (group) culture to inhale volatile substances and the way in which volatile substance abuse can be viewed as a 'cyclical' phenomenon.

### ***The cyclical nature of volatile substance abuse***

As has been discussed in Chapter 2 most people who use volatile substances experiment for a short time and then cease use altogether. It has also been noted in the academic literature that volatile substance abuse is episodic and occurs in cycles, particularly in country towns and rural communities. This was further impressed upon the Committee by people with whom it consulted and by a number of the submissions it has received. In Indigenous communities in particular a new arrival may bring the practice of solvent abuse with him or her, initiating others within the area. The Chief Executive Officer of the Swan Hill Aboriginal Co-operative has commented that:

In terms of the Swan Hill situation, glue sniffing or chroming – call it what you like – has not really been an issue until the last three to four years. We had a member of our community, who is quite transient, introduce a number of our younger youth to glue sniffing. Those younger kids were kids that were not able to access marijuana, and as a result of that we now have a group of kids who are certainly affected by this.<sup>69</sup>

The Latrobe Valley Drug Reference Group who work with Indigenous young people in Gippsland, Victoria, make similar comments:

Chroming is a highly mobile drug-taking behaviour – that is, it will appear in an area for a short period of time, disappear, and re-appear in another area, then move back or elsewhere, in a very short period of time.<sup>70</sup>

The findings of an in-depth study into the inhalation habits of young Aboriginal people in Albany, Western Australia, are also interesting:

During the six month study period, it was observed that sniffing among young people ceased altogether. This reflects previous observations that, in Albany, sniffing is a cyclical phenomenon. An outbreak occurs when it is introduced to a small group of novices either by a visitor from another town or by someone who was at the tail end of a previous outbreak who again takes it up. The outbreak runs for two weeks

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69 Raymond Moser, Chief Executive Officer, Swan Hill Aboriginal Co-operative Indigenous Forum on Volatile Substance Abuse, Melbourne, 17 August 2001.

70 Submissions of the Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3.



or so and then dies down as the young people lose interest (Western Australia Solvent Abuse Working Party 2001, p. 23).

Victoria Police has also acknowledged the cyclic nature of inhalation abuse and the problems that poses for effective policing (Victoria Police (Policy and Standards Division) 2001).

The unpredictability in the patterns of inhalation use and the mobility of users, particularly among Indigenous communities makes policy development difficult in this area of substance use (WADASO 1998, p. 1). Moreover, community agencies working in the field also recognise that not all young people who chrome or use solvents are at the same stage in terms of their chroming behaviour. As chroming is most often a group activity, it is not uncommon for people within the group to be at different stages of chroming practice or use. For example, an 'experimental' chromer may share a paint can with a 'dependent' chromer.<sup>71</sup>

The phenomenon of episodic and cyclical use is not restricted to Indigenous communities nor to the Australian context. In England, Ives (1994) notes the tendency for the prevalence of VSA to increase or decrease in an unpredictable manner. A sniffing 'craze' may strike a locality or school and then disappear shortly afterwards. Some observers have suggested such 'crazes' may follow a seasonal pattern, although such a pattern is yet to be discerned by research into VSA-related deaths (Ives 1994).

In the American context, Beauvais (1997) has noted that the episodic nature of solvent abuse is in contrast to other drugs where increases or decreases in use occur over several years. He states:

One of the concerns about these epidemics is that while most youth will stop using once the epidemic is over, each wave of use leaves behind a group of vulnerable individuals who continue to use and go on to heavier use (Beauvais 1997, p. 104).

Regardless of exact rates of inhalant use, there is an emerging consensus that VSA is a growing issue in urgent need of address. Following the announcement of an inquiry into VSA, the Drugs and Crime Prevention Committee has been contacted by the Coroner, the Chief Magistrate of the Children's Court, the Victoria Police Drug Unit and several concerned individuals, all emphasising the necessity for information upon which to base urgent interventions.

### ***Volatile substance abuse as a group activity***

Volatile substance abuse has been documented as a 'group activity'. A comprehensive survey examining inhalant practices in Western Australia found that two-thirds of its sample<sup>72</sup> used volatile substances among friends, usually outside and in secluded

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71 To acknowledge and assist in recognising such differences, the Galaxy Project, based in the western suburbs of Melbourne, has developed a *Continuum of Chrome Use Model*. This schema recognises that '[C]hroming does not necessarily occur in a regular pattern but a young person may go backwards and forwards along the continuum' (Sunshine Chroming Awareness Program 2001, p. 11). A copy of the Continuum Model is attached as Appendix 4b.

72 The sample of young people classified as current users consisted of 44 males and 36 females of whom 50 per cent were Aboriginal. Their ages ranged from 10–19 with 75 per cent of the sample being between the ages of 13–16 (Rose, Daly & Midford 1992, p. 17).

places such as bushes, parkland etc. Railway stations and railway property were also popular:

The preferred method of use was inhaling the substance from a bag. Only a very small percentage of the sample engaged in more dangerous practices such as using alone or spraying directly into the mouth.

Most (80%) obtained their glue from supermarkets or hardware stores. Some also mentioned newsagents. However, some respondents admitted to stealing their glue (Daly, Rose & Midford 1992).

The above survey findings are dated, they relate to glue sniffing rather than chroming, and they originate in Western Australia. Nonetheless, anecdotal evidence suggests that chroming practices are not too dissimilar.

A more recent survey also based in Western Australia states that the 'culture' of volatile substance abuse is very much related to the child or adolescent's self perception, family and social background, and the need to belong to a group:

One explanation for antisocial behaviour associated with VSA is that these young people are more likely to come from family and/or school situations where they have not been successful in normal, pro-social behaviours. As a result, they look towards anti-social ways and join with anti-social groups as a way to enhance their reputation. That is, if they can't be good at being good, they'll at least be good at being bad (Rose 2001, p. 9).

Houghton, Odgers and Carroll (1998) compared current users of volatile substances (VSUs) with former users of volatile substances (ex-VSUs) and adolescents who had never used volatile substances (non-VSAs). The sample consisted of a base of 123 high school students. They report the following:

Current VSUs identified themselves as both having and wanting to have a significantly more non-conforming reputation than non-VSUs but not ex-VSUs, admired drug-related activities significantly more than both ex-VSUs and non-VSUs, while ex-VSUs also admired drug-related activities significantly more than non-VSUs, and ideally saw themselves as being mean and nasty, wanting to cause trouble, breaking rules, and being unreliable (Houghton, Odgers & Carroll 1998, p. 205).

In another Western Australian study in the same year, the same researchers (1998) surveyed 40 adolescent volatile substance users. Rose reports that 'these adolescents appeared to identify strongly with an antisocial social sub-group':

Users [VSA] were found to be organised into groups and peer networks, which often were involved in theft, prostitution, and other risk-taking behaviours. More chronic users had higher status within the group (Rose 2001, p. 10, quoting from Carroll, Houghton & Odgers 1998).

For those young people who use inhalants but do not engage in antisocial behaviour, sniffing or chroming may be simply viewed as a group social activity, part of a youthful experimentation phase and seen 'as comparable to their parents having a social drink at the pub' (Re-Solv 2000, p. 2).

In contrast to the previously expressed view of the volatile substance user as 'bad' or as a 'rebel' there is evidence that both the general youth culture and the broader drug culture itself holds the sniffer or the inhaler in contempt. According to this view, inhalants are 'gutter drugs'. The World Health Organisation has stated:

Because of the derogatory attitude towards those who use solvents by both the general population and the drug subculture itself, solvent abuse tends to be ignored. Most solvent users are likely to be alienated and rejected since solvents are viewed as 'low status' compared to other drugs. Instead of being ignored, solvent use should be a marker or warning of the existence of a very serious problem (WHO 1992, p. 3).

Across the literature three major patterns of use have been identified according to the general type of user. These groups have generally but not exclusively been related to age groupings:

- ◆ The largest group are occasional or experimental users, who tend to have an average age of 12 or 13 years;
- ◆ Poly-drug abusers, who are an older group (usually in their mid to late teens), who abuse volatile substances in conjunction with a range of other drugs, and who are likely to use volatile substances in a moderate or episodic binge fashion; and
- ◆ Inhalant dependent individuals, who exclusively and frequently abuse volatile substances, often on a daily basis – this group tends to involve older adolescents and young adults (WADASO 1998, p. 7).<sup>73</sup>

As with most drugs, the amount and volume of inhalant use will vary from individual to individual and group to group. New Zealand research has indicated that among paint inhalers use can vary from:

- ◆ A can of spray paint a month
- ◆ A can per week
- ◆ Inhalants used only on weekends
- ◆ A can a day
- ◆ Multiple cans per day (Meredith 2000, p. 16).

The volume of use may be related to situational factors. For example, a lack of money to buy alcohol or marijuana may lead to greater inhalation of spray paint. Use of spray paint on weekends may be related to the user's school (or work) attendance during the week. Whatever the reason for these variations, Meredith (2000) states that management of volatile substance abuse needs to be tailored to the amount used by the individual and the group.

Unfortunately there seems to have been very little research undertaken or information available on the long-term volatile substance abuser. In Britain some limited studies have shown that the long-term and chronic user does exist:

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73 Werry (1992) states that a lack of access to alcohol can in part explain the behaviour and usage of the first two groups, while the third group often consists of ethnic and Indigenous minorities.

Since most sniffers try out sniffing for the first time in their early teens, most long term sniffers will be in their early twenties. However, there is now evidence both of extremely long term sniffers approaching their thirties, who have sniffed ever since they were, say, thirteen years old and, of older sniffers who have taken up the practice in later life, perhaps in response to shortage of cash to buy alcohol or other, more expensive, drugs. As with other forms of drug use, published information gives the impression that long term sniffers are most often male, but this may simply be another aspect of the problem of the hidden female drug user (Re-Solv 2000, p.23).

New Zealand research indicates that there are two forms of older solvent abusers: 'Those who only use solvents and those who are poly-abusers but solvents are primary' (Meredith 2000, p. 12). Meredith states that a number of specific and particular factors need to be borne in mind when developing strategies that address the needs and problems of the older solvent user. These include:

- Older solvent abusers are less likely to belong to a larger group; they have often drifted away from friends. Older users are more likely to hide the fact they use solvents than younger users;
- Women who use solvents over the age of 20 years often come forward for help when they become pregnant or after they have had a child;
- Older solvent abusers do not do well in residential programmes that cater mainly for alcoholics. They find it very difficult to relate to each other and their chosen substances;
- Older solvent abusers require a range of options to help change behaviours that have been long term (Meredith 2000, p. 13).

### ***Poly-drug use***

In any discussion of volatile substance abuse it is important to bear in mind that for many users, particularly those characterised as long-term users, volatile substances abuse and inhalation is merely one form of their drug-using practice. Any policy development or strategy formation in this area must recognise the reality of poly-drug use, particularly given that 'Tobacco, alcohol and cannabis are used far more amongst young people than volatile substances' (Rose, Daly & Midford 1992; Rose 2001). As the above quote from Re-Solv indicates, volatile substances in some cases may merely act as a temporary (and cheap) expedient for when alcohol or other drugs are inaccessible.<sup>74</sup> Certainly the experience of community agencies such as Berry Street Victoria is that there are older children and adolescents in their care who could be termed poly-drug users.<sup>75</sup> Files from the State Coroner's office also indicate that poly-

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74 The survey of Perth High School students outlined earlier in this chapter resulted in the finding that for the majority of the sample, volatile substances were *not* their preferred drug. Cannabis was by far the most used and preferred drug of the overall group. See Rose, Daly and Midford 1992, p. 20.

75 The submission of Berry Street Victoria to this Inquiry attaches a number of case studies taken from its clients' files. Many of these clients use other drugs in addition to chrome paint and volatile substances. These range from alcohol and marijuana to speed and heroin. See Submission of Berry Street Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001. These cases are included at the end of this chapter.

drug use is often one of the contributing factors in the death of a person known to 'chrome' or otherwise inhale volatile substances.<sup>76</sup>

The issue of poly-drug use amongst volatile substance abusers who are already using needs to be distinguished from the issue of whether the use of inhalants and volatile substances *leads* to or results in other forms of drug use. There is one school of thought that volatile substances are *gateway drugs*, that is their use will be a risk factor leading to other forms of drug abuse (WHO 1992, p. 3). The reason put forward for such a claim is that volatile substances are frequently the first intoxicating substances used by children. However, this argument is contentious and there has been insufficient qualitative or quantitative research undertaken to support these claims. A Victorian research consortium is currently examining inhalants as a risk factor leading to further substance use and/or dependence. The 'Early intervention for young people with drug problems' project is a study being jointly undertaken by the Australian Drug Foundation, Turning Point Drug and Alcohol Centre and the Centre for Adolescent Health. The Committee awaits its findings with interest.

### ***The importance of culture***

Beauvais (1997) has argued that the 'cultural' meanings of solvent abuse are so often ignored in any discussion of the problem. Sarah MacLean from the Australian Youth Research Centre at the University of Melbourne is currently undertaking research into the 'social meanings' of volatile substance abuse in Victoria, including the social construction of inhalant abuse as a 'problem'. She states:

Inhalant misuse in Victoria is an under-researched yet common form of drug use among young people. Evidence suggests that inhalant misuse is a marker for other forms of risk. We currently know little about the dynamics of inhalant misuse in Victoria, what cultures of use serve to sustain or limit the practice, or how it differentially affects rural and urban communities and people of different cultures. This information will be useful to inform policy development and the design of appropriate programmes for young people (MacLean 2000, p. 16).

Meredith adds that:

Solvent abuse is difficult to address in that it has a culture of its own within the general addiction field. There are actions related to solvent use that are different from the use of other drugs (2000, p. 12).

Meredith lists these actions as including:

- Solvent abusers like the freedom of the streets;
- They do not like to be closed in;
- Sharing bags and solvents are common;
- For the majority of users it is a group activity
- Those who sniff alone will often do it in private away from the public;

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76 Usually these deaths are of older users. A mixture of toluene and heroin is one form of mixed drug toxicity noted in these files. Combinations of diazepam and volatile compounds are also listed. See, for example, Case No. 215/99; Case No. 765/00.

- Withdrawing from solvents for long term users can take nine months or more before confidence is restored; and
- Withdrawal is likened to coming off benzodiazepenes (Meredith 2000, p. 12).

Both Beauvais (1997) and Meredith (2000) argue strongly that volatile substance abuse must be regarded as a serious form of substance abuse in its own right and intervention strategies must be tailored accordingly. Beauvais proposes a number of questions that should be asked in considering both prevention and treatment strategies for volatile substance abuse. Some of those questions are incorporated in our Questions to Consider listed below.

## **Case stories on chroming and volatile substance abuse**

The following case studies are taken from the submission to this Inquiry of Berry Street Victoria. They reflect a snapshot of the stark reality of volatile substance abuse for many young Victorians; particularly those in community residential care. The names of the clients have been changed for reasons of confidentiality. The Drugs and Crime Prevention Committee is most grateful to Berry Street Victoria for allowing us to reproduce these very personal stories in this Discussion Paper.

The Committee also expresses its admiration for the young people profiled in these case studies for attempting to address their chroming problems. It applauds the efforts of the Berry Street Victoria workers who are supporting them to do so.

### ***Case Stories***

All names in the following case stories have been changed, but the key facts of the cases remain the same in an attempt to illustrate graphically some of the background issues, interventions used, and personalise and individualise the stories of young inhalant users.

#### **Case Story One “Michael”**

Michael is 15 and a half years old, and has been case managed by Berry Street from Child Protection for 18 months. Michael was emotionally and sexually abused by his parents and lived in deprived circumstances in a conflictual, dysfunctional family setting. Michael went to stay with extended family when his parents were assessed as unfit to care for him – these relatives had large families of their own and Michael’s behaviour soon became too difficult for them to manage and he was subsequently admitted to out-of-home care 2 years ago.

Michael was placed in DHS placements, and was diagnosed with ‘borderline personality disorder’ along with a ‘mild’ intellectual disability.

Michael is a poly-substance user, and was a chronic chromer from the age of 12 until 15 years.

Michael has lived in several residential units since his admission to care, with a number of different agencies. In residential settings Michael has displayed a range of negative behaviours – anger towards staff and other residents, outbursts of anger resulting in damage to property, suicidal ideation, self-harming (cutting his

forearms), sexualised behaviours, resistance to undertake day programs, substance use & abuse, and absconding from placement for extended periods of time.

Michael has had a number of hospitalisations as a result of his self-harming. The majority of his self-harming has been assessed as having a direct correlation to his experiences of negative contact with either of his parents.

From the age of 13 until Michael turned 15 he inhaled chrome-based aerosols on most days (on average, at least 5 days a week). Just before Michael turned 15 he was encouraged to re-engage with a Child and Adolescent Mental Health Service (CAMHS) Worker with whom he had a long-standing relationship. At this time, Michael also became involved with community-based Juvenile Justice services and his allocated worker was his ex-Child Protection case manager with whom he had established good rapport. At this time, Berry Street also re-assigned Michael's case to a specialist Drug and Alcohol Worker, and very quickly Michael developed a close and trusting relationship with this worker. Michael responded well to these workers and they began to notice changes in Michael's attitude toward involvement in activities other than chroming. Michael's sporting activities were encouraged and it was quickly identified that he had natural talent for various physical activities and sports – he began roller-blading, joined a local Australian Rules Football club and a basketball team. Playing this many sports required physical fitness and workers pointing out to Michael that chroming was damaging his health and fitness was successful in getting him to reduce his use dramatically. Michael's involvement with two local teams (football and basketball) also had other beneficial outcomes for Michael, in that his peer group began to change and his involvement in other social activities with team-mates – such as age appropriate parties, staying with friends' families over weekends, etc – were clearly having a calming and 'normalising' impact on Michael.

In conjunction with some of the activity-based changes, Michael's workers pursued alternative accommodation for him with a smaller number of co-residents. To this end, Michael has moved into a rostered staff unit with only one other resident. The structure of this unit is more 'homely' and family-like, something that Michael has constantly articulated that he wanted. Michael has also maintained weekly appointments with his CAMHS worker to address his issues of grief and loss in relation to his family of origin, he continues to see his Drug and Alcohol worker up to 3 times per week and is now very aware of harm minimisation and is keen on the possibility of becoming a peer educator in relation to inhalant use, and since moving to his new placement, has also begun individual educational tutoring twice per week and has joined the local library.

### **Case Story Two “Maria”**

Maria is a 17 and a half year old young woman who has been a poly-drug user and chronic chromer since Berry Street first became involved over 2 years ago. Maria left her mother’s home at the age of 14 and reports that she lived in ‘squats’ for a period of 12 months until she moved in to live with her older sister for a short period (her sister was 18 at the time and was a dependent heroin user with a small baby and a violent partner). Just prior to Maria leaving home, she was exited from her school due to her drug use and influence on other students.

Shortly after Berry Street became involved Maria was admitted to Child and Adolescent Mental Health Service In-patient Unit as an involuntary client as a result of her substance use and low mood, however after the crisis period was over she was reluctant to cooperate with an on-going assessment and support and exited the hospital.

Maria reported being involved in a ‘drug ring’ whereby she paid for her substance use with sex and she was raped by her pimp/boyfriend on several occasions. Although she disclosed this information to workers, she refused to give any identifying details and police could not proceed with any investigations. During this period, Maria was also hospitalised on numerous occasions for drug overdoses.

Neither Maria nor her family report any abuse history in the family, however her relationship with her mother and father is characterised as being ‘distant’. Maria maintains some contact with her sister currently, who has now recovered from her addiction to heroin.

Maria has had numerous placements in out-of-home care, the most significant being at a residential facility for 5 young people, where she has resided for 10 months.

Maria currently uses chrome on a daily basis, usually starting at 9.00am and going all day. She has learned over time to use chrome within harm minimisation principles – she uses small bags, takes regular breaks, consumes lots of fluids and allows herself to be monitored during her use. Whilst her heroin use has decreased since coming into care, she still uses on her Youth Allowance paydays, but she is no longer placing herself at extreme risk through prostitution, and she is no longer overdosing.

Maria has been engaged with Berry Street’s Drug and Alcohol worker for the past 8 months and reports that she has learnt a lot about her drug use from this worker. In the past 8 months she has had periods where she has not used chrome for periods of up to 3 weeks, and during these times has discussed a peer-education role, however has not managed to maintain a commitment to this for an extended period. Maria is also now engaged with an outreach Child and Adolescent Mental Health Service worker and is focussing on talking about how she feels about herself. Maria’s primary worker is a generic intensive worker within



Berry Street and Maria reports that she enjoys working with Berry Street rather than Child Protection.

Whilst workers have talked with Maria constantly about treatment options such as residential detox, residential rehabilitation, education and day programs and family counselling she has remained resistant to any of these services. Maria has commented that detox units are for heroin addicts and they don't take chroming as a serious addiction.

### Case Story Three “John”

John is the youngest of four brothers. He resided in a Berry Street group home for 11 years, moving in when he was three years old. John and his brothers were admitted to State Guardianship in 1980 and lived in Allambie for two years prior to moving into the group home.

At the time John was admitted to care, his mother was a single parent with numerous personal and social problems, which interfered with her capacity to care for her children. These issues included a history of alcohol and drug abuse, numerous violent relationships and transient accommodation.

John’s mother currently lives in supported accommodation after sustaining permanent neurological and physical injuries from a motor vehicle accident in 1988.

John has continued to maintain contact with his mother, visiting her approximately every six weeks. John resided in the group home with the same caregivers for approximately 12 years. It was reported that John presented as a cheerful, energetic and friendly young man, who was popular with his peers and had a wide circle of friends. John enjoyed outdoor and sporting activities. He took part in State gymnastics competitions.

After almost 12 years in the family group home, the caregivers decided that they would no longer continue to work with the boys. The older boys moved on and sought their own accommodation. John experienced great shock in the carers’ decision to move on. John began using butane and other dangerous chemical substances. At this time John attended some counselling in relation to his substance abuse and staff responsible for his welfare attempted to provide him with support and encouragement to cease this activity.

In March 1995, John’s brother moved to a Berry Street adolescent unit and John moved to another Berry Street family group home in the same geographic area. John’s substance use (butane) increased dramatically which resulted in him being placed in Secure Welfare for a week. John spent very little time at the group home and preferred to be with his brother, who had begun chroming. The appropriateness of the group home began to be questioned, given the small amount of time John spent there and the impact of his substance abuse on other residents who were all younger. Subsequently, John moved to the adolescent unit where his brother was also residing.

John presented with a serious problem of butane and chrome use for a large part of that year. In order to address his substance use, he was referred to a Drug Treatment agency but attended irregularly stating he didn’t find it helpful.

John’s older brother received a sentence to Melbourne Juvenile Justice Centre (MJJC). This was significant for John as the freedom he felt from the pressure to be with his brother, chroming, enabled John to be motivated in seeking work – he was successful and became a brickie’s labourer. This meant he left the unit at 5.00am and would return after 6.00pm. He would then eat dinner, chrome until

11.00pm and then go to bed. John maintained this job for 6 months. When he was working he was highly motivated. When he informed staff he wanted to be more independent, he was gradually assisted in moving into a private board arrangement with a known and trusted adult.

After moving into private board it appeared that his substance use had diminished. For some time John was able to hand over his can when told he was presenting as being substance affected. John was continually referred to a number of Drug and Alcohol services but claimed he did not find them useful and why should he attend when he did not have a problem.

In May 1996, John's brother was released from MJJC and moved into a SAAP funded flat. Both boys spent a number of days together, as John stated "just catchin' up on things over a bag of chrome".

John returned to his placement after this binge with his brother, stating he needed a break.

In the middle of May of 1996, John's brother was found dead in his flat. The cause of death was asphyxiation.

Following his brother's death, John stated that he was giving up chroming but he continued to use butane on occasions.

John has continued to maintain labouring jobs and has continued to chrome or butane when he is not able to buy any dope. John is now 21 years of age and has just announced his engagement.

### Case Story Four “Sam”

Sam is 15 years of age and Berry Street have been working with him for just over 12 months. Sam first came to Berry Street’s attention when we were asked to do a secondary consultation with his Child Protection worker regarding his substance use and associated risks.

Sam’s family background is one littered with tragedy – the death of his mother when he was twelve, witnessing his younger sister being sexually abused by his step-father, the family being transient for several years – Sam describes a time when he attended 20 different schools in the course of his Year 5-6 education.

Sam’s substances of choice are chrome and tobacco, with some minimal use of marijuana, pills (depressants) and alcohol. When Berry Street first discussed Sam’s case he was living in a residential facility managed by another agency, and he was chroming very heavily (up to 3-4 cans per day). Sam’s unit was located within close proximity to a busy metropolitan railway line, railway yards and a 4-lane freeway.

Sam’s daily routine almost inevitably involved waking up, leaving the unit premises, using chrome, returning to the unit distressed and angry, causing damage to the unit (breaking windows, holes in walls, kicking staff vehicles) and then leaving the premises again only to be observed lying on the railway lines, staggering across the freeway or playing chicken with cars. Staff at Sam’s unit had tried physically removing the cans from his hands which resulted in many assault charges, the agency had an exclusion policy around substances, so Sam chromed away from the property and in secret, and staff found it very difficult to engage Sam in discussions around his substance use.

Sam was at this time placed in residential care on a temporary Protective Order which has been breached several times, with him being placed in Secure Welfare four times due to his absconding, substance use and associated health issues which placed him at immediate and significant risk.

Approximately 6 months ago, Sam moved into a Berry Street residential facility. The unit began managing Sam’s substance use in accordance with our Substance Use Policy (see Attachment One). Sam and his family were told when he moved in that we operate under harm minimisation principles and that Sam’s substance use would be closely monitored and discussed frequently. Sam was told that if he chose to use inhalants, he would be expected to do so in the backyard, but a proviso of this was that staff would monitor him and he would be asked to hand over his can every 15–20 minutes and take a break by joining staff in having a coffee, food or an outing. Sam was also told that staff would be asking him how he was feeling and why he was chroming.

Three weeks after Sam moved into the Berry Street unit, his chrome use had reduced from 3-4 cans per day to 1 can per day. Sam chromed in the backyard, but accepted that staff would be monitoring him and he was taking advantage of having regular breaks and handing his can and bags over for periods of time. Sam started talking with residential staff about his feelings of grief and started describing his life as ‘black’ and ‘lonely’ and ‘dumb’.

Two months after moving in Sam's patterns of use had changed again – he was not starting to chrome until after lunch, filling his morning instead engaging with staff on a one-one basis working on a tutoring program of basic literacy and numeracy. Sam's chroming also finished at about dinnertime. Workers still talked with Sam about his family and his life and started to witness a change in his language – he was starting to focus on the future and what was possible, rather than the past and the fact that he had no hope.

Gradually over the next couple of months, Sam had full days when he did not chrome.

Sam attended his Protective Case Plan meeting a couple of months ago (the first time he had chosen to attend a meeting with workers) and he talked about how the resi unit made him feel like he belonged and that people cared about him. He said he wanted to stop the chrome all together and said he now understands what it must be like for workers to watch kids 'do that shit' to themselves. Sam is planning to go to TAFE next year to start his Certificate of Work Education.

### **Case Story Five “Natasha”**

Natasha is a 15-year-old young woman who has been living in an out-of-home residential care program for the past six months.

Natasha was living with her mother, step-father and older brother in far north Queensland. Her father, step-mother and step-brother lived in Melbourne. She had been attending the local high school, and progressing well at school, however at the commencement of Year 8 she began to ‘go missing’ from school. It became apparent that she was poly-drug using, prostituting, and stayed away from the family home for days at a time without her mother knowing her whereabouts.

Natasha went missing for weeks at one period, and the only information her mother received was that she had left town. Natasha finally arrived in Melbourne and made contact with her father. However, because Natasha was involved in prostitution and other illicit practices to support her poly-drug use (in particular chroming) her father would not allow her to remain in his home. DHS Protective Services became involved and Natasha was moved to a residential care program. Initially she continued her risk-taking behaviour, and on several occasions clearly showed she was unable to insure she could keep herself safe. Among her other issues, she began to engage in serious fire-lighting behaviour, the combination of which resulted in her placement in Secure Welfare Services.

Upon discharge from Secure Welfare, Natasha was placed in a one-to-one residential unit, and a therapeutic model of rehabilitation was drawn upon to address her areas of need. The plan was as follows:

- Regular counselling with Child and Adolescent Mental Health Service (CAMHS)
- Continuation of the Fire Awareness Counselling Program (which commenced when she was in Secure Welfare)
- Regular attendance at a day program which is an alternative school setting aimed at reintegrating young people back into mainstream education.
- Participation in Drug and Alcohol Counselling to address her chronic chroming and poly-drug use.
- Involve Natasha in all planning, discussion and decision making relating to her current life.

When Natasha was asked why she had chromed so heavily she stated the reason was because she ‘was bored’. The above therapeutic program resulted in Natasha successfully participating in her day program, reconnecting with her mother, and breaking her poly-drug use habit.

### **Case Story Six “David”**

David is a 13 year old of Aboriginal descent. He currently resides in a residential unit with 3 other residents. His place of residence is in an isolated rural community.

David's case management has recently been contracted from Child Protection to Berry Street. David is involved with Juvenile Justice and a local Alcohol & Drug service. He attends appointments with Juvenile Justice, but is reluctant to attend the A&D service.

David was removed from the care of his parents in 1991. This occurred after a violent domestic dispute involving his parents. With David's father unable to provide a safe environment due to his transience and substance addiction problems, and his mother's passing away, extended family looked after David, shuffling David from one family to the next. David still maintains contact with his family, occasionally visiting and through phone contact. David was placed on a Guardianship Order in 1994, after which David experienced numerous placements, with most being unable to sustain an ongoing commitment to David.

David is currently registered as a high risk adolescent and has a history of engagement in high risk activities which include:

- Frequently absconding from his placement for days at a time. Even when this is in breach of his bail conditions.
- Participating in escalating self-harming behaviours such as chroming and abuse of alcohol.
- Involvement in criminal activities such as assault, property damage and theft. The last incident involving assault of 3 police officers, resulting in one officer having to go off on Workcover, with a serious injury to his knee.

David presents with a pattern of defiant and destructive behaviours and he is unable to sustain significant relationships. Involvement with CAMHS has provided a diagnosis of an emotional disturbance and severe attachment disorder.

David was introduced to chroming several years ago and he has progressed to being a habitual user and will often chrome in the presence of unit staff. David will use paints, glues (Toluylene) etc. David will also use Marijuana and alcohol if the opportunity presents itself. Having little or no income to support his habit, David frequently shop-steals. Local supermarket policy is to not detain shop stealers or pursue matters of shop stealing through the courts. When approached by local law enforcement and Berry Street personnel the supermarket has removed paints from shelves but not the glues. David is aware of this and has recently used glue on a more frequent basis.

David's chroming will usually take place with other young people in the community. The local Koori community (elders and peers) have expressed their dislike of David's chroming habit and David seldom chromes with his Koori peers,

tending to chrome with non-indigenous Australians. David is not disowned within the Koori community, often being encouraged and supported to change his ways.

David's chroming / glue sniffing results in David becoming very aggressive and he loses any sense of self-preservation. This has often brought David to the attention of the local police, when he has displayed aggressive behaviour and criminal activity.

The police have almost daily contact with David, and it has been questioned if they are, in fact, targeting David. Recent appearances in court where it was suggested by a member of the police that they would rather see David in another community may support this question.

David's involvement with the police has included being apprehended for criminal activity, being transported to the local hospital when it is suspected he has been chroming and being stopped and questioned about his activities on numerous occasions. David has been remanded on several occasions, and he has been placed in Secure Welfare Service in an attempt to curb his behaviours.

David has not attended any formal educational / vocational programs in recent times, however it is hoped that current efforts may provide better opportunities for David. He is not involved in any sporting activities, but would like to be. He enjoys occasional outings with staff, fishing, camping, movies etc., but he will sometimes forgo this to chrome instead.



### **Questions to consider**

- ◆ Does volatile substance abuse progressively lead to the abuse of other substances? In other words is it a 'gateway drug'? What are the conditions in which this may be possible?
- ◆ Are there differences in the practices of volatile substance use between males and females?
- ◆ Do male and females perceive the use of solvents differently?
- ◆ How are people of different cultural backgrounds affected by volatile substance abuse?
- ◆ How does volatile substance abuse differentially affect rural, regional and urban communities?
- ◆ In contrast to most other drugs, solvent abuse peaks at an early age (about 13). How do young people perceive volatile substance abuse?
- ◆ What are the cultural meanings of solvent abuse among those who are using?
- ◆ Why does the use of volatile substances tend to occur in cycles?
- ◆ What are the factors that may lead to a rapid decline in volatile substance abuse?
- ◆ What are the pre-determining factors that may lead to a new 'epidemic of use'?

## 6. The legal regulation of volatile substances

There is little legal regulation of volatile substances in Australia from a criminal law perspective. Generally, where State legislation does provide for criminal offences, they invariably concern the sale and distribution of the substances rather than their (mis)use per se. Most of the Australian legislation in this area refers generally to volatile substances. These include, but are not restricted to, the most common forms of inhalant abuse, such as petrol, glue and paint sniffing. This brief summary will start with an overview of the legal situation in the United Kingdom, being one of the first jurisdictions to introduce some form of volatile substance regulation. It will then discuss the provisions applicable in Victoria and other Australian states and territories. It shall subsequently examine the related areas of supply regulation, product modification, labelling and scheduling.

### United Kingdom

In the early 1980s the issue of inhalant misuse had become of increasing concern to policy makers and legislators in the United Kingdom. In 1983 a consultative Committee of the then government discussed whether volatile substance abuse (VSA) should be subject to criminal penalties. Ultimately it was felt such measures would be counter-productive:

[c]riminalising VSA would almost certainly [deter] misusers from seeking help and would [burden] many young people with a criminal record. It was also felt that criminalisation might put young people in even greater danger by leading them to abuse volatile substances in secret where, if help were needed, it might arrive too late (Advisory Council on the Misuse of Drugs 1995, pp. 1-8).

Although the government decided not to penalise the *use* of volatile substances, it was prepared to regulate their sale and distribution, particularly to children and adolescents. The *Intoxicating Substances (Supply) Act 1985* makes it an offence for a retailer to supply or offer to supply to a person under 18 years or anyone acting on behalf of a person under that age a substance 'if he or she knows or has reasonable cause to believe that the substance or its fumes are likely to be inhaled for the purpose of causing intoxication'. A retailer found guilty of an offence under this Act could be sentenced to a maximum of six months imprisonment, a substantial fine or both. Although the legislation has generally been well received, some commentators have noted that 'the net result of these laws seem to have been an increase in mortality from VSU as users shifted [from glue] to aerosols and butane gas' (Rose, Daly & Midford 1992, p. 2). One needs to be cautious, however,

about such a finding as there has been very little evaluation undertaken of the effects of either the legislation or its links with inhalation practices.

Regulations passed in 1999 also make it illegal for any person to supply a cigarette lighter refill canister containing butane to any person under 18 years. This was thought to be particularly important given that inhalation of butane is by far the most common inhalation practice by children and youth in Britain.<sup>77</sup> This differs from the situation in Australia.

Although it is too early to make comment as to how effective these regulations have been in curbing butane inhalation, Warren Hawksley, Director of Re-Solv, gave a tentative 'thumbs up' to the measures when meeting with this Committee in July 2001:

Yes, we have picked up evidence that suggests that there are a lot fewer deaths [since the regulations were in force]. The law is that under 18s cannot be sold cigarette lighter refills. We have got quite a lot fewer deaths in the first year or so. It came in on October 1, 1999. The other big thing about it was that it made the Trading Standards Office responsible for enforcing it. Up until then the private member's bill we had previously did not do that. It was an option as to whether the trading standards officers or the police or anybody else bothered with it, whereas under the new legislation the trading standards officers, who are local government officials, are actually responsible for enforcing it. And that is, I think, probably as important as legislation.<sup>78</sup>

Moreover, in Britain if a retailer illegally sells volatile substances to a person under 18, he or she runs the risk of not only losing their licence to sell these substances but also any other age-restricted licenses. In effect, for breaching the volatile substance regulations a retailer may also have a licence to sell tobacco, alcohol or even lottery tickets revoked. This can happen whether or not there has been infringement of the alcohol or tobacco sale provisions.

However Dr John Ramsey, a British medical scientist specialising in volatile substance abuse, also warned the Committee that such regulation, while valuable, could serve to displace the problem:

The problem with legislation, what concerns all of us is that it is like squeezing a balloon, you restrict access to one product and then people move to another, and there are just so many domestic products that contain volatile compounds. Aerosols can contain butane as a propellant and cigarette lighter refills are popular because they contain nothing but butane. There is a picture here on page 4 in the middle on

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77 Of interest is the fact that in Britain petrol inhalation is and has been virtually unknown. Dr John Ramsey, a toxicologist with St George's Hospital Medical School, told the Committee when they met with him in July 2001:

I think that is where there might be a big difference between VSA in the UK and VSA in Australia. We don't have petrol sniffing. It is extraordinarily unusual for anybody to sniff petrol in the UK. Out of almost 2,000 deaths we have got about 8 or 9 that have been associated with petrol.

Dr John Ramsay in conversation with the Drugs and Crime Prevention Committee, London, July 10, 2001.

78 Warren Hawksley, Director, Re-Solv in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001. Intoxicated Person's Act 1979 as amended by Intoxicated Persons Act 2000 (New South Wales) .

the left that is a picture of a cigarette lighter refill can. What makes that particularly attractive is the design of the can; you can get the gas out by clenching the nozzle. The top left-hand picture shows the nozzle with teeth marks in.

This product contains the pure gas. The cans on sale in the UK contain 250ml of gas, which is enough to keep you intoxicated for a long time. And it is enough to fill a cigarette lighter hundreds of times. A cigarette lighter contains 4ml of gas, so that is an unnecessarily large product. We tried to persuade the manufacturers to produce a 25ml can instead of a 250ml can but we ran into problems because the European Community barriers to trade wouldn't allow Britain to introduce rules to prohibit the size of the cans and the other European countries may not have the problems we have. So unfortunately that solution just didn't work.

The concern always is that if you restrict availability of one product then another one will surface, which might have more consequences. I can't help feeling that since it is almost universal around the world that the deprived population that sniffs petrol, the Native Indians in Canada and America and your Aboriginal people sniff petrol because they don't have access to the more refined consumer products. If we really squeeze down on the British population, then petrol is always going to be accessible.<sup>79</sup>

In Scotland, England and Wales there is also legislation that constitutes VSA as a specific ground for referring children to child protection agencies or panels. Criticism has been levelled at the compulsory nature of the referrals under the Scottish legislation. It was felt that compulsory referrals to a panel inhibited the relationship between police and welfare personnel who had been hitherto working well together (Rose, Daly & Midford 1992, p. 1).

The British legislation is in most respects applicable only to juveniles, thus reflecting the view that it is mainly this section of the community that has the highest propensity to misuse or abuse inhalants.<sup>80</sup>

It is not the Committee's intention at this stage to exhaustively canvass legislative provisions from other (Western) nations. For the most part the regulatory frameworks in European and North American countries are similar, targeting the supply and distribution of products rather than the user of the substances. As the Committee intends to examine the situation in New Zealand and the United States over the next few months, it will briefly make note of some provisions in those jurisdictions.

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79 Dr John Ramsay, St George's Hospital Medical School London, in conversation with the Committee, London, 10 July 2001.

80 For further discussion of the British legislative provisions, see Advisory Council on the Misuse of Drugs (UK), *Volatile Substance Abuse: A report by the Advisory Council on the Misuse of Drugs*, Home Office, London, 1995.

## New Zealand

It is not illegal to inhale solvents in New Zealand. However, the Police can hold people under the influence of solvents in a public place for detoxification under the *Alcoholism and Drug Addiction Act 1966* or deliver them to a detoxification centre. A problem with such a measure is that most centres are not specifically designed to deal with solvent abuse. However a leading policy analyst in the field has stated that the legislation is rarely used for solvent abuse alone: 'It has been used when individuals are exhibiting anti-social behaviour, or are involved in wilful damage of property as a result of using solvents' (Meredith 2000, p. 8). The New Zealand government has on a number of occasions given consideration to making inhaling of volatile substances a criminal offence.<sup>81</sup>

Alternatively, the *Children, Young Persons and their Families Act 1989* may be used where a child is deemed to be in need of care and protection. However, referral for treatment requires the cooperation of the young person affected and the user cannot be forced to enter a treatment programme.

Some New Zealand local authorities have also passed by-laws banning the use of 'mind-altering' substances in municipal public places. Mind-altering substances have been defined to include glues, solvents and other volatile substances.<sup>82</sup> There are also by-laws in some municipalities allowing police officers to remove bags from sniffers provided the bags contain chemicals and – somewhat curiously – the bags are unmarked (Meredith 1992, p. 5).

## The United States of America

It is difficult to comprehensively discuss legislative measures with regard to volatile substance abuse in the United States, given that, as in Australia, most laws pertaining to the issue are local authority and state based. Thus one has 50 state and one territory (District of Columbia) legal regimes to consider.<sup>83</sup> Nonetheless, many states have provisions regulating the supply and provision of volatile substances, product labelling and provisions for the welfare of intoxicated youth. In few states is the use of volatile substances a criminal offence.

Some states have restrictions on the sale of substances or the compounds making up the substances. These restrictions include age limits at which the substances can be purchased or making it an offence to sell such substances for the deliberate purpose of inhalation.<sup>84</sup> In Massachusetts and Nebraska, for example, stores and shops that stock and sell volatile substances are required to keep a registry of sale that is available for police inspection on demand.<sup>85</sup>

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81 For an account of these deliberations, see below.

82 See for example, Porirua City Council General By-law 1991.

83 At least 38 States have legislation pertaining to volatile substances. Most legislation is abuser-based and prohibits the inhalation of specified compounds for the purpose of intoxication. See [www.inhalants.org/laws.html](http://www.inhalants.org/laws.html)

84 [www.inhalants.org/laws.html](http://www.inhalants.org/laws.html)

85 [www.inhalants.org/laws.html](http://www.inhalants.org/laws.html)

The leading prevention, education and advocacy group with regard to volatile substance abuse in the United States is the *National Inhalant Prevention Coalition* (NIPC) based in Austin, Texas. This organisation has been agitating for a uniform approach to legislation throughout the states, covering such matters as supply, distribution and control of products, welfare interventions for intoxicated and 'at risk' youth and comprehensive and well funded education and prevention programmes. The NIPC is currently seeking to establish a National Inhalant Resource Centre that will act as a clearinghouse for resources, information, research dissemination and networking.

Texas has some of the most comprehensive legislation covering volatile substance abuse in the United States. In many respects this is due to the efforts of the founder and Director of the NIPC, Mr Harvey Weiss. The Committee was privileged to speak with Mr Weiss in Washington during July 2001. Much of Mr Weiss' time, energy and own funds are spent in addressing the problem of inhalation of volatile substances in Texas and throughout the United States. Mr Weiss communicated much of the following information on the Texas legislative framework to the Committee.<sup>86</sup>

Legislation in Texas prohibits the sale or delivery of volatile chemicals to minors (under 18 years of age). It also prohibits the use of volatile chemicals in a 'manner designed to affect the central nervous system'<sup>87</sup> or the possession of such chemicals with the intent to inhale.

Permits are required in order to sell aerosol paint in many stores throughout Texas. The revenue from such permits is hypothecated and used by the state government to finance education projects aimed at preventing inhalant abuse. Shops must also put up display warning signs stating the following:

It is unlawful for a person to sell or deliver abusable glue or aerosol paint to a person under 18 years of age. Except in limited situations, such an offence is a 3rd degree felony.<sup>88</sup>

## **Australia**

Most Australian states follow the British model of making the sale and distribution of inhalants and volatile substances subject to criminal penalties in certain circumstances, while the use or misuse of such substances is not criminalised or penalised.

Before discussing specific state legislation that concerns volatile substances, it should be pointed out that most Australian states have legislation concerning people who are found intoxicated in public. Such legislation can in effect be used to detain a person believed to be intoxicated due to the inhalation of volatile substances. In most cases it also allows authorised officers such as police to search the person for inhalants and remove the inhalants in appropriate circumstances. Western Australia has the most comprehensive legislation in this regard and is discussed below.

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86 The Committee is also grateful to MacKillop Family Services whose thorough research for its submission to this Committee has proved extremely helpful.

87 (2000) 77(R) HB 2950 Effective from 1/9/01, See also Texas Legislature Online, <http://www.capitol.state.tx.us/cgi-bin/cqcgj>

88 <http://www.capitol.state.tx.us/cgi-bin/cqcgj>

Public intoxication legislation in other states, while not specifically mentioning volatile substances, can broadly have the same effect or outcomes as the Western Australian legislation by their extended definitions of what counts as intoxication.<sup>89</sup> The other Australian jurisdictions, to varying extents, define intoxication broadly as being affected by alcohol, another drug or combination of drugs. Arguably, such a definition can encompass volatile substances without more specific references.

### ***Child welfare laws***

The common feature of the various states' public intoxication legislation is that a person who is intoxicated may be apprehended by police and either released into the care of a responsible person or taken to a sobering-up centre or similar facility. It is doubtful that in the context of (juvenile) inhalant misuse, sobering-up centres currently in existence around Australia (geared as they are to alcohol abuse) are equipped to deal with the specific medical, psychological and cultural issues specific to VSA.

### ***Specific legal provisions concerning VSA***

#### ***Victoria (Drugs, Poisons and Controlled Substances Act 1981)***

Section 57 of this Act regulates the sale and distribution of 'deleterious substances'. These are classified into two broad categories:

- ◆ Methylated spirits (or an admixture containing methylated spirit)
- ◆ Other volatile substances

Volatile substances are comprehensively defined and include but are not restricted to:

- ◆ Plastic solvents
- ◆ Cleaning agents
- ◆ Glues
- ◆ Nail polish remover
- ◆ Lighter fluid
- ◆ Petrol or petroleum based products
- ◆ Paint thinners
- ◆ Aerosol propellants
- ◆ Anaesthetic gas

Other substances may be declared to be volatile substances by order of the Governor in Council.

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<sup>89</sup> See for example, Intoxicated Person's Act 1979 as amended by Intoxicated Persons Act 2000 (New South Wales). Section 3 of this act allows for the civil detention of anyone 'seriously affected by alcohol or another drug or combination of drugs' (Section 3). It is unclear as to whether this definition extends to volatile substances in the New South Wales context.

See also Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness, Final Report, Government Printer, Victoria, June 2001.

Under Section 58 of the Act it is made an offence for a person to sell a deleterious substance to another person if the person: 'knows or reasonably ought to have known or has reasonable cause to believe that the other person intends –

- ◆ to use the substance by drinking, inhaling, administering or otherwise introducing it into his body; or
- ◆ to sell or supply the substance to a third person for use by that third person in a manner mentioned in the previous section.

The maximum penalties for convictions under this section is, in the case of methylated spirits, 5 penalty units, one month's imprisonment or both and in the case of volatile substances 50 penalty units, imprisonment of up to two years or both.

Note that this section refers to 'a person' and is thus not restricted to the sale of these substances to minors.

The problem with provisions such as Section 58 of the *Drugs, Poisons and Controlled Substances Act* is that it is very difficult to prove or establish in court what the intention of the shopkeeper or supplier was in these circumstances. For this reason, prosecutions are seldom launched and rarely successful. This was certainly the case under the former methylated spirit provisions of the *Vagrancy Act* (now superseded by the *Drugs, Poisons and Controlled Substances Act*). There is little reason to believe that similar problems will not be applicable to prosecutions concerning the sale of volatile substances.

### **South Australia (*Controlled Substances Act 1984*)**

Section 19 of the South Australian legislation provides as follows:

- ◆ A person must not sell or supply a volatile solvent to another person if he or she suspects or there are reasonable grounds for suspecting, that the other person –
  - intends to inhale the solvent; or
  - intends to sell or supply the solvent to a further person for inhalation by that further person.

The applicable penalties are a maximum fine of \$10,000 or imprisonment for two years. The parent Act also gives the Governor in Council powers to make extensive regulations with regard to inter alia, the production, manufacture, distribution, packaging, sale, prescribing, possession and storing of volatile solvents.

### **Western Australia**

The *Protective Custody Act 2000* (WA) defines intoxicants as specifically including volatile substances. Furthermore, it also gives authorised officers such as police the power under section 5 of the Act to seize an intoxicant from a *child* if:

The child is consuming or inhaling the intoxicant; or

The officer reasonably suspects the child is likely to become intoxicated if the intoxicant is not seized;

The intoxicant may be seized even if the child is not intoxicated; and



The officer may destroy the intoxicant.

Previous Western Australian legislation allowed police to apprehend persons in possession of a 'deleterious drug'. A challenge to that legislation resulted in the Western Australian courts ruling that volatile substances were not drugs.<sup>90</sup> The current legislation, the *Protective Custody Act 2000*, gets around this problem by specifically defining intoxication as including volatile substances. In its recent Final Report on Public Drunkenness, the Drugs and Crime Prevention Committee of Victoria recommended the adoption of legislation similar to the Western Australian *Protective Custody Act 2000*. Specifically, it was recommended that the definition of intoxicant and intoxication encompass the inhalation of volatile substances (Drugs and Crime Prevention Committee 2001).

The provisions of the Western Australian *Protective Custody Act 2000* for the most part cover the field. However, under more general welfare legislation there is also the possibility for a police officer or welfare worker to apprehend a juvenile who is abusing volatile substances and take them to their home or into the care of a responsible adult.<sup>91</sup>

Other Western Australian legislation (*Aboriginal Communities Act*) allows for Aboriginal communities to make by-laws against petrol sniffing and other forms of inhalant abuse within their community lands and boundaries. Similar provisions have also been enacted in South Australia and the Northern Territory. For example, under the Junjuwa Community Incorporated By-laws (Section 3) the Junjuwa Community have the power to apply by-laws on community land prohibiting the use of deleterious substances (including glue or other volatile liquids). That there are conflicting views as to whether such by-laws are appropriate for Aboriginal communities has been argued by d'Abbs and MacLean (2000, p. 47):

There is disagreement over whether these by-laws should be maintained. Some government officials and magistrates ... believe that by-laws do not deter [petrol sniffing] but rather have the effect of relieving the community of a sense of responsibility for doing something about it. In any case police are reluctant to enforce the by-laws and place young people at risk in custody ... However [Some Aboriginal community representatives] ... strongly oppos[e] revoking of the by-laws without alternatives in place to combat petrol sniffing...

There is also a special provision in Western Australian by-laws that concerns the possession of solvents by a person on railway premises. This provision makes illegal the possession of a volatile substance 'capable of producing a narcotic effect if inhaled or ingested' unless there is a lawful excuse for such possession.

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90 Similar provisions exist in New South Wales under the *Intoxicated Persons Act 1979* (as amended by the *Intoxicated Persons Act (Amendment) Act 2000*.)

91 Section 138B *Child Welfare Act 1947*.

**Northern Territory (*Misuse of Drugs Act 1996*)**

Section 18 of this Act provides that:

A person who sells or supplies a volatile substance to another person and who knows or who ought to know that the other person intends to use the substance by administering it to himself or herself or a third person or to sell or supply it to a third person for use by the third person to administer it to himself or herself or to a fourth person, is guilty of an offence.

Penalty: \$2,000 or imprisonment for 2 years.

The definition of a volatile substance is wide and includes petroleum, paint thinners, glues and lighter fluids. As with most legislation of this type, the Minister may, by notice in the *Gazette*, declare a substance to be a volatile substance.

It should be noted that across Australia there is no uniform definition of volatile substances. In some states the definition is according to the type of product that is circumscribed (for example, paint thinner or petrol). In other states the definition may be according to the constituent chemical compounds of the substance.

***Problems with policing***

Police, welfare organisations and youth workers have all been critical of the lack of a comprehensive system for assisting young people who have been found or are known to abuse volatile substances. The following responses to the Committee's Inquiry are typical of many people working in the field:

The problem is that if you ring the police they'll say it's not illegal and it's not a police issue and then you ring child protection, and they say it's not really a protection issue, contact mental health, so then you contact mental health, and they say it's a protection issue, and then child protection says, have you tried the police? Workers have literally been on the phone all day from 10.00 am to 10.00 p.m. trying to get someone from these services or from drug and alcohol to do something, and absolutely nothing happened.<sup>92</sup>

An Indigenous community worker at a forum on inhaling auspiced by the Victorian Department of Justice has made similar criticisms:

The police ... were saying that they are also frustrated by the fact that it is not illegal to sniff glue. We seem to have a number of kids within the group who are glue sniffing who are very much aware of their rights in that area. They were going into one particular shop in Swan Hill, purchasing glue, putting it in a bag with a receipt and going away. They would then use. Then they would come back with another person with the empty can, the receipt in the bag and proceed to lift another can off the shelf – a replacement can – and walk out the door again.

The shop owners who came to the meeting were quite concerned about that. The police were also saying, well look, we really can't do anything in the sense that there

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92 Staff worker, MacKillop Family Services, in Submission of MacKillop Family Services to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 23.

is a receipt in the bag, there is a full can, and so there has been no crime committed. We can't but pull these kids up walking down the street. We know what they have been doing. There really is an issue for the whole community in how we tackle this. The police powers to prevent self-harm such as suicide need to be extended to cover inhalants. That comment is the one that has been put forward by our drug and alcohol counsellor because of his previous experience within the police force. I think the police also need to be aware to take possession for safekeeping, if you like, of items from people they believe, on reasonable grounds, will be used for inhaling and then a parent or a responsible person from behind the community needs to be contacted. It is no good locking them up. It is not about charging them or anything like that.

The use of drug diversion initiatives for persons they found in possession of inhalants needs to happen. As Barb said before, we need places set up to which we can refer them. We don't have anything up our way, and neither do you fellas down here. We are frustrated by this. Our court system is frustrated by this. The community is frustrated by it.

In Victoria, the police are also frustrated with the legal framework as it currently exists. Victoria Police has stated that prosecutions of suppliers under Section 58 of the *Drugs, Poisons and Controlled Substances Act 1981* rarely succeed, requiring as they do proof of knowledge of the supplier that the substance is to be used for deleterious purposes. Attempts to prosecute users under the offensive behaviour provisions of the *Summary Offences Act 1966* have been similarly unsuccessful and in any case are acknowledged by many police to be counter-productive. Provisions of the *Children and Young Persons Act 1989* that allow for police to seek protection orders for young people who are deemed to be at risk of physical harm are cumbersome and 'require a significant provision of police resources'.<sup>93</sup>

This Committee has received submissions from a variety of divisions of Victoria Police making similar comments about their 'powerlessness' in dealing with (young) people who misuse volatile substances. One submission states:

Victoria Police has no legislative powers to arrest and protect people intoxicated by substances, or to transport them to a place of safety where they can be supervised. This is of great concern to Victoria Police members who may be called to a situation where a person appears intoxicated through the inhalation of a volatile substance. This person may be uncooperative, aggressive and a risk to him/herself. Victoria Police members are understandably concerned that they are placed in a seemingly impossible position. Failure to act may attract some legal liability for any resulting harm, yet any action to detain or transport the intoxicated person to a place of safety may attract criminal charges of assault or false imprisonment.<sup>94</sup>

These problems are felt to be particularly acute in rural and regional Victoria. The problem is perceived in the Mildura/Swan Hill area as being of such magnitude that

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93 Information taken from Victoria Police (Policy and Standards Division) Submission to the Drugs and Crime Prevention Committee Inquiry into the Inhalation of Volatile Substances, August 2001.

94 Submission by Victoria Police (Policy and Standards Division) to the Drugs and Crime Prevention Committee Inquiry into the Inhalation of Volatile Substances, August 2001, p. 2.

police officers from that area have applied to the Victorian Law Drug Enforcement Fund for funding to coordinate and host a one-day workshop on the issue titled 'Kids and Chroming – A recipe for disaster'.

Inspector Trevor Carter, District Inspector for the Swan Hill area, claims that:

Traditionally police have had a reactive role in dealing with persons affected by inhalants. That is, contact with persons using inhalants is usually made through public complaint or patrols in known high-risk areas. Inadequate legislation and supportive processes limit the ability for police to adequately deal with persons affected by inhalants. A common complaint from police facing these situations is that there is little that can be done to prevent and detect persons using inhalants, let alone assist them when they are affected.<sup>95</sup>

It is operational police who feel the most frustration at this situation. It is worth reproducing the following comments at length:

I have lived in the Swan Hill area for the past 26 years and know that this has [been] and is an ongoing problem that is gaining popularity among the youth of the area.

Most of the locations that the youths use for chroming are in secluded areas [but] the police station [also] received numerous calls in relation to children chroming in the main street of Swan Hill. The local war memorial, which is located only 100 meters from the police station in the main street, is commonly used by these youths. This memorial is next to the post office and is situated in the centre of town with most of the local traffic passing by.

On Thursday the 10th of August I was working divisional van duties with another Probationary Constable John Lal. At approximately 11.30 pm we received a task to attend an address in X Street, Swan Hill. Upon arrival I spoke to a young Aboriginal male who was approximately 15 years of age. This male informed me that there were approximately 4 male and 12 female Aboriginal youths in the rear yard of the house who were chroming. Further information received from this male indicated that there were approximately 30 people in the house, due to a funeral for an elder in Swan Hill the previous day. The male that had asked for police to attend was concerned about the other youths chroming. The male also stated that all he wanted was for the other youths to stop chroming in his uncle's house. This put Constable Lal and I in a position where we had a complaint but could not do anything about it. We had no power of entry under legislation that was clear enough for us to enter at that time. This made the complainant feel as if we were just brushing off the matter and did not want to help him. He asked why we couldn't do anything about the kids chroming. After explaining why we could not enter the premises the male stated that he would go in and sort it out himself, seeing as we were not going to do anything about it. There was no breach of the peace at the time or offensive behaviour, and

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95 Submission of Victoria Police, General Policing Department, Region 3, Division 5, Swan Hill Ganawarra District Office to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, p. 1.

we did not have any powers to stop the youth chroming, as it is not an offence under any act.

The problem has been the topic of many discussions between some of the members at Swan Hill, with members reading parliamentary acts and legislation.

Members have considered charging the offenders with a number of offences such as:

- Offensive behaviour – Section 17(1) of the Summary Offences Act.
- Possess articles to cause criminal damage – Section 199 of the Crimes Act.
- Littering – Section 5 of the Litter Act.

This list of offences has been discussed with senior members ranging from the Senior Sergeant at Swan Hill, Swan Hill's Prosecutor and the Regional Training Officer. It has been suggested that members are pushing the boundaries of the meaning in these Acts. In the past members have resorted to calling in a C.J.P or ringing the Aboriginal Co-Op and passing the information on to them, in the hope that they may be able to do something about the youths. This is done for both Aboriginal and Non Aboriginal youths, as the groups are nearly always together. As a junior member I am not in a position to push the boundaries of any legislation for fear that a complaint file for pushing the boundaries may in one way or another affect my confirmation. This is always on your mind. And the thought that if you arrest or charge someone on the technicalities of legislation that costs may be awarded against the Police force.

It has been suggested that certain contents contained in spray paint should be deemed as a drug/poison pursuant to section 11 of the *Drugs, Poisons and Controlled Substances Act*. This is largely due to the similar effects that chroming has to the use of other drugs such as marijuana. If spray paint was classified in such an Act it would give the police a power to remove items and to charge the offenders. Police could be justified without fear of backlash on themselves or the department ... Laws giving Police a power to seize items from children when chroming can only be seen as a good thing, after all, is it not the children's welfare that is our primary concern? I do not believe that any adult, parent, could or would oppose a legislative bill that helps to protect the children in our communities.<sup>96</sup>

Of particular concern to the operational police of the Mildura/Swan Hill district was the issue of people driving while under the influence of chrome paint or other volatile substances. Again the views of a senior Swan Hill police officer are apposite:

Swan Hill Police have established direct links between several local crimes and inhalants, including commercial burglaries, thefts from motor cars and an incident of dangerous driving ... On the dangerous driving occasion the offender was found by myself sitting at the steering wheel of the vehicle. He was inhaling or drinking petrol from a plastic bottle, he had just endangered the lives of the occupants of the other vehicles. This same offender has also acted in a violent manner on other occasions when it was suspected that again he was under the influence of the inhalant petrol.

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96 *ibid*, pp. 5–6.

This incident highlighted a serious problem with Section 49(1)(a) [of the] *Road Safety Act*. The legislation which covers driving a motor vehicle whilst under the influence of alcohol or drugs [does] not cover this situation ... there is not an offence for driving under the influence of an inhalant.<sup>97</sup>

Indigenous community representatives have also expressed their concern about the inability [or perceived unwillingness] of police to act in these circumstances:

The inability of existing legislation to prohibit chroming or to restrict access to chroming materials is undermining strategies to address chroming practices and reduce the damage being done to young Aboriginal people. If existing legislation is inadequate then specific legislation or regulations should be considered. Legislative impotence does little to impede the move to substance abuse, in general, and chroming as its most available expression.... The capacity of the police to assist in dealing with chroming is compromised by the legality of the materials ... and the apathy of the police force to utilise preventative practices with Aboriginal youth. It would appear the police are unwilling to be proactive, even where they have reasonable belief of the intent to commit a crime, or where they would reasonably have a duty of care to act in the best interests of the young people, due to the fears of being accused of racism or harassment and the difficulties in finding someone to refer the young people on to.<sup>98</sup>

Agencies working with young people in the field express similar qualms. This response from Berry Street Victoria is representative:

One barrier, which can severely impact on the ability of an agency such as Berry Street implementing some of the above strategies, is the understanding of local law enforcement personnel. It has been Berry Street's experience that Police struggle with the issues relating to inhalant use. Whilst the substance use is not 'illegal', community expectations suggest that Police should be 'doing something' about young chromers in their neighbourhoods. Whilst Berry Street would not necessarily advocate changing current legislation, Berry Street would encourage the Victoria Police to provide education for its personnel in relation to harm minimisation and harm reduction strategies in relation to inhalant users. This may assist in developing consistent strategies for Police to deal with inhalant users, rather than the ad hoc experiences which range from Police ignoring inhalant users, to Police targeting inhalant users and 'locking them up' to get them off the streets.<sup>99</sup>

One recognises the frustration such community workers feel about the seeming helplessness of the 'system' to address the problems associated with volatile substance abuse. Nonetheless, it would seem that this is a frustration keenly felt by police themselves, as can be noted from the various submissions received by this Committee

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97 *ibid*, p. 2.

98 Submission by the Binjirru and Tumbukka Regional Councils (ATSIC, Victoria) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, pp. 4–5.

99 Submission of Berry Street Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances. August 2001, p. 9.

from Victoria Police and its individual officers.<sup>100</sup> The police are caught between the Scylla of upholding the law as it currently stands and the Charibidis of assisting young people, their families and community who are clearly in vulnerable positions. Certainly, a system such as that in place in Western Australia whereby police are empowered to use 'welfare interventions' seems to have promise. It also has the potential to satisfy *both* community groups and police, as young people may be taken to youth appropriate health and welfare placements without being arrested or facing criminal charges. The Committee welcomes receiving the views of interested parties with regard to civil apprehension schemes such as those in Western Australia.

### ***A criminal response to users?***

In 1997 the Justice and Law Reform Committee of the New Zealand Parliament was asked to write a report on a petition presented to the Parliament to, in effect, make the inhalation of volatile substances a criminal offence. The petition was worded as follows:

The Petition requests that the House of Representatives enact legislation to make it an offence to be under the influence, or in possession, of substances commonly associated with what is termed "glue sniffing". In particular, the Petition seeks to make it an offence

"to unlawfully and without good cause be in possession of or misuse any hydrocarbon based chemical or combination of chemicals or similar toxic substance or substances which are capable of inducing or have brought about a drug induced state of any person or persons."<sup>101</sup>

The report commissioned by the New Zealand government to address the submission was far-reaching and comprehensive. It examined the medical, social, health, welfare and legal aspects of the issue and finally recommended that such an offence not be adopted. It concluded:

The legislative proposals in the Petition are fraught with difficulties in interpretation, evidential matters, and enforcement and administration...

In our view, it is more appropriate to approach solvent abuse as a social problem. As such, rather than legislative intervention through the criminal justice system, what is continued to be required is a co-ordinated approach by government agencies, private and community groups, schools, and caregivers, with a focus on harm

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100 There are a number of Victoria Police initiatives that seek to address volatile substance abuse in a pro-active and sensitive manner. The involvement of Werribee Police with local traders and community groups in minimising 'chroming' in that area has already been mentioned. Swan Hill Police are to be commended in its efforts to raise awareness of inhalant abuse in its region through its community oriented policing strategies and its efforts to conduct and host seminars and workshops on the issue in collaboration with the local Indigenous community. Another initiative that has shown promise is the 'Street Surfer' bus located in the western suburbs of Melbourne. This project is run in conjunction with the Sunshine Chroming Awareness Program. The local police Youth Liaison Officer has a bus which is fitted with Nintendos and other games. It visits shopping centres and other places where young people identified as 'chromers' congregate on Friday nights. It aims to distribute information about chroming (when desired) in non-threatening and non-didactic ways.

101 Submission by the Justice and Law Reform Committee (New Zealand) to the Government of New Zealand, October 1997, p. 1.

minimisation and restoration to personal and social health.<sup>102</sup> This approach is supported by government crime prevention and drug/mental health strategies that also seek to address the wider circumstances of young people at risk.<sup>103</sup>

Ultimately, the government agreed with this recommendation. The Justice and Law Reform Committee's detailed reasons for rejecting the proposal of a criminal 'inhaling' offence are as follows:

- A legislative framework already exists in New Zealand for dealing with intoxication-related offences, other offending by solvent abusers, the care and protection of children and young persons, and the labelling of toxic substances.
- Given the predominant age profile of solvent abusers, enforcement of any legislative sanctions in New Zealand generally would be dealt with under the care and protection or youth justice provisions of the *Children, Young Persons and Their Families Act 1989*. Principles under that Act require concern for *whanau/family*<sup>104</sup> participation in decisions affecting children and young persons, that the welfare of the child or young person be given first and paramount consideration, that criminal proceedings should not be instituted against a child or young person if there is an alternative means of dealing with the matter, and that any measures taken under that Act for dealing with offending must have due regard to the victims of that offending.
- Other concerns such as the health and income-earning capacity of solvent abusers, and the degree of seriousness of related offending, generally would provide barriers to imprisonment and/or the payment of fines.
- A solvent abuse conviction could have other consequences which may not be proportionate to the harm caused (for example, be detrimental to subsequent job prospects).
- The provision of additional criminal sanctions is unlikely to have any further effect on the incidence of solvent abuse. Overseas experience in jurisdictions which have placed sanctions on the supply of solvent-containing substances have shown that there is little (if any) correlation between criminal sanctions and disincentives to solvent misuse, or to reduction in solvent abuse. Solvent abusers may simply move on to other substances if the use or supply of a particular solvent is restricted.<sup>105</sup>
- Experience has shown that where the Police and local authorities have sought to control public solvent abuse, solvent abusers generally tend to move to areas

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102 This approach is recommended in J. Watson, *Solvent Abuse*, 1986, pp. 204–14; K. Pickens, *The Young and the Volatile: Coping with Solvent Abuse*, 1985, p. 40; and more recently in World Health Organisation, *Programme on Substance Abuse: Solvent Abuse: Report of WHO Consultation, December 1992*, Geneva, World Health Organisation, 1993. The Government's crime prevention and drug/mental health strategies also seek to address the wider circumstances of young people at risk.

103 Submission by the Justice and Law Reform Committee (New Zealand) to the Government of New Zealand, October 1997, pp. 8–9.

104 *Whanau* refers to the customary concept of the extended family and kin in traditional Maori culture.

105 J. Watson, *Solvent Abuse*, p. 187.



where they escape or receive less attention, often placing themselves at greater risk. In such an event, there is also less chance of intervention.

The arguments put by the New Zealand Justice and Law Reform Committee are persuasive, although it is too early in this Committee's deliberations to reject out of hand the concept of an 'inhaling offence' for Victoria. Certainly, the Committee welcomes further input as to the desirability of such an offence.

In Victoria, most of the individuals and agencies working with or somehow associated with 'inhalers' that have submitted to this Inquiry thus far are opposed to the creation of an 'inhaling offence'. This is also the predominant view of the academic literature. Legal Aid Victoria states:

Many juveniles (especially younger adolescents) in the protection system are inhalers. These young people inhale because it is cheap and easy to locate these substances, as opposed to the harder substances ... It is highly unlikely that any legislative change to make inhaling illegal would have any impact on the use of inhalants. All it would do is add another group of 'criminals' to the Children's Court ... Criminalising the activity merely adds to the raft of problems already being experienced by these young people. It is not even part of a solution.<sup>106</sup>

This view is also shared by many police officers. When the issue was being debated in Western Australia, a senior police officer stated:

...[p]olice cells are not, and that point can not be stressed enough, a suitable venue for the placement of juveniles [intoxicated on volatile substances] ...the need is for involvement by departments more akin to welfare (Hanwell 1990, p. 14).<sup>107</sup>

Another salient point with regard to criminalising inhalation of volatile substances is made by the Western Australian Drug Authority:

The very high incidence of cannabis use amongst [inhalers] ... throws doubt on the utility of making the use of volatile substances illegal. Indeed, such a move may elevate the status of these substances which are currently seen by the using population as 'gutter drugs' or 'kids drugs'. As opposed to most other drug use, volatile substances tend to decrease after the age of 15. In this regard, it may be better to let 'sleeping dogs lie' (Rose, Daly & Midford 1992, p. 28).

Certainly reports of the Western Australian police/welfare approach to intoxication under the *Protective Services Act* have generally been positive.<sup>108</sup> The Northern Territory Coroner has also commented on the desirability of such an approach. In the context of a coronial Inquiry pertaining to the death of a young Aboriginal petrol sniffer the Coroner was to recommend:

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106 Legal Aid Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, pp. 1–2.

107 Certainly, it was the view of the Committee during the deliberations of its Inquiry into public drunkenness that in the context of alcohol intoxication criminalising the (non-violent) behaviour of juveniles was counter-productive.

108 In a recent background paper produced by the Western Australian government's Solvent Abuse Working Party a law aimed at the user was specifically not recommended. (WADASO 2001, p. 2).

[a]ppropriate legislative change to better assist law enforcement officers and others in addressing the behaviours of those suffering the effects of petrol abuse and of those who assist in the provision of petrol to such abusers.<sup>109</sup>

Despite the criticisms levelled in the previous section, on balance most people who work with people who inhale volatile substances are opposed to the idea of criminalising the use of volatile substances. Certainly, the recommendations of the Drugs and Crime Prevention Committee in its previous Inquiry with regard to public intoxication encompass the possibility of the police civilly detaining a young person who uses volatile substances for his or her own health and safety. Furthermore, such a recommendation has received the commendation of some members of Victoria Police.<sup>110</sup>

On the basis of current academic research and after having heard the views of many in the community, as a *prima facie* position and subject to further investigation the Committee would be cautious about any proposals to make the inhalation of volatile substances a criminal offence.

## Supply regulation

### *Supply and distribution laws*

As with laws that criminalise the behaviour of users of volatile substances, there are also divided views as to the efficacy of initiating laws aimed at the suppliers and distributors of volatile substances and associated by-products. As noted previously, Victoria Police have been sceptical about the worth of prosecuting suppliers of volatile substances under the *Drugs, Poisons and Controlled Substances Act* in cases where they believe the supplier is aware that the purchaser will use them for deleterious purposes. Unless the legislation had a reverse onus of proof provision, in itself a contentious and controversial proposition, establishing the intention of the supplier in selling the product is notoriously difficult.

Furthermore, as also noted previously, it has been stated that in Britain laws aimed at prosecuting and restricting suppliers of volatile substance products have not been successful in reducing volatile substance abuse. A recent report by the Western Australian Working Party on Solvent Abuse states:

Legislative changes in the United Kingdom in the mid 1980s appeared to have the effect of shifting VSA from the less hazardous abuse of glue to the more hazardous abuse of butane gas and aerosols. While deaths from glue stabilised and even dropped a little, overall deaths from VSA went up from 82 deaths in 1983 to 132 in 1988. The increased deaths were all attributable to a three-fold increase in gas and aerosol deaths (Rose 2001, p. 30).

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109 Coroner's Office of the Northern Territory, Case No. 3013, Coroner W.L. Donald, 2 September 1998.

110 Submission of Victoria Police (General Policing Department, Region 3, Division 5 – Swan Hill Gannawarra District Office, per District Inspector Carter) September 2001, p. 2.

Thus far the form of control examined has been to prosecute the supplier for knowingly supplying a product for deleterious purposes. A different, although related, form of supply control is to restrict the sale of products containing volatile substances to people over a certain age, such as 18 years. If sales were not completely banned, products such as spray paint cans could be kept in locked cabinets or at least re-positioned in areas that are less susceptible to theft.<sup>111</sup> This would be similar to current restrictions on the purchase of tobacco and alcohol by juveniles. Young people would be required under such a system to provide age identification when purchasing products containing volatile substances. Britain has taken this approach with its recent regulations banning the sale of butane lighter refills to people under 18 years of age. As stated, it is too early to make any judgements as to the effectiveness of the British measures. Similar recommendations have been made in Australia.<sup>112</sup>

Some of the arguments against implementing supplier directed legislation have been put forward by Sandra Meredith, a leading New Zealand policy analyst in the area of volatile substance abuse. She states reasons why such legislation may be counter-productive:

- Young people might be stopped unnecessarily when in possession of a product being used for perfectly legitimate reasons;
- Young people may have purchased a solvent based product on behalf of a parent;
- General enforcement would be difficult;
- Prosecutions would not necessarily change behaviour;
- If supplies of some products are restricted it could encourage use of other products;
- The problem could become visible again if there were publicity on restrictions (Meredith 2001, pp. 3-4).

A further problem associated with the banning or restriction of sales of volatile substance products to juveniles is simply the huge range of products that can be used as inhalants, including many household products such as cleaners. It would be impractical, if not impossible, to ban the sale of all possible products. Moreover, some workers in the field have made the blunt comment that if some young people cannot purchase the products they will simply steal them. For example, the Committee has received a submission from a Victorian supermarket manager:

In my employment as a supermarket duty manager I have had experiences with young people who use spray paint and plastic produce bags to obtain these highs. Occasionally the paint is purchased but generally it is stolen.

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111 Various local trading initiatives currently have put such restrictions in place. For a discussion of some of these initiatives see Chapter 8.

112 It should be noted that in 1993 following a coronial investigation into the death of three young people who died after inhaling volatile substances, the Victorian Coroner recommended that consideration be given to prohibiting or restricting the sale of lighter fluid to minors. See State Coroner Victoria, Case No. 1754/91 (8 September 1992 – Coroner Maughan).

As far as the Committee is aware such recommendations have not yet been implemented.

Initially when we had our problems, in agreement with the local police, we refused to sell spray paint to anyone who was not 18 years of age. This worked for a short time until it became easier for Chromers to steal than buy.<sup>113</sup>

Nonetheless, the restriction of substances is worth some consideration. The Drugs Policy Branch of Human Services Victoria in a submission to this Inquiry states:

To reduce the supply of solvents to young people a campaign directed at retailers may be equally effective as legal sanctions and could be conducted in lieu of or in support of additional legislation. For the introduction of the UK legislation the British Health Education Authority led a 'responsible retailer' campaign. The other option (or additional step) may be to introduce a 'Code of Practice'. Currently no such code exists in Victoria, however most traders are reported to be cooperative when approached to ensure young people do not have access to volatile substances and many are active members of drug committees.<sup>114</sup>

The above comments indicate the importance of cooperative measures with traders and industry in addressing the problems associated with volatile substance abuse. Such cooperation would seem to be crucial whether or not restrictive legislation is proposed and many view this as preferable to a 'punitive' approach towards traders.

This is an approach strongly endorsed by the Wyndham City Council, based in Werribee on the western fringes of Melbourne. In its Wyndham Substance Abuse Strategic Action Plan the Council identifies volatile substance abuse as a significant 'drug' problem for the municipality and its youth. In its submission to this Inquiry it highlights the importance of community initiatives and local partnerships in addressing drug issues. The concept of community partnerships will be discussed in detail in Chapter 8 of this Discussion Paper. It is suffice to state that in the context of product regulation the Council applauds one initiative spearheaded by Werribee Police to combat volatile substance abuse amongst Werribee youth:

During 2000 the Werribee Police commenced an awareness raising campaign regarding the misuse of volatile substances occurring in the Wyndham community. This was in response to growing community concern and prevalence of this practice in specific public spaces in Wyndham – particularly trains, train stations and parks. The awareness campaign was directly targeted to traders that sold the substances that could be potentially misused by inhaling. Through personal visits from local police officers, the Werribee Police were able to raise awareness of volatile substance misuse to traders. They were also able to provide useful strategies to reduce the availability of misused inhalants to the young people who were at risk of volatile substance misuse.

Some of the strategies identified included:

- re-positioning of stock in areas that are less prone to theft

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113 Mr Adrian Setter, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001.

114 Department of Human Services (DHS) Drugs Policy and Service Branch, Victoria, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001c, p. 4.

- not selling the products to at risk youth
- recognition of symptoms of volatile substance misuse.

Many of the local traders were very supportive of this campaign. Through their activities the police were able to reduce the publicly visible instances of chroming within the Wyndham community. This was a very positive result.<sup>115</sup>

The Council adds, however that as satisfactory as these results are:

[I]t was not clear whether the visible reduction in volatile substance misuse incidences in Wyndham resulted in a decline of the practice or whether it moved to a neighbouring geographical area or more chroming was occurring in the home.

They therefore concluded that for such a campaign to be successful it needs to be targeted 'across borders'.

In Western Australia strategies with regard to suppliers and traders of volatile substance products have a three pronged 'carrot and stick approach'. This consists of:

- ***Redeveloping and distributing the Retailers Resource Kit***<sup>116</sup>  
The *Retailers Resource Kit* and *Code of Conduct*, aimed at supporting business to restrict the sale of solvents, will be redeveloped and subsequently further distributed by Local Drug Action Groups, Community Drug Service Teams and police.
- ***Promoting businesses taking positive action***  
Those businesses taking positive action regarding availability of solvents and other drugs will be promoted through the *Drug Aware* business program.
- ***Pressuring non-compliant businesses***  
Options, such as police intervention, for community members to influence retailers who ignore requests to reduce the supply of solvents to minors will be developed and publicised (Western Australian Solvent Working Party 2001, p. 8).

As laudable as such cooperative efforts are, agencies in the field have recognised that 'creating interest at a community level is problematic' (Sunshine Chroming Awareness Program Galaxy Project 2001b, p. 5). The Sunshine Chroming Awareness Program, auspiced by the Salvation Army's Galaxy Project is one of the leading initiatives in combating volatile substance abuse in Victoria. The Project has developed a comprehensive kit for traders informing them about volatile substance abuse and instructing them about the best ways to address it.<sup>117</sup> The response from traders has been mixed:

Contact has been made with traders through a range of avenues and a number of traders have changed their selling and promotional practices in relation to chrome

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115 Wyndham City Council, Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 4.

116 Western Australia Drug Strategy Office, *Retailers Acting Against Solvent Abuse – Resource Kit*, Perth, 2001. For a description of this kit see Appendix 5a.

117 The Sunshine Chroming Awareness Program is profiled in more detail in Chapter 8. A copy of the traders 'kit' is to be found in Appendix 5b.

paint ... Gaining support from smaller traders in relation to changing selling practices of chrome paint has proven to be more difficult than larger traders, who may have national headquarters who are aware of the issue and able to support local traders in changing their practices ... One of the most successful avenues [in fact] in creating change was for letters to be sent to the head offices of larger traders raising the Group's concerns about chroming and requesting action to be taken at the local level (Sunshine Chroming Awareness Program Galaxy Project 2001, pp. 5-6.).

Another legitimate concern about engaging suppliers and traders in voluntary agreements is that consistency of approach is not necessarily guaranteed. This potential problem is outlined in the submission of a local councillor from the Melbourne suburb of Frankston. This is an area also claimed to have a significant 'chroming' problem. As a result of this a 'partnership approach' was undertaken to minimise the problem:

... Police, Council and local businesses agreed to restrict the availability of pressurised cans of paint and butane lighter fluid by placing these products behind the counter or in lockable cabinets. At this time I was performing duties as a member of the Police Force at Frankston Police Complex. During my patrols I noticed that this action drastically reduced the number of incidents involving these products.

Over the years since that time, new businesses and managers have arrived to the area and have the obvious task of improving profits. The pressurised cans of paint have now reappeared from behind their secure areas and are easily available to a new generation of streetwise youth.

I have been working in the youth industry in Frankston since leaving the Police Force in 1999 and have noticed the increasing ease in which these young people, often aged around 14 years, obtain these mind altering, oxygen restricting inhalants. Often the users enter the stores in large groups and 'rack' (shop-steal) the cans of spray paint in multiples of six cans each.<sup>118</sup>

Councillor Smith concludes his submission by recommending that in addition to voluntary agreements, the Frankston Council should enact by-laws restricting and controlling the sale of inhalants.

### ***Scheduling and labelling***

All Australian states have adopted standards for the scheduling of drugs and poisons. Drugs and other chemical substances are classified in Schedules that restrict their sale, labelling and packaging. For the most part, the compounds and products used by young people are either exempt from scheduling or located in the schedule subject to the least restrictions. Many community agencies and health experts have in the past been vocal in pressuring for butane to be listed on Poisons schedules (Rose, Daly & Midford 1992, p. 27).

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118 Councillor Reade Smith, Individual Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, p. 1.

One of the few compounds commonly found in aerosol inhalants which is classified as a poison is toluene, the substance that is often a constituent of glues and adhesives. As such, toluene based products should not be sold to juveniles.

One form of 'regulation' that has been used fairly widely in Australia and overseas is for volatile substance products to have clearly displayed health warnings printed on packaging and on containers such as spray cans. In Britain, for example, major producers of aerosol products have standardised warnings on their product labels with the exhortation 'Solvent Abuse Can Kill Instantly' (Re-Solv 2000, p. 10). Such labelling seems to reflect the very good and cooperative relationship British health authorities and the voluntary sector have with industry. The Director of Re-Solv commented on this when the Committee met with him in July 2001:

When we first suggested to marketers [that] they put the word "kill" on their cans they didn't throw us a party. In a way, when the problem was explained to them and the research was so extensive and [when it] showed very clearly that it was understood people didn't ... there was no negative reaction to a product that carried this label, it was very positive, we found absolutely no problem with acceptance of [it] by the industry at all.<sup>119</sup>

The Drugs and Poisons Unit of the Victorian Department of Human Services encourages manufacturers to place such warning labels on volatile substance products in line with the recommendations of 1985 by the Senate Select Committee on Volatile Substances. The Department of Human Services (Drug Policy Branch) in its submission to this Inquiry states:

[a]lthough there [were] arguments for not identifying products with a warning label, [thereby bringing the practice to the attention of young people] on balance the evidence in favour of warning outweighed evidence against them. It [The Select Committee] recommended that industry progressively identify all products containing abusable volatile substances with a warning against their misuse.<sup>120</sup>

The Department of Human Services and other agencies support the labelling of volatile substances with health warnings. The question remains as to whether this should be encouraged as a voluntary undertaking or given the force of legal regulation.

### ***Product development and modification***

Although product development is not strictly speaking associated with the regulation per se of volatile substances, it is related to issues of regulation and is therefore appropriately dealt with in this section.

A key principle of harm minimisation is to lessen the dangers associated with the consumption of particular drugs. The merits or otherwise of harm minimisation principles is discussed in greater detail in Chapter 7. Nonetheless, the modification of the receptacles containing volatile substances or the changing of the product itself to

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119 Warren Hawksley, Director, Re-Solv in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

120 Human Services Victoria (Drugs Policy and Service Branch) Submission to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001c, p. 8.

make it less toxic is put forward as one strategy to combat the harms associated with volatile substance abuse.<sup>121</sup>

Product modification and indeed product substitution has to some extent already been undertaken with regard to the problem of petrol sniffing in outback Australia. Some remote Aboriginal communities have been encouraged to use 'Avgas' rather than petrol or unleaded rather than leaded petrol. In Western Australia the state Drug Strategy Office assists Aboriginal communities to apply for Comgas subsidies from the Commonwealth government to assist them in substituting gas for petrol (Western Australian Solvent Working Party 2001, p. 8).

Modification campaigns have also targeted propellants in aerosol cans. Aerosols are a particularly dangerous vehicle for the inhalation of volatile substances. Rose, Daly and Midford state that:

Besides being the leading cause of VSU mortality in Australia, the English experience suggests that anything which can reduce the lethal potential of these products is worthy of investigation.

Pump action sprays are gaining more attention as being environmentally friendly. A new design of pump action hair spray has become recently available. Any legislation, tax incentive or other measure to increase the use of these products may reduce the risk of experimentation, especially amongst girls who are the primary consumers of these products (Rose, Daly & Midford 1992, p. 26).

In Britain, modifications to the nozzles of aerosol cans have been trialed. Unfortunately, they 'appear to have little effect on discouraging abuse, as "fixed" nozzles, whilst not being easily removed, do not present a problem to determined access' (Re-Solv 2000, p. 10).

In London during July 2001 the Committee met with British voluntary sector and government representatives concerned with the inhalation of volatile substances and was generally very impressed with the cooperative, supportive and close relationship health agencies in the field have with British trade and industry. The British Aerosol Manufacturing Association (BAMA) has a key role to play in preventing the abuse associated with the inhalation of aerosol products. The Association represents approximately 70 companies in the aerosol industry including Gillette, Reckitt Coleman and Johnson. BAMA has a Committee specifically convened to address strategies for lessening the problems associated with aerosol inhalation. The Drugs and Crime Prevention Committee met with Sarah Ross from BAMA who described the brief of the BAMA volatile substance abuse committee:

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121 Drug Arm Victoria in a submission to this Inquiry relates how in the early 1980s after the death of a young girl who had been sniffing 'Liquid Paper', a small amount of mustard was added to the mixture. Apparently 'this dangerous fad stopped very quickly'. Drug-Arm recommends in its submission that: 'A solution which will radically reduce the toll of young lives. Add an unattractive odour to volatile substances and enthusiasm for their use will decline rapidly'.

Submission of Drug-Arm Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 4.



[It] is to ensure that we continue helping experts and liaise with the experts on the issue, making sure the industry is fully aware of all the issues and what exactly is going on and what [we] can do to help.

[W]e are looking at education initiatives because time and time again that comes through as the best way of reducing the problem and addressing it.

We have recently been looking at the technical products: can you make your products less abusable technically.<sup>122</sup>

BAMA also runs a concerted publicity and education campaign aimed at traders and retailers. It provides stores and shops with leaflets, training materials and stickers, the latter displaying warnings such as 'We will not supply under 18 year olds with these [butane] cans'. BAMA even has its own web-site devoted to professionals and retailers.<sup>123</sup> Even outside the BAMA, British industry has generally been cooperative in its approach to addressing volatile substance abuse.<sup>124</sup> A recent initiative that has shown promise is a working partnership between Re-Solv and Shell Corporation to develop a method of making cigarette lighter refill fluid unpalatable to potential inhalers. The addition of an extremely bitter substance known as 'Bitrex' to the lighter fluid is hoped to make it far less attractive to potential users.

Despite such positive initiatives, a cautionary note is appropriate. While product modification may be a necessary tool, it is not a panacea or solution in itself to addressing the problems associated with volatile substance abuse. Given the huge number of products available to inhale, a determined user will usually be able to find alternative methods and substances to inhale. Ms Ross from BAMA states in this regard:

About two years ago we held a brainstorming session where we trialed [sic] about 260 ideas of making aerosols less abusable, all sorts of weird and wonderful things. We did the typical 'no technical barriers' and looked at everything. We whittled those down to four and we have been working with Richard, who is unfortunately not here, on talking to professionals and chronic abusers as to whether that would be feasible. The results haven't been too - the trouble is everything you try to do a determined sniffer will get around it. The one thing we must not do is produce more of a hazard than [we] ... might have [already].

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122 Ms Sarah Ross, Representative of the British Aerosol Manufacturers Association in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

123 See [www.canban.com](http://www.canban.com)

124 It is interesting to note that Re-Solv was established in 1984 by the 'adhesive industry'. Indeed, many of its Directors and Chairpeople were executives from glue and adhesive companies. It certainly could be argued that this results in charitable organisations such as Re-Solv not being at 'arm's length' from the Industry and therefore subject to Industry demands or interests. Nonetheless, the relationship between Re-Solv and BAMA generally seems to be one in which the concerns of those addressing volatile substance abuse are genuinely taken seriously by industry groups.

The United States also has a tradition of relying on Industry groups to at least partially fund some of its volatile substance abuse community initiatives. For example, an education booklet and video produced by the National Inhalant Prevention Coalition entitled 'A Parents Guide to Preventing Inhalant Abuse' is sponsored by the SC Johnson Wax Company. For further information on similar American initiatives, see [www.nipc@io.com](mailto:www.nipc@io.com)

One of the suggestions was to have a control valve so you only got a metered dose, but then they would have four or five cans and use them one after the other, so you don't solve it that way. If they don't get to the valve they pierce the can and then you have a flammability issue so we've been looking at all sorts of ways of trying to get around that. That work is still under way. We decided that the chronic sniffers will sniff; there is nothing you can do about that. We need to target our efforts more on the experimental. That is the next phase of the work we are going to do, find out in some way what would deter an experimental sniffer.<sup>125</sup>

### Questions to consider

- ◆ In this Committee's report for the Inquiry into Public Drunkenness it recommended that

Comprehensive legislation dealing with the civil apprehension and detention of intoxicated persons and related matters should be enacted: and that for the purpose of this legislation the definition of drug should include a volatile substance capable of intoxicating a person.

To what extent would this legislation assist or improve the current situation in relation to VSA? Are there any problems you could envisage with this legislation?

For further discussion of the Committee's recommendations with regard to the civil apprehension and detention of people found intoxicated in public places, see Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness, Final Report 2001, Victorian Government Printer.

- ◆ What aspects of legislation from other jurisdictions, if any, could usefully be incorporated into Victorian model legislation?
- ◆ What lessons can Victoria learn from the experiences of the other States with regard to the legal framework of decriminalisation?
- ◆ Should the user of volatile substances for the purpose of intoxication be subject to criminal penalties?
- ◆ Some submissions to this Committee have called for the practice of chroming and the use of inhalants to be made unlawful. What are your views with regard to such propositions?
- ◆ Should there be an age limit on the purchase of certain volatile substances? If so, which ones?
- ◆ If age restrictions were to be put in place, should a person have to prove identification to purchase?
- ◆ What policy or legal measures can be initiated that will limit the availability of volatile substances?

125 Ms Sarah Ross, Representative of the British Aerosol Manufacturers Association in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

- ◆ How can manufacturers and retailers restrict the appeal and access to products containing volatile substances?
- ◆ What modifications can be made to products to minimise the harm associated with volatile substance abuse?
- ◆ Should suppliers and retailers of volatile substances be subject to criminal penalties for selling volatile substances to under-age children?
- ◆ What responsibility should a retailer have to restrict sales?
- ◆ How useful and applicable would a Retailer's Code of Practice such as that produced by the Western Australian government (and attached here as Appendix 5A) be in the Victorian context?
- ◆ How can medical personnel be engaged positively in community VSA programmes?
- ◆ How can police be engaged positively in community VSA programmes?
- ◆ What responsibility should a parent have for purchases made by their children?

## 7. Education issues pertaining to volatile substance abuse

Education and information provision has been seen traditionally as one of the best approaches by which to address the problem of substance misuse. Teaching about the problems associated with volatile substance abuse, however, is fraught with difficulty. While one can warn the adolescent of the dangers of volatile substance abuse, as with tobacco and alcohol 'restricting their misuse by a determined young person is not so easy' (Meredith 1996, p. 2).

Education on inhalant abuse has also 'been positioned down the 'bottom of the list' for some time in terms of training, education and information. Consequently a number of agencies feel ill-equipped to deal with the issue of inhalant abuse'.<sup>126</sup>

There are two particularly controversial issues pertaining to education strategies to address volatile substance.

First, there is the vexed problem of whether information provision about volatile substances aimed at young people and adolescents actually encourages them to engage in a practice which they hitherto had been unaware of.

Second, the application of harm minimisation principles and policies can be highly controversial. How suitable are they in addressing volatile substance abuse?

Both of these contentious issues will be addressed later in this chapter. Prior to that, a general discussion of volatile substance abuse education is necessary.

### **The need for information provision**

Myself and John have come down here from Shepparton. We all work there. We have a young client at the moment, who is 20 years old, a male, and we are all at a loss. We don't know what to do with this client. He is chroming, we guess, three, four, five maybe cans a day; we don't know. We have got to the stage now we are depressed in ourselves. We are disheartened, and we don't know what to do with him. I think what I am asking is that if there is anyone in here who is willing to give us their phone number before they leave that we can ring up and talk to you, so if anyone has any advice for us, could you come and see us before you go? Anyone?<sup>127</sup>

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126 Submission of the Department of Human Services (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 11.

127 Indigenous Drug and Alcohol/Youth Worker participating at the Indigenous Forum on Chroming, 17 August 2001, Melbourne.

The above comments are from a young Indigenous Drug and Alcohol worker based in country Victoria. They were expressed at a forum of Indigenous workers and community agencies convened to discuss the problem of volatile substance abuse in Indigenous communities. They reflect her desperation at her inability to find either information about volatile substance abuse or ways of assisting her clients, or referrals for ongoing care. Members of this Committee attended this forum. Unfortunately, this was not an isolated complaint. Indeed, throughout this Inquiry common questions from individual workers, parents, agencies and other affected parties, both Indigenous and non-Indigenous, are: Where is the information? What can I do? Who can help?

Certainly there are information brochures produced by generalist drug and alcohol agencies<sup>128</sup> (often reproduced from overseas material) as well as specialist information pamphlets directed at specific groups such as traders.<sup>129</sup> Medical information on the effects of volatile substance abuse is published in medical and academic journals but is often inaccessible to the general reader. The Australian Drug Foundation also has a helpful web-site with a page devoted to Inhalants.

Nonetheless, despite these resources, the perception among both professionals and non-professionals in the community is that this information is scarce, referrals are few and there is no coordination between or within community agencies or government departments who may have involvement directly or indirectly in issues pertaining to volatile substance abuse. Coordination between and within non-government and government agencies has been recognised in other jurisdictions as a key part of effective programme development and implementation in addressing volatile substance abuse (Meredith 2001, p. 12).

For Indigenous people, the few programmes that are operating may not necessarily be culturally appropriate. The views of a trainer of Indigenous Drug and Alcohol workers is representative:

With the chroming issue there is very, very little out there at all. When we did consultations around the state, one of the first things we were asked was: is chroming included in the drug and alcohol training? It was. We have been asked to touch on that a little more than the other substances, and that tells me a hell of a lot. It tells me, one, the problem is still there; two, that nothing has ever been done in the past to deal with it, even though it has been in demand all these years; and three, it is still not going anywhere. We are still sitting here today talking about the same thing ... There is a lack of information, a lack of resources, a lack of culturally appropriate programmes out there. There is an absence of a coordinated approach.<sup>130</sup>

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128 For example, see the brochure produced by the Australian Drug Foundation titled *Inhalants – How Drugs Affect You* (Australian Drug Foundation 1999).

129 See for example the brochure produced for traders by the Sunshine Chroming Awareness Program. This brochure is discussed in Chapter 8 and reproduced as Appendix 5b.

130 Ms Barb Honeysett, Western Suburbs Aboriginal Drug and Alcohol Outreach Worker (Ngwala Willumbong) at the Indigenous Forum on Chroming 17 August 2001.

## **Who should education on volatile substance abuse be aimed at?**

The following groups have been identified by the Committee as those for whom targeted education strategies need to be developed:

- ◆ Young people and adolescents
- ◆ Professionals (Doctors, Nurses, Teachers, Social Workers, Youth and Substance Abuse workers)
- ◆ Parents and Caregivers
- ◆ Indigenous workers and Communities
- ◆ Police, Ambulance officers, Railway personnel
- ◆ Traders and Industry representatives
- ◆ Editors, Journalists and Media representatives

### ***Young people and adolescents***

The specific issues pertaining to providing young people with information about volatile substance abuse and inhalants are dealt with in detail in the section pertaining to publicity later in this chapter. At this point it is sufficient to point out that targeted interventions for young people may have to differentiate between those who are using volatile substances to intoxicate and those who are not. It is generally thought more appropriate that information pertaining to volatile substance abuse is provided to the former group but not the latter. The Drug Policy Branch of the Department of Human Services Victoria states in this regard:

Broad-based community education has generally not been a feature of the prevention approach to inhalant abuse in Victoria. This is because broad-based community education aimed at non-users has been found to be counter-productive in attempting to reduce the incidence of chroming, in that education has been found to increase the profile of the drug and raises the interest of potential new users (Mundy 1995, Ives 1990). Consequently most education projects tend to be directed at welfare workers (such as school staff, youth workers, the police and staff of youth residential units) and to a lesser degree current inhalant users.<sup>131</sup>

With young people who are not currently engaging in volatile substance abuse it is thought preferable to use educational material and strategies that concentrate on general drug education, through schools, youth groups, churches and other community organisations. When New Zealand had a major problem with solvents in the mid to late 1980s it was found that provision of specific information on solvents to students who were not engaging in solvent abuse was counter-productive. The problem was exacerbated by the high media coverage that the issue received in New Zealand at this time. Research conducted by New Zealand government agencies in conjunction with the World Health Organisation concluded that:

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131 Submission of Human Services Victoria, (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 5.

- Discussions with young people showed that the increased knowledge also made them inquisitive about solvents and more likely to try them;
- The lists of solvent products media gave out also told young people what they could use;
- The increased information escalated experimentation and the potential for fatalities;
- Survey [research] of 25 older users in New Zealand indicated that this group had learnt about solvent use from their peers and *from education programmes that discussed the dangers of solvents* (Committee's emphasis) (Youth Affairs New Zealand 2000, p. 1).

This issue of 'information as encouragement' is discussed further below.

A different approach is recognised as appropriate for those young people who are already engaging in volatile substance abuse. In its submission to this Inquiry the Youth Substance Abuse Service (YSAS) states that information provision needs to be straightforward, direct, non-judgemental and minimalist: 'Chromers will simply not read heavy pamphlets'.<sup>132</sup> Moreover, YSAS suggests any information given to young people should be given by workers who can 'knowledgeably discuss chroming related issues with the recipient'. In doing so the worker's role includes:

- Providing support that is consistent and responsive to changing needs;
- Safeguarding the young person's respect and dignity;
- Negotiating support roles relevant to the young person's respect and dignity;
- Assisting the young person to develop insight into the context of their use;
- Assisting the young person to maximise control by focussing on positive strengths, skills and goal setting;
- Providing access to relevant information;
- Having best practice aims to reduce the harms and risks associated with use as well as educating/supporting the young person with clear and individually tailored information/interventions.<sup>133</sup>

Most importantly, YSAS argues that education and information provision with young volatile substance abusers must avoid moralistic and judgemental approaches to drug use in general and recognise the reality of the substance use from the user's point of view:

Shock tactics, which [seek to] dissuade experimentation by emphasizing drug horror stories [are counter-productive]. The marked lack of success enjoyed by such approaches led to information approaches. These too failed because drug use [and by extension, all risk taking] was presented as abnormal and negative while failing to recognize the obvious [at least to adolescents] pleasurable and functional aspects of

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132 Submission of YSAS to Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 1.

133 *ibid*, p. 5.

drug use. Attempts to inculcate moral disapproval of drug use succeeded only in ensuring drug use became a major symbol of generational difference.<sup>134</sup>

The approach promoted by YSAS is based on principles of *harm minimisation*. A strategy that 'avoids the minefield of moralistic arguments about whether drug use is inherently bad or good' (Hamilton, Kellehear & Rumbold 1998, p. 138). The concept of harm minimisation principles and the controversy surrounding their application are discussed in detail later in this chapter.

Currently the Drug Policy Branch of the Human Services Department (Victoria) attempts to incorporate the methods suggested by YSAS in providing drug education through its provision of Youth Outreach Services (YOS) as outlined by the Department in its submission to this Inquiry:

It is well known that young adolescents are generally less inclined than young adults and adults generally to access drug treatment services, and particularly so when the drug in question is a volatile substance. To address the issue of access for young people to drug services the Youth Outreach Services (YOS) were established. The YOS aim to assist these young people to access help and there are currently fifty-eight Youth Outreach positions (funded by the Drugs Policy and Services Branch of DHS) located throughout the state. The Youth Outreach workers provide outreach to young people and connect them to appropriate services including drug treatment. Specifically youth outreach provides information about drug treatment and youth services, assists young people to improve their health and reduce harm related to drug use; assist with accessing treatment such as drug withdrawal and residential services, and assist with accessing legal help, welfare and employment services.<sup>135</sup>

The Western Australian Solvents Working Party has also identified adolescents and young adults in detention and juvenile justice centres and supported youth accommodation agencies who are substance users as discrete groups and possibly requiring different types of education. The Committee welcomes any input as to how such strategies can best be developed. It is also keen to receive more information on programmes in which young ex-users of volatile substances are trained to become *peer educators*. This is a concept whereby it is thought those who 'have been there' are best suited after appropriate training to interact with their peers and contemporaries about their own experiences with volatile substance abuse and the associated dangers.<sup>136</sup>

Education with regard to volatile substance abuse is problematic for a range of reasons. Nonetheless, it would seem important to bear in mind, as Berry Street Victoria states, that:

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134 *ibid*, p. 2.

135 Submission of Human Services Victoria, (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, pp. 5–6.

136 The Committee is aware that Berry Street Victoria user peer educators as part of its own strategies to address volatile substance abuse. In some cases the peer educator may still be a (residential) client of the agency.



No one strategy applies to every young person – all strategies adopted need to be flexible, creative, and individually applicable to the young person with whom you are working.<sup>137</sup>

### **Professionals**

Knowledge about and responses to volatile substance abuse amongst professional workers seems to be variable in Victoria. There are some education programmes devised for teachers, student support and welfare workers (including the staff of youth residential and juvenile justice units) that are auspiced by the Department of Human Services. But the Department itself recognises that ‘This type of training occurs intermittently’.<sup>138</sup> Other agencies of the Victorian government also play a role:

For example the Child Protection and Care Division of DHS are developing training resources around the issue for their staff, the Department of Education, Employment and Training (DEET) Student Wellbeing Unit are finalising a manual for school staff on the issue titled FACE – Fresh Air Clean Environment, Responding to Volatile Solvent Use. Additionally a number of Community Drug and Alcohol services provide education on an ad hoc basis to school staff and youth workers in their area.<sup>139</sup>

Despite such initiatives, some community workers with whom the Committee has met or received submissions from have been less than impressed with the level of expertise and knowledge displayed by some professionals who interact with young ‘chromers’. This criticism has been particularly directed towards teachers and health professionals:

We have been sitting here talking all day about education, schools and spiritual stuff and everything, but why can’t we have someone from the education department on this committee I was asked by our local schools to go in there and do some drug and alcohol education. I did that. I went in and spoke to the principal. She told me – her exact words were, to quote her – “Chroming is not an issue in our community”. So they need some education themselves. If you want to get into the schools to do [education] you need to get one of them into this committee, too.<sup>140</sup>

The Western Australian Solvents Working Party has also been critical of the lack of knowledge of schoolteachers with regard to volatile substance abuse. It quotes with approval from one American approach to the issue:

The Massachusetts Inhalant Abuse Task Force recommends schools to review their approach to teaching about volatile substances. Rather than teaching about these substances as a drug they recommend they are linked to prevention messages around topics such as poisons, product safety, first aid, and fire safety:

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137 Submission of Berry Street Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 8.

138 Submission of Human Services Victoria, (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 5.

139 *ibid.*

140 Ms Barb Honeysett, Indigenous Forum on volatile substance abuse, 17 August 2001. The Committee referred to is a Committee established at this Forum to address issues of volatile substance abuse among Victorian Indigenous communities.

*Prevention messages should promote awareness that these products may contain poisons, toxins, pollutants, and/or highly flammable liquids and gases. Procedures for appropriate and safe use of these products should be emphasized. Using this approach associated these products with product safety concerns and poisons instead of drugs.*

This may be a useful strategy, particularly for pre-adolescents. It allows volatile substances to be discussed without increasing its attraction as a drug and possibly reducing its status as a reputation enhancing substance(s), particularly as these products are implicated as environmental pollutants (Rose 2001, p. 26).

Doctors, nurses and other health workers are another professional group that may be in need of comprehensive training with regard to volatile substance abuse. This has certainly been the case in the United Kingdom where:

A survey of professionals revealed that there is a general lack of understanding of substance abuse and that, as a group, GPs demonstrated less awareness of the problem than teachers and other professionals. There is an overall gap in the knowledge of solvent abuse and misconceptions about the products available, their effects and the symptoms to be aware of. Due to a lack of confidence, GPs seem unwilling to take on the problem and are the least likely to have the appropriate materials and information for reference. Less than half the doctors involved in the study had literature available for reference, though all were keen for more general information. However the common feeling was that specific information was not necessary until the GP came into direct contact with the problem (Re-Solv 2000, p. 5).<sup>141</sup>

The Committee is keen to know whether a similar situation exists in Victoria and other states of Australia. It also seeks knowledge as to what training programmes, if any, medical and health professionals and students receive on volatile substance abuse. Certainly one worker with whom Committee members has had contact has been less than impressed with the extent and depth of knowledge about 'chroming' in the medical sector:

I am part of the Aboriginal family support workers at the Royal Children's Hospital. Chroming hasn't been addressed at the Royal Children's Hospital and I was outraged when I went around the different departments to find that no-one is addressing it. I have been consulting with the adolescent health unit in regard to the communities concerned about chroming. At this point in time we have a couple of paediatricians who are going to donate their time in terms of travelling around the communities doing mental assessments. When that comes on board I am happy to pass on that information. If anyone wants to travel up to the communities, we are happy to do that. It has been a long time coming, but I think these medical assessments can take place in the community where community members can still feel safe and have that

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141 PPP Health Care (UK) in conjunction with Re-Solv the national umbrella organisation in Britain on volatile substance abuse now funds and trains British general practitioners on volatile substance abuse. Doctors who do this training course are subsequently accredited by the Royal Society of General Practitioners as specialists in this area.

Information provided by Warren Hawksley, Director of Re-Solv, in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

community support rather than them coming down to the Children's Hospital and being isolated.<sup>142</sup>

Community agencies have stressed to this Inquiry that any training or educational materials devised for teachers, doctors and other professionals take into consideration and incorporate gender and cultural differences and tailor the materials accordingly. The Committee suggests that such recommendations are equally applicable to any agency, body or group that provides training on substance abuse issues.<sup>143</sup>

### ***Aboriginal communities***

The last quote in the previous section indicates a level of frustration felt in the Aboriginal community about volatile substance abuse and its effects on their children. There has been a fairly comprehensive literature on inhalant abuse and its effects on Aboriginal communities. There have also been some excellent training materials produced for and by Aboriginal trainers, educators and community workers on the subject.<sup>144</sup> Unfortunately, most of these materials are concerned with petrol sniffing and most are produced by and applicable to Indigenous communities in Western Australia, South Australia and the Northern Territory. There has been little produced, for example, on chroming and its effect on Koori communities in Victoria.

The Department of Human Services (Drug Policy Branch) in its submission to this Inquiry provided a detailed and useful account of the structure of Koori drug and alcohol services in this state. Rather than 'reproducing the wheel' we reproduce this part of the submission in full:

Currently the Drugs Policy and Services Branch of DHS funds two types of Koori-specific alcohol and drug treatment services in Victoria, the Koori Community Alcohol and Drug Worker (KCA&DW) and the Koori Community Alcohol and Drug Resource Service (KCA&DRS – formerly known as 'Sobering-Up Centres'). These services are provided to Aboriginal people and their significant others who are affected (either directly or indirectly) by alcohol and/or other drug use or who are at risk of being affected by alcohol and/or other drugs.

The Koori Community Alcohol and Drug Workers (KCA&DW) undertake a number of program development activities based on a harm minimisation approach, including health promotion, information provision, education activities, development and maintenance of community linkages, referrals, counselling interventions, the provision of advice to generalist services, liaising with relevant programs and fulfilling

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142 Indigenous community worker (name unknown) at Indigenous Forum on volatile substance abuse, Melbourne, 17 August 2001.

143 The Buoyancy Foundation in its submission to this Inquiry included a paper produced by the Foundation entitled 'Empowering Young Vietnamese Women Living in a Drug Culture'. This interesting and useful paper outlined ways in which drug education strategies for Vietnamese women (and indeed other ethnic groups) can be tailored to take into account cultural and gender specificities.

See Submission of Buoyancy Foundation to the Drugs and Crime Prevention Committee, August 2001.

144 See, for example, the excellent manual *Petrol Sniffing and other Solvents: Community Development* (Biven 2000).

an advocacy role on behalf of the service user. There are seventeen workers across eleven Aboriginal community controlled services across the state.

The Koori Community Alcohol and Drug Resource Service (KCA&DRS) provides an alternative to incarceration for Koori persons who are found to be alcohol or drug affected in public. It provides short-term accommodation for up to 48 hours in a safe, culturally appropriate, non-threatening environment which is focused on meeting the needs of the individual and the continuity of their care through appropriate referral processes. The KCA&DRS operates from the basis of harm minimization, which aims to reduce the harm associated with the use of alcohol and drugs. The Commonwealth Department of Health and Aged Care funds an additional seven Koori Alcohol and Drug Workers around the State.

On the issue of community education and prevention (as well as the work of the KCA&DW) currently DHS has allocated \$450,000 (as part of Victorian Government Drug Initiatives) for the next three years for Koori drug prevention and community education activities. Additionally the Commonwealth *National Illicit Drugs Strategy* has provided funds (over \$300,000) for a Koori Parent Drug Education program (ABCD program). The program will run statewide, over three years and provide education to Koori parents about drugs and how to deal with adolescent drug problems.

On the issue of training there has been a need to better resource the Koori Alcohol and Drug Workers. An accredited alcohol and drug training program specifically on alcohol and drug issues in the Aboriginal community has recently commenced. The training will be available to the 19 Koori Alcohol and Drug Workers across the state, along with the staff from the 7 Koori Alcohol and Drug Resource Centres, many of whom have no formal training in Drug and Alcohol issues. The training program will be completed by December 2001.

Turning Point Drug and Alcohol Centre (as a part of their service and funding agreement with DHS) is to evaluate the Koori Community Alcohol and Drug Workers Program along with the Koori Community Alcohol and Drug Resource Centre Program to determine future program directions. The evaluation will also ensure that these projects consider the issues of coordinated care, linkages between services, quality of care and equity of resources for Koori Services. The evaluation will also ensure that the program remains relevant within the context of the project and ensure that it is 'user friendly'.

Additionally DHS is in the process of developing a manual for the operating of the Koori Community Alcohol and Drug Resource Centres. This manual will allow for all seven centres to operate under the same guidelines.<sup>145</sup>

The Department of Human Services itself recognises that despite these initiatives the problem of inhalant abuse amongst Koori communities, though recognised, has not necessarily been dealt with effectively:

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145 Submission of Human Services Victoria, (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, pp. 6–7.

Inhalant abuse has been recognised as a problem in the Koori community for some time. The KCA&DW have dealt with the issue in their own communities, often through calling 'public meetings' and working with the young people and their families directly. Recently the Indigenous Issues Unit of the Department of Justice initiated a Koori Chroming Workshop (held on 17 August 2001) in recognition of the seriousness of the problem and the need for a coordinated response. As a result the Koori Solvent Abuse Working Group has been set up in partnership with DHS, the Indigenous Unit of the Department of Justice and the Victorian Aboriginal Community Controlled Health Service (VACCHO) to address some of the immediate needs of the Koori community on the issue of inhalant abuse.<sup>146</sup>

Members of this Committee were present at the forum referred to. They are aware of the degree of powerlessness and frustration felt by many members of the Indigenous community on this issue. The Committee notes with satisfaction, however, that in the area of education the Koori Drug and Alcohol Workers training courses run by Ngwala Willumbong in partnership with Swinburne TAFE includes comprehensive educational materials on chroming and other forms of volatile substance abuse as part of its syllabus. Committee research staff have been privileged to attend parts of this course and they have found the instruction and material to be of a high quality.

It is hoped that this Inquiry and the Koori Solvent Abuse Working Party will continue to work in tandem with each other to produce some positive outcomes in this area.

### **Parents**

The Drug Policy Branch of the Department of Human Services (Victoria) has emphasised the importance of drug education for parents. It adds that while there are various parent drug education programmes operating in the state, most do not specifically mention inhalant abuse:

Rather, most parent education is designed so that educators are able to respond to the issue of inhalant abuse when it is raised by parents. DEET is responsible for the 'Creating Conversations' and Drug Summits program which is delivered in schools and aims to encourage conversation between young people and their parents on drug issues. DHS is responsible for the ABCD parenting program which is a statewide parenting drug education program to commence early in the new year. Additionally there is the School Focused Youth Service (a joint initiative of DHS and DEET) which aims to coordinate preventative and early intervention strategies for young people around a range of issues including drug use.<sup>147</sup>

It has been suggested by a number of community groups that specific educative material for parents on volatile substance abuse be provided. This is particularly important in light of the fact that American survey research has found that 95 per cent of American parents surveyed 'would be extremely surprised to find out that their child was using inhalants' (NIPC 2001, p. 6). Education should be tailored as a prevention

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<sup>146</sup> *ibid*, p. 7.

<sup>147</sup> Submission of Human Services Victoria, (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 5.

tool and also for parents who currently have a child who is a volatile substance abuser. Too often it is claimed parents with children who abuse these substances feel lost, uncertain and overwhelmed. This was certainly the view of 'Anne' whose submission to this Inquiry introduced this Discussion Paper.

Education materials for parents need to be easy to understand and access, and culturally sensitive to particular groups from culturally and linguistically diverse backgrounds. Some agencies believe they may also need to incorporate harm minimisation strategies. Dear and Helfgott (1997) state:

Although an uncomfortable situation for many parents, being able to provide practical advice to your teenager and inform them of behaviours that are risky may reduce accidents (p. 4).

The authors then list a number of ways in which parents can assist their child to minimise the risks of volatile substance abuse. These can include advising them not to sniff alone or in dangerous places, not to use plastic bags or to use smaller plastic bags to minimise the danger of suffocation, and not to smoke or drink alcohol while inhaling. Parents are also advised to be familiar with first aid and emergency procedures. Such strategies are practical expressions of the concept of harm minimisation. This concept is referred to in detail later in this chapter.

The Committee is pleased to hear the views of parents and other parties as to ways in which parents and caregivers can best be assisted to address the issue of volatile substance abuse. A positive 'first step' is a recent initiative of the Department of Human Services that will enable parental drug training to be accessed outside the school system in a variety of community settings.<sup>148</sup>

### ***Police, ambulance officers and railway personnel***

A variety of community agencies have stressed to the Committee the importance of police and ambulance officers receiving comprehensive and uniform training about volatile substance abuse. Certainly individual officers, commands and divisions of Victoria Police have made concerted efforts to address the problem in their jurisdictions. The efforts of the Swan Hill Police to raise funds for an awareness programme in their area is testament to this.<sup>149</sup> Victoria Police supports the concept of drug education but not necessarily from a harm minimisation focus. In its submission to this Committee it states:

The Victoria Police Community Consultation and Crime Prevention Office and the Police-Schools Involvement Program indicate that the following issues should be addressed as part of any educational strategy. Inhalant abuse prevention education should:

- be done as part of general substance abuse education, not as an isolated focus or to the exclusion of other types of drug education
- avoid creating a "how to" primer for experimenters

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148 *ibid*, p.11.

149 See Chapter 6.

- include parents and teachers.

Additionally, safety in relation to the handling of hazardous chemicals should be taught as part of a general education about these substances.<sup>150</sup>

This Committee found when it was investigating the issue of public drunkenness that comprehensive and culturally appropriate training of police and ambulance officers is essential in efficiently addressing the multi-faceted aspects of the problem. It believes that addressing volatile substance abuse is no less complex and requires similar approaches. The Committee welcomes hearing from Victoria Police and metropolitan and rural ambulance services as to the training it receives on volatile substance abuse.

Finally, Western Australian research has suggested that volatile substance abuse often takes place on railway property, such as disused stations, railway tracks and in railway tunnels (Rose 2001). Anecdotal evidence from community workers and the material we have received in submissions suggests that a similar situation exists in Victoria. If this is the case it would seem appropriate that railway personnel are also trained with regard to issues pertaining to volatile substance abuse. Again the Committee would be interested in hearing the views of the relevant public transport authorities on this matter.

### ***Industry, traders and retailers***

It is of paramount importance that those involved in the manufacture and retailing of products that contain volatile substances be aware of the issues pertaining to volatile substance abuse. This topic has already been comprehensively discussed in Chapter 6. Suffice to state at this stage that the Committee reiterates its approval and support of the community/industry partnerships that have been established in the United Kingdom. It also welcomes the localised partnership strategies between police, traders and community agencies that have sporadically been formed in Victoria. An account of one of the most prominent – The Sunshine Chroming Awareness Program – is given in Chapter 8.

## **Debates concerning education strategies**

### ***Harm minimisation***

*Maria currently uses chrome on a daily basis, usually starting at 9.00am and going all day. She has learned over time to use chrome within harm minimisation principles – she uses small bags, takes regular breaks, consumes lots of fluids and allows herself to be monitored during her use. Whilst her heroin use has decreased since coming into care, she still uses on her Youth Allowance paydays, but she is no longer placing herself at extreme risk through prostitution, and she is no longer overdosing.*

*Approximately 6 months ago, Sam moved into a Berry Street residential facility. The unit began managing Sam's substance use in accordance with our Substance Use Policy ... Sam and his family were told when he moved in that we operate under harm*

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150 Submission of Victoria Police (Policy and Standards) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3.

*minimisation principles and that Sam's substance use would be closely monitored and discussed frequently. Sam was told that if he chose to use inhalants, he would be expected to do so in the backyard, but a proviso of this was that staff would monitor him and he would be asked to hand over his can every 15-20 minutes and take a break by joining staff in a coffee, food, or an outing. Sam was also told that staff would be asking him how he was feeling and why he was chroming.*

The above quotes are taken from case studies of clients in care at Berry Street Victoria.<sup>151</sup> They reflect an approach to substance misuse known as harm minimisation. Harm minimisation principles are controversial at the best of times; in the case of volatile substance abuse they are particularly contentious.<sup>152</sup> Harm minimisation is not necessarily a consistent policy, taking different forms depending on the drug in question and the group that is being targeted. The rationale for harm minimisation is based on the view that:

Neither law enforcement (prohibitionist) policies nor prevention through information and education strategies have succeeded in curbing either the supply of drugs or the demand for them, and many treatment responses have met with only modest success. This has led to the emergence over the past decade of a new way of thinking about drugs: harm minimisation. Harm minimisation tries to assess the actual harm associated with any particular drug use and asks how this harm could be minimised or reduced. This approach accepts that:

- Psychoactive substances are and will continue to be part of our society;
- Their eradication is impossible; and
- The continuation of attempts to eradicate them may result in maximising net harms for society.

The objectives of the harm minimisation model are:

- The identification of the harmful consequences for individuals, those around them and the community overall; and
- The implementation of strategies to minimise this harm. (Hamilton, Kellehear & Rumbold 1998, pp. 135, 136).

Conceptually, Erikson et al. (1997) identifies the following elements as being part of harm minimisation strategies:

- A value-neutral of drug use;
- A value-neutral view of users;
- A focus on problems or harmful consequences resulting from use;
- An acceptance that abstinence is irrelevant;

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151 Additional case stories taken from the submission of Berry Street Victoria are attached in Chapter 5.

152 There is a wealth of literature explaining the concept of harm minimisation and the related principles of risk reduction. In an Occasional Paper produced by this Committee in 1996 these principles are thoroughly outlined (Drugs and Crime Prevention Committee 1996). There are also many good secondary references on the subject that can be consulted. In particular the text by Hamilton, Kellehear and Rumbold (1998) offers an excellent overview



- A belief that the user has and should continue to have an active role in making choices and taking action about their own drug use (Erikson et al. quoted in Hamilton, Kellehear & Rumbold 1998, p. 137).

These conceptual elements ideally produce practical strategies that:

- Seek to maximise those strategies that lead to harm reduction;
- Support pragmatic programmes that can be eclectic and flexible;
- Incorporate any scheme that will assist in net harm reduction;
- Aim to be user-centred, including users in planning;
- Emphasise choice, taking account of the users' own interests and the responsibilities they retain in their societal context (Hamilton, Kellehear & Rumbold 1998, p. 137)

In current drug policy, needle exchange programmes are a clear example of harm minimisation to reduce the transfer of blood-borne diseases. In the context of volatile substance abuse, Berry Street Victoria's policy of allowing residents to inhale on premises in strictly delineated circumstances is an example of harm minimisation, albeit a contentious one. Berry Street justifies this decision by pointing out that the 'hard core' of users in their care engage in extremely dangerous behaviour while chroming at high levels. Walking across busy freeways, stumbling on to live railway lines and falling off rooves being not uncommon occurrences. Their harm minimisation policies are targeted at reducing the amount of chroming done by their clients and encouraging them to use in safer environments. In their view, to simply ban the practice is futile and counter-productive. A modified and more common version of this policy that is practised by other agencies is to simply provide information to young people about 'safer' methods of use.

In 1980 the British Institute for the Study of Drug Dependence (ISDD) conducted a 'casualty reduction' education programme in an effort to reduce risk factors associated with volatile substance abuse. A variety of strategies resulted in a dramatic reduction in the number of deaths occurring due to plastic bag asphyxiation (ISDD 1981). Similarly, this British programme stated that one of the worst hazards associated with volatile substance abuse was the fact that parents and educators were giving out undifferentiated 'don't do it' messages. It found this simply did not work.<sup>153</sup> As a health education counter-measure it recommended to workers and parents:

Don't be afraid to point out that some already familiar glues, already commonly used are relatively safe if used sensibly ... Kids learn to leave the more dangerous products completely alone, using glues in place of other solvents (ISDD 1981, p. 4).

While such advice may be appropriate in the case of glues, the 'jury is still out' on whether similar advice can apply in the case of substances that are recognised as more dangerous, such as chrome paint. The practical and ethical dilemmas surrounding harm minimisation policies as they apply to volatile substance abuse are exemplified in the following quote:

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<sup>153</sup> The British approach is reflected in the Western Australian pamphlet '*Solvent Sniffing: An Information Guide for Parents*' (Dear & Helfgott 1997) referred to above.

The Institute for the Study of Drug Dependence (ISDD) in London has found that attempting to stop people using volatile substances simply does not work and may be positively harmful in denying sniffers the information they need to minimise hazards and to avoid accidents. But the strategy of harm minimisation has been criticised and even those educators and workers sympathetic to it have had both practical and political problems in trying to implement it. Richard Ives of ISDD says on the one hand, the impossibility of cutting off such supplies of solvents made harm minimisation seem a more realistic strategy than trying to prevent all use. On the other hand, the fact that potential sniffers of solvents are so young raised ethical issues and practical problems about whether harm minimisation messages would be misunderstood. These issues have become less public, but have not been resolved (Mundy 1995, p. 10).

The Western Australian Solvents Working Party in its recently published *Background Paper* recognises there is a place for harm minimisation policies in the area of volatile substance abuse. It states:

It's not always possible to stop young people engaging in VSA. The message to give these young people is that while any VSA is hazardous, there are ways to reduce dangers:

- Change to less hazardous substance (eg aerosols more hazardous than glue).
- Use in less hazardous places (not near rivers, railways, roads and with someone else).
- Use less hazardous methods (do not spray directly into throat, keep flames away from volatile substances), exercise and excitement can result in sudden sniffing death (SSD).
- Explaining harm reduction measures can be counter-productive if the young person is suicidal or engaging in self-harming behaviour or thoughts.
- Use sensitivity to inform caregivers, parents, peers and workers as necessary (Rose 2001, p. 30).

A number of submissions have been received from a variety of Victorian community agencies. Most would appear to support the application of harm minimisation principles in working with volatile substance users, at least in terms of information provision with regard to 'safer' inhalation practices. Views as to the harmful nature of volatile substance abuse and the appropriateness of harm minimisation policies have even divided staff members within the same agency.<sup>154</sup> The following are some of the ways that the various agencies that have made submissions to this Inquiry have incorporated harm minimisation policies into their daily work or recommended strategies to those ends.

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154 See for example, the submission of the Salvation Army (Southern Territory) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3.

### **Youth Projects Inc.**

Youth Projects is a non-profit organisation providing support for youth and families in Melbourne's north. In its submission to this Inquiry, it states:

It is commonly recognised that inhaling paint and other volatile substances is dangerous – there is no safe way to do it. However, there may be some ways of inhaling that reduce the environmental risks of the user. These are:

- Encouraging users not to inhale alone;
- Offering CPR training through schools and youth services;
- Encouraging users not to use near potentially fatal sites, such as water and railway lines;
- Some substances are less harmful than others, ie: glue versus paint;
- Encouraging users to find alternatives to plastic bags. E.g. a young man was observed by a NESP (Needle and syringe exchange programme) worker 'chroming' out of a paint filled coke bottle. This would drastically reduce the risk of death by asphyxiation.<sup>155</sup>

### **Youth Substance Abuse Service**

The Youth Substance Abuse Service in working with substance dependent young people advises that 'interventions need to be tailored to the individual young person in a friendly non-judgmental way'. The role of the youth worker in such circumstances is:

- Provid[ing] support that is consistent and responsive to changing needs.
- Safeguard[ing] the young person's respect and dignity.
- Negotiat[ing] support roles relevant to the young person's priorities.
- Assist[ing] the young person to develop insight into the context of their use.
- Assist[ing] the young person to maximize control, by focussing on positive strengths, skills and goal setting.
- Provid[ing] access to relevant information.
- [Utilise] Best practice aims to reduce the harms and risks associated with use as well as educating/supporting the young person with clear and individually tailored information/interventions.<sup>156</sup>

The Youth Substance Abuse Service employs a harm minimisation tool known as a Chroming Wheel. It is described as a 'simple tool for engagement and discussion with the young person'. It is a tool to measure what young people perceive the main risks of chroming to be and how they address them. Using the wheel:

[f]orms the basis for introducing harm minimisation information in context. The wheel is used in conjunction with prompts such as:

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155 Submission of Youth Projects Inc, to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances. August 2001, p. 20).

156 Submission of Youth Substance Abuse Service to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 5.

“Would you know what to do if your mate was sniffing and dropped”? This would open the way to a discussion regarding the dangers and potential harms.

“What is most dangerous – glue or butane”? Opening the way for dissemination of information regarding toxicity and long term harms.

“Where is the best place to chrome”? Discussion of environmental risks like falling from roofs, into canals etc.

“Do you know any one who chromes alone”? Social/environmental harms

By keeping such questions in the third person they remain non-confrontational.<sup>157</sup>

### **Berry Street Victoria**

The harm minimisation approaches taken by Berry Street Victoria have already been referred to. It is thought that allowing supervised chroming with stringent safeguards on Berry Street premises in conjunction with intensive counselling and other harm reduction programmes is a lesser ‘evil’ than children and young people dying as a result of accidents and harmful practices engaged in while chroming. Berry Street Victoria explicitly bases their policies on harm minimisation principles as enunciated in their Substance Misuse Manual:

Harm minimisation is a public health model that involves the assessment and identification of the actual harm associated with drug use and asks how this can be minimised or reduced. In adopting this approach, Berry Street recognises that, unfortunately, licit and illicit drugs are part, and will continue to be part, of our society. The objectives of the harm minimisation approach are to identify the harmful consequences for individuals, those around them and the broader community and to implement strategies to minimise these harms.

Harm minimisation contains three core strategies to minimise drug-related harm:

- Supply reduction – designed to disrupt the production and supply of drugs;
- Demand reduction – designed to prevent the uptake of harmful drug use, including information provision and education;
- Harm reduction – designed to assist people using drugs to do so in the safest possible manner.

Harm minimisation approaches may use a single harm reduction strategy or a combination of demand, supply and harm reduction strategies. For example, an approach may simultaneously enforce laws against possession and sale of these drugs (supply reduction), and also provide a clean needle program and safe injection/vein care information for young people who continue to use (harm reduction) (Berry Street Victoria 2001, p. 26).

As has been stated, not every agency nor individual worker within an agency would agree with harm minimisation or harm reduction principles as applied to volatile substance abuse. In the United States, for example, this approach is not always met with approval. Neither Harvey Weiss, Director of the National Inhalant Prevention Coalition

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<sup>157</sup> *ibid*, p. 5.

(USA) nor Dr Jane Maxwell, Chief of Research of the Texas Commission Against Drug Abuse, gives their imprimatur to the use of harm minimisation policies as applied in this context.<sup>158</sup> In fact when learning of some of the approaches used in Australia, Mr Weiss replied 'I was kind of stunned at the notion of the harm reduction as related to inhalants'.<sup>159</sup>

Such responses may reflect a more conservative approach to drug policy in the United States. Nonetheless, harm minimisation policies as they apply to volatile substance abuse also have their critics closer to home. Some members of the Victorian Indigenous community, for example, are highly critical of concepts such as the 'Chroming Wheel' outlined above:

I am very, very critical of the Department of Human Services. As Andy said, I have actually had a lot of experience working with the board. For 25 years I had worked on the board and have also worked as the manager of the Aboriginal rehab service for a period of three years or so.

I don't know whose idea it was, but when they introduced the harm minimisation program, where they funded dollars and dollars to get people to go out to talk to young people in schools ... They didn't talk to the young kids about getting addicted to these sorts of things. They didn't think about the after effects. I firmly believe that is why we have a lot of the problems we have today. I was absolutely appalled last year when I went down to the Latrobe Valley region, I was actually given a chroming wheel - this is funded through DHS - it was done through an agency called Turning Point. They actually had a chroming wheel there showing young kids how to chrome properly. I was absolutely appalled by that. I am not saying that is the reason why all of our kids are doing it now, but I can certainly say that it would have had some influence on a lot of our kids now who are using these sorts of substances, whereas before it was basically alcohol and drugs. I am really critical about that.<sup>160</sup>

MacKillop Family Services, one of the leading agencies that work with young people who 'chrome', also has misgivings:

The legal issue is a difficult one, but the more difficult issue for us is harm minimisation. I know of an agency that has a dedicated chroming area at the back of its house, so that harm can be minimised, but this can also give a wrong signal that it's OK to chrome. It's also really hard on other young people who are not chroming to have that happening in their house's yard.<sup>161</sup>

It is trite therefore to state that this issue is problematic. The Drugs and Policy Branch of the Victorian Department of Human Services also recognises that 'a harm

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158 These views were expressed in meetings with the Drugs and Crime Prevention Committee (Dr Maxwell, 23 October 2001) or in personal communications between Mr Weiss and the Committee's research staff.

159 Personal communication forwarded to Mr Pete Johnston, Research Officer, Drugs and Crime Prevention Committee by email, 6 November 2001.

160 Marion Hansen, ATSIC Commissioner for Victoria. Views expressed at Indigenous Forum on Chroming, Melbourne, 17 August 2001.

161 Staff worker quoted in Submission of MacKillop Family Services to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, October 2001, p. 23.

minimisation approach in this area is contentious and seen by some in the community as something of a last resort'. In its submission to this Committee it states:

However, while most efforts are likely to be focused on preventing young people from engaging in inhalant abuse, harm minimisation approaches such as labelling on products, education to those who currently inhale volatile substances and public safety issues are necessary and important measures.

Currently there is limited harm minimisation information available in Victoria both to those who inhale volatile substances and to those who work with them and this gap needs addressing.<sup>162</sup>

This is a statement that the Committee endorses.

## **Publicity and media**

When it comes to the issue of representing information pertaining to volatile substance abuse to the wider community there are two potential problems. These are:

- ◆ (Mis)representation of the factual situation pertaining to volatile substance abuse, and
- ◆ The vexed issue as to whether by publicising facts about volatile substance abuse, however accurately and dispassionately, one runs the risk of encouraging the practice.

### ***Misrepresentation***

Volatile substances have been represented in the media as a terrifying scourge that parents and professionals can do nothing about. This makes everyone feel paranoid and helpless and it is this fear which has often resulted in the greatest harm to young people by publicising volatile substances to potential users and unintentionally shifting current users into more dangerous practices (Mundy 1995, p. 10).

Mundy states that there are three areas in which the practice of volatile substance abuse is particularly susceptible to exaggeration, misrepresentation and inaccurate reporting. These are:

- ◆ The 'incorrect belief' that severe brain damage will result from the experimental use of solvents;
- ◆ The fear that experimental use of solvents will immediately lead to addiction; and
- ◆ That volatile substance abuse results in young people becoming uncontrollable and dangerous with a propensity to commit violent crimes (Mundy 1995, p. 10).

While our research has shown that although each of these factors *may* occur in isolated cases as a result of volatile substance abuse, they tend to be the product of inhalation of volatile substances over a long period of time. Even among long-term users, depending on the substance used, these are not common outcomes.<sup>163</sup> As Mundy argues 'the fact is

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162 Submission from Human Services Victoria (Drug Policy Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 7.

that most harm results from accidents while intoxicated or from the method of use of solvents such as spraying directly into the mouth' (Mundy 1995, p. 11).

Rose, Daly and Midford (1992) state that the prurient and disproportionate interest in volatile substance abuse shown by the media and the general public is in part due to the young age group involved in volatile substance abuse, in part because of the 'mystique of the substances involved as viewed by adults', and the legal status of their use 'which seemingly allows for unchecked intoxication by young people' (Rose, Daly & Midford 1992, p. 7). The authors argue that much publicity surrounding volatile substance abuse is simplistic, unsophisticated and counter-productive, reflecting 'strong emotional responses to youth drug use'. Furthermore, ensuring that young people who don't inhale volatile substances do not commence the practice is:

[c]ompounded by the media which has focused on 'glue sniffing' in a way that amplifies disgust and fear of a practice already foreign and frightening to adults. Indeed it is this very fear which has often resulted in the greatest harm to young people by publicising VSU to potential users and unintentionally shifting current users into more dangerous practices (Rose, Daly & Midford 1992, p. 30).

This disquiet with media representation has been particularly felt at a local level. Community workers in the Swan Hill district have been most concerned with the way in which 'chroming' in that area has been portrayed by the local paper:

The most angering thing out of all that was our local media has a role to play in terms of how we approach this, how we work with it and how we deal with it. If anything comes out of today, I would hope that from a parliamentary angle, people sitting around from that spectrum, will certainly take on board our comments, because the media can make or break us. We have already started to do that in our home community.

We are very angry about the way in which our local paper attempted to portray glue sniffing as being an indigenous-only issue within our community, and it is not. We are particularly angered about the fact that we have taken it to local community forums with non-indigenous people and non-indigenous people in our community would rather stick their heads in the sand and see it as a non-issue.<sup>164</sup>

In 1985, the Senate Select Committee on Volatile Substance Fumes issued the following request to the media:

The subject of volatile substance abuse is highly sensitive and it is well established that the media can both assist in reducing its prevalence and exacerbate the problem by promoting the practice. In reporting on the activities of the Committee, and the evidence given before it, the Committee specifically requests that the products subject to abuse not be named, and that the methods used not be described nor depicted.

The Committee also request that the following guidelines be observed:

- Reports of inhalant abuse deaths should be factual, and not sensationalised or glamourised.

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<sup>163</sup> See Chapter 2.

<sup>164</sup> Mr Raymond Moser, Chief Executive Officer, Swan Hill Aboriginal Co-operative, Indigenous Community Forum on Chroming, Melbourne, 17 August 2001 Melbourne.

- Articles on causalities of volatile substance abuse should not be superficial. The causes are complex, they vary from region to region, and may be different for each individual involved. Reliable organisations should be contacted for information.
- Stories should include a local contact telephone number or source organisation for further information (1985, p. v).

It seems that these exhortations were observed more often in the breach. In 1994 Rose and Midford published an article informing social workers and other concerned professionals on how to engage with the media positively in the area of volatile substance abuse in order to combat the too often sensationalised coverage that the issue was receiving at that time in (Western Australian) papers. (Rose & Midford 1994). Seven years later Rose authored the *Background Paper* on volatile substance abuse for the Western Australian Solvents Working Party. In this comprehensive analysis of volatile substance abuse in that state he again notes that the media have not always behaved responsibly in reporting stories on volatile substance abuse. Similarly, stories in Victorian newspapers concerning chroming have not always been in the 'spirit' of the Senate guidelines.<sup>165</sup> Nonetheless, he also notes that there are methods of engaging with the media that do seem to produce positive results. These include:

- Developing a positive relationship with editors and reporters.
- Providing human interest, good news stories.
- Providing media with copies of the key points from the Senate Select Committee on Volatile Substance Fumes request to the media.
- Having a central point/person to manage media requests.
- Having training in media management including how to take charge in an interview, how to make the media work for you, and how to say no to an inappropriate interview (Rose 2001, p. 26).

Western Australia has generally been the leader in Australia in producing quality research in the area of inhalation abuse. The recently published *Western Australian Framework for Action on Solvent Abuse* (2001) was developed by the Solvents Working Party for the Western Australian government. As part of its recommendations the framework has recommended a 'Media Code of Practice' based on the request to the media issued by the Select Senate Committee outlined above. It also has produced a media resource kit enabling community workers and others who are asked to comment on inhalation issues to do so effectively.

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165 There have been some positive and responsible stories concerning chroming in local communities. See for example, 'Girls into Chroming' (9 May 2001) and other stories published by the *Preston Leader* profiling sensitively the chroming problem in the Darebin area.



### ***Publicity: A two edged sword?***

Information provision and media publicity concerning volatile substance abuse and its dangers is a highly contentious issue. This is reflected in both the academic literature and the views of those working in the field.

#### **Positive aspects of publicity**

The Western Australian Solvents Working Party (WASWP) in its recently published *Framework for Action on Solvent Abuse* (2001) has acknowledged that well targeted local publicity and information campaigns can be of benefit in addressing problems associated with volatile substance abuse (WASWP 2001, p. 6).

In Britain a concerted media advertising campaign in 1991 was launched aimed at alerting parents that domestic products could be used as 'drugs'. The Department of Health had expressed great concern about the rising number of deaths of young people attributed to volatile substance abuse. Subsequently, it spent over two million pounds putting volatile substance abuse on the 'drug abuse agenda'. This went against the received wisdom discussed below that publicising the alternative use of such products would encourage young people to take up a practice which hitherto they may have been unaware of. In fact the campaign seems to have been remarkably successful. When the Committee met with Dr John Ramsay of St George's Medical School, London, he testified to this fact in a comprehensive presentation outlining volatile substance abuse in Britain:

The first slide on the other page, this is a statistical manipulation of the data, and it shows that the decrease in deaths, which is represented by that vertical bar is absolutely coincidental in time with the Department of Health's advertising spin. Since that date we have all concluded that we believe this roughly halving of mortality in the UK was attributed to the focus on advertising aimed at parents alerting them to the fact that ordinary domestic products could be used as drugs and were killing young people.<sup>166</sup>

Media publicity has also been a useful tool for community groups initially trying to get support for local projects devised to deal with volatile substance abuse problems in their communities. In these cases the publicity or information provision is not necessarily about the practice itself as much as the efforts of the strategy, taskforce or partnership being formed to deal with the problem. Certainly the Sunshine Chroming Awareness Program (SCAP) has found the support of the *Brimbank Messenger* useful in this respect. When the project was first being established it discussed the issue of publicity in detail:

It has been recognised that publicity is going to be a crucial part of the program, in order to promote the work of the group but also to provide community education. Concerns about how to publicise the issue so that chroming is not seen to be promoted have been raised and discussed.

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<sup>166</sup> Dr John Ramsay, St George's Hospital Medical School, London in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

Contact was made by a reporter from the local newspaper, the *Brimbank Messenger*, about the issue of chroming which had been raised in Parliament. It appeared that a local Member of Parliament had raised the dangers associated with chroming as well as the possibility of banning the substance. This provided an ideal opportunity for the Project to gain some publicity about the group and about the approaches that the group was taking in relation to accessibility issues as well as understanding what Sunshine’s young people’s needs are.

The reporter has been very interested in supporting the Program and to date has been cautious in terms of approaching the issue. She has advised that she will endeavour to advertise the Program’s meeting dates and progress.

The following figure outlines the arguments for and against education and intervention as summarised by the Sunshine Chroming Awareness Program

**Figure 7.1: Arguments for and against the provision of information with regard to ‘chroming’**

FOR INTERVENTION:	AGAINST INTERVENTION:
The dangers of chroming are well known – to stand by while young people potentially harm themselves is wrong.	Much chrome use may be a “passing phase”.
If nothing is done, the problem will grow.	Young people may rebel and use more if interventions are established.
There are pressures from some individuals/groups to take action.	
Young people need to see that people will take action when they behave in potentially dangerous ways.	If chrome users are seen to be getting “special attention” other young people may be encouraged to engage in similar activities to get equal action.

Source: Sunshine Chroming Awareness Program 2001a, p. 12.

### Issues for concern pertaining to publicity

Nonetheless, given that the majority of ‘chromers’ are experimental users, whether publicity is through the media or as part of education and prevention campaigns, it is incumbent on those who publicise to:

[b]alance the dubious success rate of such processes with the risk of advertising the existence of a product that in many instances may be found in any households laundry and kitchen.

Similarly [we] should endeavour to avoid the ‘advertising’ effect of media sensationalism.<sup>167</sup>

167 Submission of Youth Substance Abuse Service to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 5.

The British agency Re-Solv also stresses the importance of achieving the 'right balance' in both media publicity and education strategies:

Young people will probably be aware of a wide range of products which can be sniffed ... Most young people will know more about volatile substance abuse than their parents. However, much of their knowledge is picked up from their friends and may be misinformed ... Education on VSA should take into account the 'innocent' element who may only have a sketchy picture of the problem. It is unnecessary to provide details of abusable products, beyond what is usually 'common knowledge', for example glue-sniffing. Too much information may alert children to potentially sniffable products about which they previously knew little (Re-Solv 2000, p. 3).<sup>168</sup>

The Youth Affairs Department of New Zealand shares these concerns. It states in the context of volatile substance abuse education:

Youth Affairs is of the opinion that general education about solvents does have the potential to:

- Cause experimentation
- Increase use in a community where there may be a small group that is undetected
- Lead to possible Sudden Death Syndrome (Youth Affairs New Zealand 2000, p. 3).

Youth Affairs New Zealand (YANZ) believes education strategies amongst young people can only be effective if linked to other support services such as the family or, in the New Zealand context, the *whanau*.<sup>169</sup> It is also thought that education with young people *must* be complemented by working with retailers, medical personnel, teachers and parents in communities where volatile substance abuse has been identified as a problem (YANZ 2000, p. 3).

The dilemmas surrounding drug prevention and education are also prominent in the United States. When the Committee met recently with Dr Jane Maxwell, Chief Researcher with the Texas Commission on Drug Abuse (TCADA), she expressed her own doubts as to the wisdom and effectiveness of education strategies in this area:

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168 The Yarrambiack Shire Council located in the Wimmera region of Western Victoria has been grappling with these issues. In its submission to this Committee it states:

Inhalation of volatile substances (chroming) is not a major problem in Yarrambiack Shire Council – yet! We believe this is due to the lack of knowledge about inhalants in our community, however this will no doubt change. People can legally obtain the substances required for 'chroming' and will no doubt do so when they are more knowledgeable about inhalants.

To date educators, police and community workers have avoided talking about chroming. If we tell the kids about it – they will try it!

Unfortunately, an article on the front page of the *Wimmera Mail-Times* (27 August 2001) will certainly raise the profile of this activity.

(Submission of Yarrambiack Shire Council to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 1).

The newspaper article in question is reproduced in Appendix 7.

169 The *whanau* refers to the customary concept of the extended family and kin in traditional Maori culture.

I think the hardest thing with inhalants – and it has always worried me – is that in a sense you want to educate parents about inhalant abuse, but some of the campaigns show the various products that can be used. I always had a concern about whether we are just telling kids about substances they have not thought of using, but then you think that they probably already know about it. I do not know.

... It is a dilemma: how do you educate the parents without telling the kids that gold and silver paint are better than red and blue paint?

Some people say that clearly education through the schools is very effective. I do not have an answer on this one. I have gone back and forth on this one. It is a knotty problem. Some of the posters that our agency put out I did not really like, because I thought they were showing specific substances and giving kids ideas.<sup>170</sup>

Some of these dilemmas stem from the basic fact that children will *always* experiment with and be curious about any form of substance that their parents view with disdain. Phil Mythen of Health Promotion England, the British government's health promotion and education unit, puts the paradox well:

[w]hen I was at school there were kids at school with me who would sit at the back of the classroom and sniff a bottle of Tippex, which now they can't do because the toluene is no longer in Tippex. I don't think any of the children actually thought they were taking drugs. They are kids who were experimenting at the age of 12, 13 upwards, with trying out new things – getting on with it. I don't think you could ever expect to have zero abuse. That would be ideal but it is very unlikely.

If a girl sat painting her nails and she liked the smell of nail varnish because over a short period of time – she might feel different over the five minutes she spends painting her nails and makes a connection that it is the nail varnish that makes her feel like that, you can't stop them from painting their nails. So the education that these are potentially harmful products – you can go down that route – but you have to temper it with not advertising potentially harmful products that generates interest in them, so it is a fine line to walk along.<sup>171</sup>

### ***A policy of silence?***

In Australia, since the early 1970s and the publication of the report *How to Launch a Nationwide Drug Menace* (Brecher et al. 1972), it has been stated that:

Australia has aimed to minimise sensational reporting of VSA by the media as well as limiting broad-brush approaches to teaching young people about volatile substances (Rose 2001, p. 25).

The Senate Select Committee on Volatile Substance Fumes (1985) endorsed this approach and recommended:

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170 Dr Jane Maxwell, Texas Commission on Drug Abuse in conversation with the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, Melbourne, 23 October 2001.

171 Mr Phil Mythen, Health Promotion England in conversation with the Drugs and Crime Prevention Committee, London, 10 July 2001.

Undoubtedly, however, a 'policy of silence' is desirable in certain circumstances, particularly in populations where prevalence is low and knowledge among young people is not widespread. However, rather than a blanket censorship, a discretionary approach needs to be adopted whereby parents and welfare professionals, but not young people, are provided with factual information. In recommending this approach, however, the Committee emphasises that it will only succeed if a sensitive and responsible attitude is adopted by the media in avoiding sensationalised and explicitly descriptive reports (p. 82).

This approach was thought to be sensible policy at a time when the research reflected very low levels of volatile substance abuse. For example Houghton, Odgers and Carroll (1998) found only 2.3 per cent of a sample of 1,294 high school students engaged in volatile substance abuse. Rose argues that:

[At the time] These figures support[ed] a 'policy of silence' as teaching about VSA may arouse curiosity and experimentation in the 19 out of 20 students who have not engaged in VSA and may not have been previously thinking about it (Rose 2001, p. 25).

More recently, however, Rose has argued there may be a need to moderate the policy of silence, particularly in light of the more recent and larger Australian School Students Alcohol and Drug Survey that showed a larger percentage of 20 per cent of students ever having used volatile substances. Rose argues that:

In considering the value of educational approaches which explicitly teach about volatile substances, it's important to discriminate levels of abuse at the local level while considering state-wide trends (Rose 2001, p. 25).

The issues pertaining to publicity clearly require a measured approach. The Committee is keen to hear from interested parties about strategies that may achieve and maintain the balance needed between education promotion and harm prevention.

### **Questions to consider**

- ◆ Are current drug prevention and education programmes excluding solvent abuse as a topic?
- ◆ Do intervention strategies and educational programmes need to be tailored differentially to discrete groups of abusers?
- ◆ How can intervention strategies and prevention programmes strike a balance between providing information and not encouraging the commencement or continuation of volatile substance abuse?
- ◆ What educational, preventative and treatment interventions should be developed for Indigenous communities?
- ◆ Should these incorporate holistic healing centres?
- ◆ How can parents be best assisted in undertaking a preventative and educative role with volatile substance abuse?
- ◆ Should education, prevention and treatment strategies be specific to volatile substance abuse or part of a more general process of drug education?
- ◆ What should the role of the school be with regard to volatile substance abuse?
- ◆ How effective are harm minimisation practices? How appropriate are they?
- ◆ What concerns do you have in relation to harm minimisation practices?

## 8. Addressing volatile substance abuse: Strategic frameworks and local responses

As the previous section has demonstrated, the response to the issue of volatile substance abuse must be carefully considered. A simple awareness campaign may succeed only in publicising an activity confined to relatively few individuals. Conversely, there is an acknowledgment that some form of response is needed, and quite urgently if anecdotal evidence of an increasing incidence of volatile substance abuse is to be believed. The following chapter outlines the national and state-wide frameworks within which drug issues are addressed. Following a brief overview of these strategies, examples of 'inhalant specific' local community initiatives are noted. Each of these initiatives was developed within either national or state frameworks.

### **The national framework**

The National Drug Strategic Framework 1998–99 to 2002–03 reaffirms Australia's commitment to harm minimisation as the guiding principle of national drug policy. It aims to improve health, social and economic outcomes for both the individual and the community. The framework includes a variety of integrated approaches.

One of the primary objectives of the above drug strategy is to develop a partnership approach to drug-related issues. The National Drug Strategic Framework policy document states:

The development of a closer working relationship between the three tiers of government and affected communities (including drug users, their families and those affected by drug-related harm), community-based organisations, business and industry, the medical profession, and research institutions has therefore been identified as a priority. In recognition of this, and acknowledging that a partnership approach is still evolving, 'building partnerships' is the theme for this next phase of the National Drug Strategy (Ministerial Council on Drug Strategy (MCDS) 1998).

The Framework seeks to strengthen and expand partnerships in a number of ways, including:

- Through a commitment to consultation and collaboration on all aspects of Australia's response to drug-related harm, *emphasising community involvement* (Committee's emphasis);
- By allowing for representation of individuals from community-based organisations, business and industry, affected communities (including drug

users, their families and those affected by drug-related harm), the medical profession and research institutions ;

- By developing mechanisms at the State and Territory and local government levels to encourage organisations and individuals outside government to become involved in the development of policies and programs;
- By disseminating information about successful models of community action, to help communities develop local responses to drug-related harm. This will be facilitated by the Community Partnerships Initiative announced as part of the National Illicit Drug Strategy (MCDS 1998, pp. 21–2).

According to the 1997 National Illicit Drug Strategy, the Community Partnerships Initiative was developed to encourage 'quality practice' in community action to prevent illicit drug use. It aims to demonstrate:

- ◆ A range of local community partnerships for primary prevention of illicit substance use;
- ◆ Examples of quality practice in community participation and action on a significant public health issue;
- ◆ An increase in capacity of communities to develop effective prevention action;
- ◆ National dissemination of quality practice in primary prevention of illicit substance abuse; and
- ◆ An increase in sustainable community action across Australia (Commonwealth Department of Health and Aged Care 2001).

The Community Partnerships Initiative provides grant funding to assist communities in developing their own community based education and prevention programs (Commonwealth Department of Health & Aged Care 2001a). The first two rounds of funding allocated \$5.88 million to 87 projects. Applications for a third round closed in August 2001 (Commonwealth Department of Health & Aged Care 2001a). Programmes supported to date have included training schemes, peer education programmes, information dissemination and resource production initiatives (Department of Health and Aged Care 2001a). The Community Partnerships Initiative has also produced a *Community Partnerships Kit*. The Kit outlines a community action model that can be utilised by local communities to develop drug strategy plans. It is readily accessible and available on the internet.<sup>172</sup>

While the Community Partnerships Initiative specifically focuses upon *illicit* drug use by young people and their use of illicit drugs, the relevant policy document recognises poly-drug use, '*as well as the issue in some jurisdictions of problematic use of solvents and of petrol sniffing*' (Committee's emphasis) (Commonwealth Department of Health and Aged Care 2001, p. 3). Consequently, programmes seeking to address volatile substance abuse may apply for funding under the scheme.

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172 See [www.communitypartnerships.health.gov.au/cpkintro.htm](http://www.communitypartnerships.health.gov.au/cpkintro.htm)



## The state framework (Victoria)

The need for local community action has been further supported by the Victorian Drug Policy Expert Committee (DPEC). The Committee was established by the State Government in November 1999 to provide advice on the implementation of drug policy. In fact, while recognising the need for broader coordination on the part of state and national authorities, the DPEC stated that opportunities to involve local communities had been missed in recent years and called for a systematic response at the local level (DPEC 2000). The Committee argued that local communities have a distinct role to play because:

- Many actions can only be taken at local level;
- Only local effort can harness local community resources;
- Each community is different and responses will need to be tailored accordingly;
- Communities that act on their own behalf are more healthy (DPEC 2000, p. 4).

The DPEC make a number of recommendations to the State Government with the intention of recognising existing local initiatives and encouraging further local action. The following is an excerpt from the Committee's Stage One report.

### *Local drug strategies*

That broadly based and multifaceted local drug strategies be implemented as a key element of the Victorian Government's drug policy.

*Given the widespread problem being experienced across the State, the Committee believes that it is important that all areas and communities are encouraged and supported to play a role in reducing the impact of drugs on individuals, families and communities.*

**Recommendation 1.1** The Victorian Government provide support to local governments and communities, to assist them to mobilise community involvement in responding to local drug issues.

**Recommendation 1.2** The Victorian Government encourage local governments, which have not done so, to develop formal local drug strategies relevant to the drug use in their communities, including strategies for prevention, treatment and rehabilitation and community safety. Such strategies should be explicitly linked to parallel processes such as municipal corporate plans, municipal public health plans and community safety plans.

**Recommendation 1.3** The Victorian Government encourage local government to work with a range of stakeholders in the development of local drug strategies. These stakeholders include:

- drug users;
- Victoria Police;
- residents;
- traders and other local business;
- cultural and language groups;

- local schools;
- community organisations;
- drug and alcohol service providers; and
- other service providers.

**Recommendation 1.4** The Victorian Government support communities of interest and the Koori community to similarly mobilise to respond to issues affecting them, wherever possible in association with local government initiatives.

(Drug Policy Expert Committee 2000, p. 7)

While the above recommendations are relatively broad, the DPEC did propose a number of elements seen to be central to any local drug strategy:

- Improving information provision and linkage between stakeholders;
- Providing youth-focused prevention and early intervention;
- Managing public space;
- Providing advocacy and advice to State Government;
- Intervening to reduce drug-related harms;
- Developing community support strategies (DPEC 2000, p. 4).

In 2001, the State Government accepted the recommendations of the DPEC pertaining to local drug strategies. A team was established within the Department of Human Services to work with local government to develop appropriate strategies for local areas (DPEC 2000b). As part of this strategy the Victorian Department of Human Services (DHS) advertised for submissions for the funding of 'Community Strengthening' projects, 'to enhance the capacity of local communities to prevent drug use and respond to drug issues' (DHS 2001d). Funding was offered for up to three years for projects focused on drug prevention.

There is clearly financial and political support at all levels of government for local community responses to drug issues. In providing for such responses, the national and state drug strategies acknowledge that those within a local community are often best placed to coordinate a response to issues that arise within that community. Indeed, an appreciation of the networks and sensitivities that define a local community's culture is of utmost importance when devising a response to a community drug problem.

In respect of specific state responses to volatile substance abuse, there are few formal projects. Inhalant abuse is instead addressed in a generalist way through the existing service system which includes drug treatment, youth services, family support and special programmes such as the Common Assessment and Referral Project (CARP).<sup>173</sup>

CARP provides training for Police to enable them to make referrals for young people at risk. In some areas this has involved the referral of young people engaging in inhalant abuse. In order to make these referrals, police work in partnership with the DHS and

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173 Submission of the Department of Human Services, Drugs Policy and Service Branch, to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001c, p. 3.

local youth services, the latter who work to refer individuals to the appropriate agency.<sup>174</sup> The inability of the current state-wide service system to specifically address issues of volatile substance abuse again emphasises the necessity of a local response to the issue.

## Local community initiatives

The need for a local community response and for local preventative strategies has particular relevance for volatile substance abuse. In 1992, the World Health Organisation (WHO) hosted an international conference and forum on volatile substance abuse. During this forum delegates from many nations with disparate cultural, legal, economic and health backgrounds gave presentations on the ways in which volatile substance abuse was manifested and addressed in their respective countries. Although each country was very different from each other there were two findings that were common among the participant nations:

- ◆ Data as to the extent and nature of the problem was insufficient and in some countries non-existent;
- ◆ Localised community strategies were viewed as being the best way of tackling the problem.<sup>175</sup>

As a result of the conference, the WHO Programme on Substance Abuse published an extensive document on how local communities can address volatile substance abuse. It states that:

The first step in setting up a project for the prevention of solvent abuse is to establish a community advisory group or steering committee to guide the direction of the programme planners. This may be a coalition formed especially for this purpose or a subcommittee of an already existing larger committee or board. In either case, it should include several representatives from various segments of the target community, project staff, and other individuals. Its role should be seen as one of empowering and facilitating as opposed to controlling or directing. A representative group may include the following:

- Community residents;
- Bilingual and/or bicultural professionals (if this is appropriate in the situation);
- Representatives from the target population (solvent users);

Other interested or influential people, such as elected officials, school personnel, religious leaders, staff from community health centres, representatives from local government and law enforcement, larger employers in that community, parents, voluntary organizations, social service workers, and any other representatives who may seem to be appropriate (WHO 1992, p. 7).

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174 *ibid.*

175 World Health Organisation, Programme on Substance Abuse, *Proceedings of the International Consultation on Solvent Abuse*, 7 December 1992, WHO Headquarters, Geneva, p. 3.

The key participants and keynote addresses were from the Ivory Coast, Morocco, Rumania, Bangladesh, the Philippines, Guatemala and New Zealand.

The WHO states further that the importance of community strategies in tackling substance abuse problems lies in the fact that it encourages shared decision making and collaborative approaches. Furthermore:

This approach empowers the community by providing a forum where they can take active roles in planning and implementing a solvent abuse programme. Working with a committee rather than separate, individual contacts has several other advantages:

- The group's interaction generates more information and ideas from which to identify and develop strategies.
- The group's interaction, particularly if it has diverse representation, can be informative about actual community dynamics.
- It may help identify major opinion leaders in the community, who may be missed otherwise, but should be included in the planning process.
- It can help identify and examine other community concerns or sub-groups that should be considered in developing the programme.
- It allows more people from different segments of the community to 'buy into' the programme-building effort and serve as advocates for the programme (WHO 1992, p. 8).

Closer to home, Rose (2001) outlines a number of varied interventions that should be implemented at local community level. Although they were developed for the Western Australian Solvents Working Party framework on solvent abuse, with appropriate adjustments they could be applied usefully to Victorian communities. The recommendations include:

- Assessment, promotion, and where required, development of a range of recreational and diversionary programs, activities and facilities, and educational and employment opportunities for young people;
- Provision of resources to enable local retailers to improve controls over the sale of commonly abused products to those suspected of volatile substance abuse;
- Encouraging local schools to engage in [School Drug Education Projects] and to ban the use of commonly abused products such as aerosols and typists' correction fluid;
- Provision of general parent drug education which includes a section on volatile substances as well as other generic issues such as positive parenting and monitoring;
- Connection to other preventative programs run by [state government departments];
- Developing good relationships with local media and providing them with 'good news' stories about young people (Rose 2001, p. 28).

Volatile substance abuse, as was noted in Chapter 5, is often an episodic and localised activity, particularly in rural communities. To recall the comments of the Latrobe Valley Drug Reference Group:

Chroming is a highly mobile drug-taking behaviour – that is, it will appear in an area for a short period of time, disappear, and re-appear in another area, then move back or elsewhere, in a very short period of time.<sup>176</sup>

Such mobility makes broad policy development difficult and emphasises the need for very localised responses. Nonetheless, in line with the United Nations principles enunciated above, it is encouraging that a number of local communities have taken the opportunities and direction provided by the above 'strategic frameworks' to address drug use issues within their local area.

The Victorian Department of Human Services notes that a number of local drug action groups, comprised of concerned community members, have emerged across the state in response to 'outbreaks' of inhalant use in local areas.<sup>177</sup> These groups are often of temporary duration and tend to take a community development approach, establishing recreation activities for young people and reducing the supply of volatile substances.<sup>178</sup>

Local councils are also increasingly taking up the issue of volatile substances as part of local drug action plans. As part of its submission to this Inquiry the Wyndham City Council has given the Committee copies of its Substance Abuse Framework Strategy. This strategy is referred to in detail later in this chapter.

The following discussion outlines projects that incorporate community action strategies and local partnerships. The Committee has been made aware of these projects through the initial stages of the Inquiry.

### ***The Galaxy Project***

The Galaxy Project is a Salvation Army (Crossroads) project in its third and final year of funding under the Commonwealth Community Partnerships Initiative. Based in the Western Metropolitan Region of Melbourne, the Project aims to prevent and/or reduce the harms associated with drug use by young people. One of the programmes that has been initiated within the Galaxy Project is the Sunshine Chroming Awareness Program. The specific aims of the Program are to:

- ◆ Form a group with representatives from local community agencies and traders to develop an action strategy / pilot programme to address chroming issues in the Sunshine shopping areas;
- ◆ Document a best practice model for other communities to use when dealing with chroming and other commonly misused substances in their local areas.

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176 Submission of the Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 3.

177 Submission of the Department of Human Services, Drugs Policy and Service Branch, to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001c, p. 3.

178 *ibid.*

The Programme draws together the key concepts of the Federal government's community based partnership strategy. Throughout the course of the Chroming Awareness Program, active participants have included representatives from:

- ◆ Sunshine Police;
- ◆ Sunshine Youth Housing;
- ◆ Sunshine Traders;
- ◆ Alcohol and other drugs programme, Westcare;
- ◆ Good Shepherd Youth and Family services;
- ◆ Westcare Residential Services;<sup>179</sup>
- ◆ Youth Outreach Team;
- ◆ IMYOS (Mental Health Agency);
- ◆ Rotary Club;
- ◆ Department of Education, Employment and Training;
- ◆ Brimbank City Council;
- ◆ Smorgon Family; and
- ◆ Open Family.

These representatives have worked to address chroming-related issues in the local community. The most pressing problem identified was the need to reduce the accessibility of chrome paint (Sunshine Chroming Awareness Program, Galaxy Project 2000). Representatives of the Chroming Awareness Program successfully established cooperative relationships with local traders. The traders were regularly involved in discussions at the Program's forums. These forums were seen as integral to the Program's success. They provided an opportunity for the expression and integration of wide-ranging views. Such views were seen as vital to the development of a 'whole-of-community' approach (Sunshine Chroming Awareness Program 2000). In July 2000 the Program reported major success in changing the paint-selling practices of several local traders (Sunshine Chroming Awareness Program 2000). One of the most successful avenues used in creating this change was the sending of letters to the head offices of larger traders raising concerns and requesting action at local level (Sunshine Chroming Awareness Program 2001b). Of concern, however, is the information the Committee has received from representatives of the Galaxy Project that some of the momentum for maintaining this approach may be at risk.

The Galaxy Project has also undertaken data collection surveys to better understand the motivations behind 'chroming'. These surveys identified a number of underlying factors that were impacting on the use of chrome paint. Boredom among local youths was identified as the primary contributing factor (Sunshine Chroming Awareness Program

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179 The artwork on the cover of this Discussion Paper was produced by young people attending the programme run by Westcare.

2001b). As a result, the Programme sought to redirect its focus to the development of affordable and accessible leisure activities for youth in the Sunshine area.

The project has also 'mapped' the areas of Sunshine in which chroming is either known or thought to take place. Survey data identified sites of chroming activity, such as the Sunshine Railway Station. Identifying this site enabled Project representatives to make contact with the relevant transport operators and to develop a working relationship as a means of minimising chroming activity in the vicinity (Sunshine Chroming Awareness Program 2001b). Acting upon information compiled through the surveys, the Sunshine Chroming Awareness Program has identified a further number of places where chroming takes place. This information is able to then inform preventative measures such as outreach teams and allow local authorities to act to deter such activity becoming established in known haunts.

Having sought to address issues of supply reduction in its initial stages, the next phase of the Programme aimed to address the needs of young people and develop positive community strategies to support them.

### ***Wyndham City Council***

In March 2000 the Wyndham Substance Abuse Committee was formed, with representation from key stakeholders including local service providers, concerned community members, police and the business community. This group emerged in response to increasing local substance abuse issues and 'a need for a united community voice in response to these issues' (Wyndham Substance Abuse Committee 2001). It was committed to developing local strategies and actions to reduce the harm associated with the misuse of drugs in the municipality, adopting the DPEC local action model as the framework through which to do so (Wyndham Substance Abuse Committee 2001).

In a submission to the Drugs and Crime Prevention Committee, the Wyndham City Council noted that statistical data on the prevalence of volatile substance abuse was very difficult to obtain.<sup>180</sup> The Council praised the Galaxy Project as an example of best practice, stating:

The Sunshine Chroming Awareness Project (*sic*) through the Galaxy Project has been an important source of information and has provided Wyndham with a model for community action on this issue.<sup>181</sup>

The Wyndham Council sought to build upon this model by outlining a proposed project, the Wyndham Chroming (inhalants) Awareness Project, as part of a Wyndham Substance Abuse Strategic Action Plan 2001–2004. The Project was proposed as follows:

#### ***1 Target groups and project partners***

- Local business (particularly those selling inhalants)
- Shop assistants
- Train services (in Wyndham Bayside Trains)

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180 Submission of the Wyndham City Council to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 1.

181 *ibid*, p.3.

- Local Council
- Police
- Schools
- Drug & Alcohol Services
- Frontline workers
- 'At risk' youth.

**2 Phase 1 – Awareness raising, education and engagement of key community stakeholders**

This phase of the project aims to:

- Engage the key community stakeholders and raise awareness about chroming – its effects, what types of solvents are used, what strategies can be put into place to reduce the availability of solvent misuse.
- Reduce the ease of access to solvents and other volatile substances that may be potentially misused.
- Raise awareness amongst the 'at risk' group – (place warning stickers on products).
- Develop/distribute a sales and stocking protocol on solvents and other identified volatile substances. This will include the development of an appropriate process eg referral process etc.
- Develop a data collection process to identify issues and hotspots. This information to assist in providing targeted prevention and early intervention programmes to youth misusing these substances.
- Collect data (statistical and/or anecdotal) on solvent and other volatile substances misuse.
- Assist schools in delivering educational sessions on safe use and handling of solvents and other volatile substances.

**3 Phase 2 – Training and education program development and implementation**

Training and education issues may be identified in phase 1 of the project.

This project phase aims to:

- Develop (in consultation with key community stakeholders) training and education program for relevant frontline workers and traders.
- Engage relevant workers and groups/individuals in the Wyndham community that are more likely to be in contact or interact with youth that abuse solvents or other volatile substances.
- Produce and distribute relevant resource materials, information and training sessions to those frontline workers/stakeholders that are most likely to come into contact with youth prior to, during or after they have inhaled volatile substances.



- Develop workable strategies for workers/groups/individuals to implement regarding solvent and other volatile substance misuse, such as:
- Development and implementation of a 'solvent sales and stocking' protocol – eg location of products (ensure that they are not easily accessible or easy to shop lift).
- Training of sales staff (ie what 'chroming' is, identification of most 'at risk' youth, how to handle the situation, dealing with challenging behaviours).
- Training of frontline workers (eg Bayside train staff, police, community services workers, shop owners) how to interact with youth who have used solvents – not just adopt a move them on policy but provide them with information, services that they can attend etc.
- Record the incident and develop a system for monitoring and distributing this data.
- Develop referral protocols to services for instances of youth inhaling volatile substances.
- Map public chroming hotspots.

#### **4 Phase 3 – Targeted chroming awareness program for at risk youth**

Development and implementation of targeted interventions such as:

- Group/peer support
- Counselling provided to at risk youth
- Recreational activities
- Harm minimisation programs
- Linking at risk youth to current community activities
- Providing positive role models to reduce the likelihood of continued use, harmful use, or taking up abusing volatile substances and/or being involved in other antisocial or harmful activities
- Ensure that these substances are less readily accessible
- Outreach to 'hotspot areas'
- Training, education and awareness of frontline workers and traders
- Ongoing support, education and training for key stakeholders
- Peer support/outreach provided to at risk youth
- Development of a referral process/protocol targeting at risk youth.<sup>182</sup>

Although this proposed plan is yet to be implemented, a number of initiatives have already taken place at the local level in Wyndham. Despite the lack of statistical data, anecdotal reports of increasing volatile substance use in public places in Wyndham – particularly trains, train stations and parks – have been sufficient to raise community concerns. A key proposal of the Wyndham Strategy Plan is the recognition of the

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182 Submission of the Wyndham Council, to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, pp. 7–8.

importance of sophisticated ‘mapping’ of the ‘hot spots’ for chroming in the area and to note reasons as to why these may be popular places in which to chrome. In response to the growing concern about chroming in the Werribee area, Werribee Police commenced an awareness raising campaign regarding the misuse of volatile substances in the Wyndham community.<sup>183</sup> This strategy was targeted directly at local traders, who were made aware of the potential dangers of volatile substances through personal visits by police. Police identified a number of strategies through which traders could reduce the availability of misused inhalants, including:

- ◆ Re-positioning of stock in areas that are less prone to theft;
- ◆ Not selling products to at risk youth;
- ◆ Recognition of symptoms of volatile substance misuse.

Traders were reportedly supportive of this campaign and police were able to reduce the public visibility of chroming. However, it was not clear whether this reduction in visibility was due to a decline in the practice or whether it moved to a neighbouring geographical area. For this reason, the Council emphasised the need for coordinated community action across Council boundaries.

### ***Latrobe Valley Drug Reference Group***

The Latrobe Valley Drug Reference Group was established in early 2000 as a response to concerns about the usage and level of chroming that had commenced late in 1999, in the Latrobe Valley area of Gippsland.

It is a good example of a community strategy based on the needs of a rural and regional area with a relatively high proportion of Aboriginal residents. The reference group is made up of the following representatives:

- Wanjana Lidj Aboriginal Family Preservation Program
- Department of Human Services – Intake & Program Coordinators
- High Risk Adolescent Reference Group
- Central Gippsland Aboriginal Health & Housing Cooperative – Bendin House & Kurnai Hostel
- Youth Substance Abuse Service
- Victoria Police
- Anglicare
- Latrobe City Youth Services
- Latrobe Community Health Service
- School Focused Youth Services
- Department of Education, Employment & Training – Turning the Tide Programme.<sup>184</sup>

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183 Submission of the Wyndham City Council to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 4.

184 See Submission of Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, p. 1.

The reference group was established in part due to some alarming statistics being collected by the Gippsland High Risk Adolescent Referral System. From August 1999 to July 2001 approximately 263 referrals were received from across Gippsland with regard to young people up to 18 years of age. The collated statistics showed:

- The average age of adolescents referred was 14 years 4 months;
- Overall 35% of referrals were for inhalant use;
- This was the major risk type for the two year period for referrals across Gippsland;
- Chroming was conducted by young people aged 9–18 years of age, both male and female, with average age of 14 years;
- 51% of Chroming referrals were for Koorie young people;
- 70% of Koorie referrals were related to Chroming;
- There is a high correlation between Chroming and mental and physical health issues;
- There is some correlation between Inhalant use and unstable accommodation (ie. transient and/or inappropriate accommodation situations);
- Four young people referred had been hospitalised, as they were unconscious due to Inhalant use;
- Six young people who were referred were found to be directly under the influence of inhalants, as observed by being found asleep on the street, unable to communicate clearly, walking down the middle of the street while under the influence, or walking down the middle of the railway line under the influence of Inhalants.<sup>185</sup>

The response of the Reference Group to what was perceived as an alarming state of affairs incorporates many of the community action strategies referred to above. The Group initiated the following actions:

- Gathering further information about the location and incidence of Chroming;
- Discussion with young people who were chroming, and with family members (funded by Court Fund);
- Extension of the currently operating High Risk Adolescent Referral System – utilised by Police to refer young people to appropriate Services (usually YSAS) on each occasion where Chroming was observed;
- Sending letters, followed up by personal visits, to local Businesses, who were in the market of selling volatile substances (usually Paints) at a low cost;
- Increased Police patrols in areas identified as being more likely places of Chroming behaviour;
- Clearing out of undergrowth etc where young people were known to be Chroming to make the behaviour more observable (and therefore more open to safety factors & responses);

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<sup>185</sup> Information taken from Submission of Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, pp. 1–2.

- Teaching harm minimisation behaviours to users (supported by YSAS staff, Aboriginal Cooperative staff, Police etc);
- Establishing a Youth Club and youth program for Koorie young people in Morwell (with transport link-up to Moe, Churchill and Traralgon);
- Providing recreational, leisure, cultural, educational, health and social programs – funded by School Focused Youth Service ; and
- Establishing a communication flow between the Aboriginal Cooperative and other organisations (especially Schools – Secondary and Primary).<sup>186</sup>

Some of the observable outcomes over the past 12 months as a result of these initiatives have included:

- Reduced level of Chroming behaviour;
- Safer Chroming behaviours used;
- Withdrawal, or more appropriate placement of volatile substances (especially paints) within Businesses;
- Placing of volatile substances (eg. spray cans) on shop security systems (electro-magnetic field alarm system);
- Reduction of shop-lifting of volatile substances;
- Not selling volatile substances to anyone less than 15 years of age (checking identity etc);
- Increased involvement by young people in the Youth Centre/Club activities;
- Increasing number of volunteers who assist in Youth Centre activities;
- Schools beginning to make use of Koorie Drug & Alcohol Workers, and
- Increased promoti7g of Koorie cultural values/practices including employment of Koorie staff.<sup>187</sup>

The Latrobe Valley Reference Group provides an excellent example of community strategies being adapted successfully to the needs of the local community. It is to be congratulated on the comprehensive ways in which it has tackled volatile substance abuse and the outcomes it has achieved.

### ***Further initiatives***

The lack of statistical data has proven an obstacle to the design of appropriate community responses to volatile substance misuse. Such responses are likely to be compromised without an accurate appreciation of the extent of the problem. Some have sought to overcome this obstacle by attempting to measure local prevalence. Youth Projects Inc., for example, coordinated a project whereby a Drug Safety Worker kept a journal of chroming activity in the Kensington / Flemington area over a four-week period. As the worker responsible stated:

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186 Submission of Latrobe Valley Drug Reference Group to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, August 2001, pp. 3-4.

187 *ibid*, p. 4.

The journal records four known 'chroming' sites in the Newmarket area. It seeks to provide a more accurate picture of 'Chroming' and other drug related activities in the area. It is hoped that more accurate strategies may be developed from the outcomes (Begley 2001).

The Department of Human Services has noted that local councils are increasingly taking up the issue of volatile substance use. Attention was also drawn to the joint initiative designed by Darebin City Council and the Youth Substance Abuse Service called 'Can It'.<sup>188</sup> This project was in a developmental stage and an application for funding had been lodged.

## Conclusion

Within the guiding structures of national and state drug prevention strategies, local initiatives are gradually emerging in response to the misuse of volatile substances, particularly by youth. To date there has been no rigorous evaluation of community approaches to address VSA as the projects are still in their infancy. Moreover, evaluation is compromised and difficult to undertake without appropriate statistical data being readily available. Nonetheless the Committee acknowledges the positive signs that have flowed through from initiatives such as the Galaxy Project, the Wyndham Council and the Latrobe Valley Drug Reference Group. The Committee would welcome any additional information of local strategies currently established or being implemented within local communities throughout Victoria.

### Questions to consider

#### *Questions for community agencies involved in VSA*

- ◆ What are the current issues pertaining to the inhalation of volatile substances that are most pressing for your agency?
- ◆ What are the strategies that your agency has found best in addressing chroming and related problems? Are these developed for different target groups? For example, parents, teachers, young people, doctors and nurses, police, traders?
- ◆ Do harm minimisation policies such as those incorporated by Berry Street Victoria (allowing young people to chrome 'safely') encourage further volatile substance abuse amongst other young people or clients in care? What are the arguments for and against such policies and practices?
- ◆ How can intervention strategies and prevention programmes strike a balance between providing information and not encouraging the commencement or continuation of volatile substance abuse?
- ◆ One of the issues of concern in Victoria is that there seems to be a lack of agreement between some groups in the community (for example local

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<sup>188</sup> Submission of the Department of Human Services, Drugs Policy and Service Branch, to the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, September 2001, p. 3.

government) and others such as the media. This lack of agreement centres on whether the issue of chroming or inhalation should be publicised to any degree. The opponents of publicity seem to be arguing that such publicity only serves to make young people aware of the practice and thus encourage it. What are your views on this?

- ◆ What are the most appropriate strategies to engage these young people?
- ◆ Does the Project or your agency collect data with regard to inhalant abuse? What problems do you experience in collecting such data? What information do staff require on volatile substance abuse?
- ◆ Does volatile substance abuse progressively lead to the abuse of other substances?
- ◆ How does the issue of volatile substance abuse impact upon various ethnic groups in your community? What about in terms of gender?
- ◆ What are the most effective prevention and education strategies to counter solvent abuse?
- ◆ What age/gender/ethnic specific factors need to be addressed in devising and implementing these strategies?
- ◆ What factors can be utilised to encourage local traders to participate in community VSA programmes?
- ◆ What problems do you experience with current funding arrangements for programmes?
- ◆ What support for funding of community programmes and research are you aware of?
- ◆ What programmes would you like to establish if funding was available?
- ◆ What research do you think should be undertaken?
- ◆ What should the role of parents be with regard to volatile substance abuse? How can parents be supported in assisting a child who is using volatile substances?
- ◆ If your agency engages with young people who abuse volatile substances or have clients who are volatile substance abusers,
  - Do you know:
    - How the young persons 'learnt' to use volatile substances?
    - Why they use volatile substances?
    - How long have they been using?
    - Do they use as part of a group?
    - Do their parents/caregivers know of their use and how do they feel about it?
    - Are they interested in reducing or stopping their use?

Have they learnt how to use in more safe ways?

Do they know where to get help if they need it?

Do you know whether the young people use volatile substances in conjunction with or to substitute for other drugs?

***Questions for local government***

- ◆ What role should local government have in developing programmes aimed at preventing and treating VSA?
- ◆ How effective is local government in addressing VSA in their communities?
- ◆ What are the problems confronting local government in relation to VSA?
- ◆ What leadership focus should local government have in addressing VSA?
- ◆ What programmes and support (if any) are local government funding or providing to local communities in this area?

## 9. Concluding remarks

*While there can be no objection to including solvents in general drug and alcohol education programmes, it is important they be kept in perspective as Lilliputian compared to the Gullivers of tobacco, ethanol, cannabis and licensed 'pushing' of benzodiazepenes and similar drugs by the medical profession (Werry 1992, p. 12).*

As the above quote suggests, in terms of volume consumed and attendant social problems, the consumption of alcohol, tobacco and other drugs is far more problematic for young Victorians than the inhalation of volatile substances. This does not mean that the problem is insignificant. Nor does it mean that it should not be tackled as a matter of urgency. For the communities, the parents and loved ones affected by volatile substance abuse statistics may be meaningless. Privileging one form of substance abuse over another is counter-productive in these circumstances.

One of the problems in addressing volatile substance abuse is that there are so many questions that remain unanswered: Does inhalant abuse lead to other forms of drug abuse? What are the risk factors leading to volatile substance abuse? Is it addictive? How dangerous a practice is it in reality? These are but a few of the issues that the subject of volatile substance abuse raises in abundance. One reason why these questions remain unanswered is the appalling lack of quantitative and qualitative research being undertaken in this area and the lack of coordinated and meaningful data being collated.

The difficulties in addressing volatile substance abuse are also compounded by the different forms the practice takes and the different types of user who engage in inhaling volatile substances. As was pointed out in Chapter 5, there is no one stereotype of inhalant user. The 'sniffer' may be male or female, Indigenous or non-Indigenous, a 'chromer' with 'huffer's rash' or a doctor who gets high on anaesthetic gases. The reality of multi-variate forms of inhaling demands strategies that are tailored accordingly.

This Discussion Paper commenced with an excerpt from the submission by 'Anne', the plea of a mother desperately trying to get assistance for her daughter, a 'chromer' on 'a merry-go-round of self destruction'. She finishes her letter with the following exhortation:

*Please don't disregard this letter, please help me to keep my daughter alive and all the other children who are slowly killing themselves and destroying their families.*

It is the hope of this Committee that in some way this Discussion Paper will at least bring some focus and attention to the problem of volatile substance abuse and result in some positive contributions to the debates and issues that it has raised. We welcome the on-going contributions of Victorians and other interested parties across the country in addressing this issue of great concern.





# Appendices

## Appendix 1 – Commonly abused legal and accessible volatile substances

Group	Substances	Chemicals
Adhesives	Modelling glue 'Kwikgrip' (Super glue) Rubber cement	Toulene; Ethyl acetate; Benzene; n-Hexane; Xylene
Aerosols	Spray paint Hair spray Deodorant	Butane; Toulene; Propane
Cleaning Agents	Degreaser	Tetrachloroethylene; Xylenes
Solvents and Gases	Nail polish remover Paint stripper Correction fluid Fuel gas and Lighter fluid Fire extinguishers  Petrol	Acetone; Ethyl acetate; Toulene; Acetone; Trichloroethylene; Propane; Butane Bromochlorodifluorometane  Benzene; Lead; Toulene Aliphatic hydrocarbons
Food Products	Whipped cream bulbs Non-stick sprays	Freons
Nitrites	'Room odorisers' (Sex aids)	Alkyl nitrite, (iso)amyl nitrite; (iso)butyl nitrite; isopropyl nitrite

## Appendix 2 – Hazards of chemicals found in commonly abused inhalants

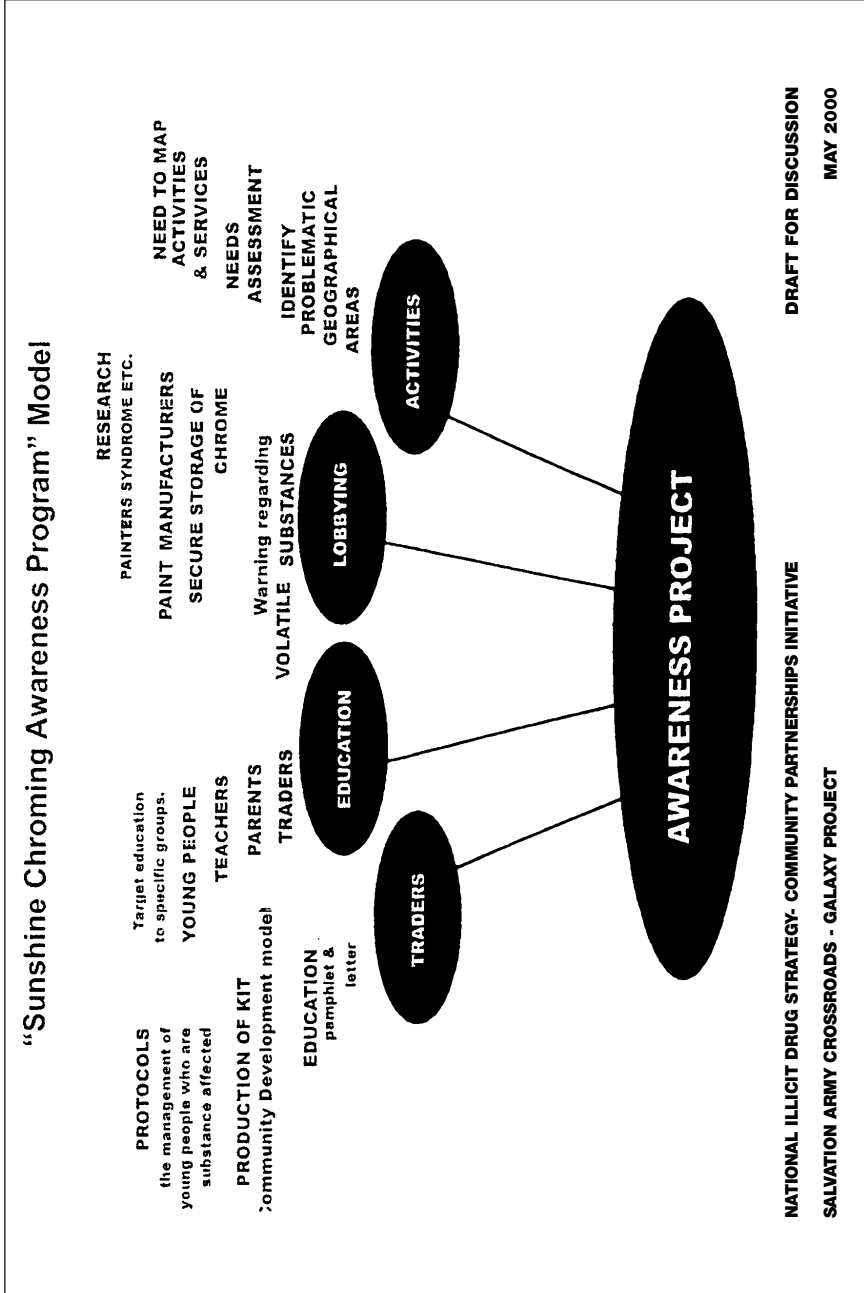
<b>Amyl Nitrite, Butyl Nitrite</b>	Suppressed immunologic function, injury to red blood cells (interfering with oxygen supply to vital tissues)
<b>Benzene</b>	Bone marrow injury, impaired immunologic function, increased risk of leukemia, reproductive system toxicity
<b>Butane, Propane</b>	Sudden sniffing death syndrome via cardiac effects, serious burn injury (resulting from flammability)
<b>Freon</b>	Sudden sniffing death syndrome, respiratory obstruction and death (from sudden freezing injuries to airways and / or larynx), liver damage
<b>Nitrous Oxide, Hexane</b>	Death from lack of oxygen to brain, altered perception and motor coordination, loss of sensation, limb spasms, blackouts caused by blood pressure changes, depression of heart muscle functioning
<b>Toulene</b>	Brain damage (loss of brain tissue mass, impaired cognition, gait disturbance, loss of coordination, loss of equilibrium, limb spasms, hearing and vision loss), liver and kidney damage
<b>Trichlorethylene</b>	Sudden sniffing death syndrome, cirrhosis of the liver, reproductive complications, hearing and vision damage

(Source: NIDA Research Report Series)

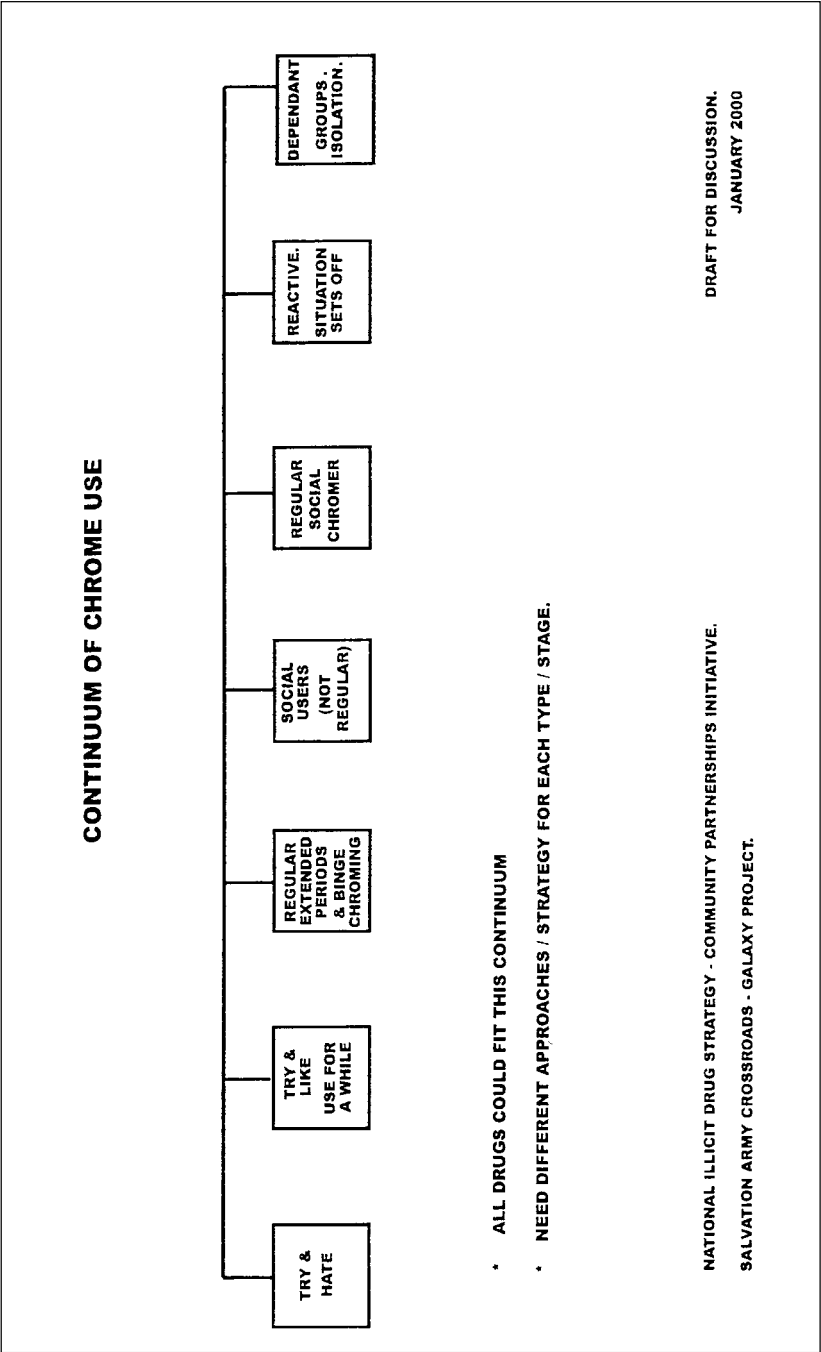
## Appendix 3 – Methods of use and effects

<b>Method of Use</b>	<b>Danger</b>
<b>Inhaling from large plastic bag</b> <i>User places bag over head or sits in bag and releases substance</i>	Suffocation due to lack of oxygen inside bag or passing out inside bag due to excess consumption, again leading to suffocation.
<b>Spray directly into mouth</b>	Refrigeration gases used as propellants in spray cans can freeze throat muscles or cause the larynx to go into spasm, blocking off the air supply to the lungs and causing asphyxiation. With this method there is the additional danger of the paint or other compounds in the container also being inhaled.
<b>Small container</b> <i>User places substance in a container such as a soft drink can</i>	Easily carried and concealed, leading to constant use and higher levels of intoxication.
<b>Small plastic bag</b> <i>Releases substance into small plastic bag and inhales</i>	Greater concentration of substance. Danger of falling unconscious with bag over face leading to suffocation.
<b>Inhaling from rag or clothing</b>	Safest method of use.


# Appendix 4a – Sunshine Chroming Awareness Program Schematic Model



# Appendix 4b – Sunshine Chroming Awareness Program Continuum of Chrome Use Model



# Appendix 5a – Western Australian Voluntary Code of Practice for Retailers – Availability of materials used for solvent abuse<sup>189</sup>



## AVAILABILITY OF MATERIALS USED FOR SOLVENT ABUSE

### VOLUNTARY CODE OF PRACTICE FOR RETAILERS

Retailers can provide a great service to their communities by limiting the opportunities for materials to be obtained for the purpose of solvent abuse.

The code refers particularly to all solvents, glues, butane and other aerosols.

The code encourages retailers to take reasonable steps to limit the likelihood of these materials being obtained for solvent abuse by such actions as is appropriate to their circumstances, which may include any of the following:

- Displaying these materials in sight of shop staff, near tills, on high shelves, under the counter, or in locked display cabinets
- Use of dummy containers for display purposes
- Avoiding sale of products to children unless accompanied by adults
- Identification of the purpose of use of large quantities of product
- Display of signs indicating your right to refuse sales
- Politely refusing sale of these substances to those you suspect of being a solvent abuser

*This code of conduct has been developed by the government of Western Australia in partnership with community organisations, recognising the contribution of retailers in the effort of Western Australians to control drug abuse.*

# SOLVENTS

There are numerous commercially available products containing potentially intoxicating inhalable solvents and aerosols. They are found in everyday products and as propellants in aerosols. Solvents and aerosols belong to a group of substances known as 'inhalants' because of the manner in which they are used. Other substances in this group include nitrites (amyl and butyl nitrite). Solvents and aerosols are described as 'volatile substances' because they are gases or give off fumes at room temperature.

## Who uses solvents

Research indicates that individual solvent use is generally an experimental or temporary phenomena among some young people between the ages of 7 to 15 years. However, there also appears to be some geographical areas, groups or individuals where solvent use is not a passing phase, but used on a continuous basis. Overall, individuals who do inhale solvents generally try it for a limited period and then discontinue.

It has been known for adults to use and/or purchase supplies for younger users.

## Effects of Solvent Intoxication

The effects of solvents are similar to alcohol (although they come on and wear off faster). As with alcohol these effects depend on:

- The drug itself (amount, strength, and the way it is taken).
- The characteristics of the person (health, personality, mood, expectations, previous experience with the drug).
- The occasion on which the drug is taken (alone, with friends, while using other drugs, driving etc)

**Requests for plastic bags at the same time as the purchase of solvent-based products should raise your suspicions immediately**

<sup>189</sup> The Committee would like to acknowledge the Western Australian Drug Strategy Office, Western Australia Police Service and the North East Midland Community Drug Service Team for their kind permission to reproduce this Code of Practice.

# Guidelines to Retailers

**Q1. Is it illegal to sell solvents?**

A. At this stage there is no law against selling, buying or possessing solvent products in Western Australia. This is because many solvents have a legitimate use (i.e. petrol, glues, paint thinners, paint etc.) which makes them difficult to restrict to any member of the community.

**Q2. As a retailer do I have a responsibility to not sell solvents to an individual whom I believe may be using them for purposes other than their intended use?**

A. Yes. Retailers and their staff are called upon to develop a moral and responsible approach to the sale of volatile substances. If the retailer and/or staff begin to believe that a particular compound is likely to cause harm or be used for the purpose of intoxication, then the decision not to sell should be supported.

**Q3. Is there any legislation that states that a shop owner has to sell solvents to customers?**

A. No. Retailers are often concerned that if they do not sell particular products that they will be taken to court for discrimination or such like. There has not been any recorded case of this happening. However, a retailer has the right to withdraw a particular item from sale if they so choose.

**Q4. Do retailers have the right to evict any individual from the store?**

A. Yes. The store manager has the right to ask any individual to leave the store. Particularly if an individual appears to be demonstrating unusual behaviour and/or has been known to steal from the shop in the past.

**Q5. Should I display a sign indicating that solvent products will not be sold to any person under suspicious circumstances?**

A. Yes. A sign can state "We reserve the right to refuse the sale of certain harmful substances if we believe they are going to be used in a way other than the purpose for which they were intended".

## Immediate effects

Intoxication leads to a feeling of excitement. This intoxicating effect only lasts for a short time, usually less than an hour. Intoxication is similar to that of alcohol and may include:

- Erratic behaviour, unsteady gait, slurred speech, sensitivity to light, sneezing, coughing, impaired judgement, nausea and vomiting.
- Depression of body functions like breathing and heart rate.
- Feelings of relaxation.
- These effects are often followed by drowsiness. Repeated intoxication over a period of minutes or hours may lead to disorientation, loss of control, fits and unconsciousness.
- Afterwards the user may experience a mild hangover (headaches and poor concentration).

## Long term effects

Some studies have linked the heavy use of certain solvents and aerosols to liver, kidney and nerve damage. Temporary and permanent interference with brain functions has been reported, although permanent cases of brain damage are rare.

## Identifying the user

- Be aware of individuals standing around counters in stores or areas where aerosols or other solvent based products are displayed
- If you are worried or suspicious **Call the Police**
- Be aware of frequent purchases of solvent-based products and aerosols by the same individual
- Traces or smell of solvent on a person's clothes, or
- Other indications of solvent or substance use are red eyes, heightened colouring, reddening spots around the mouth and nose, uncontrolled excessive giggling and rowdy or silly behaviour

Produced by NorthEast Metropolitan Community Drug Service Team  
(The Juice, The Medicine Initiative on Alcohol and Addiction)





The inhaled solvents are rapidly absorbed through the lungs and quickly distributed to the brain and other organs. The effects therefore appear within minutes of inhalation and may last for 15 to 40 minutes. The user will feel dizzy for a period of 1 hour and suffer no more than a headache.

St John's Ambulance suggest using the DR-ABC method:

- D - Danger: Is self and others, remove plastic bag from face, check for other young people with the victim.
- R - Response: Call out to the person or nearby stable to assess consciousness.
- A - Airway: Check always, as not obstructed.
- B - Breathing: Check person is breathing.
- C - Circulation: Feel for a pulse.

***If a person is drowsy or unconscious:***

- Lay them on their side and make sure always are clear
- Make sure they are breathing fresh air
- Call an Ambulance if the person is unconscious, it is better to be safe than sorry
- If they stop breathing commence CPR immediately and continue to help arrive

***If the person is conscious:***

- Keep them calm and relaxed until they have completely sobered up
- Don't try to talk to them about their sniffing problems
- Don't chase them or get them stressed, this may lead to them having a cardiac arrest
- The important thing is for you to stay calm

**Q6. Should shop assistants be trained in how to deal with incidents?**

- A. Training of all staff members is an important part of addressing the issues of solvent use and the stealing of products from your shop. Each staff member should be given training in how to recognise and communicate with individuals who they suspect are solvent users. Each staff member must know their rights and responsibilities in the sale of solvent products. Situations that arise are best handled calmly and without fuss.

**Q7. What should I do if an individual becomes threatening?**

- A. Call the police. Retailers and staff should not put themselves in danger trying to prevent the sale or stealing of volatile substances from the shop. If an individual becomes agitated or angry do not engage him/her in an argument, call the police first, and then call the manager.

**Q8. What products are being used to sniff?**

- A. It is difficult for retailers to keep track of the entire range of solvents used. It is more important for retailers to keep the whole shop or properly safe rather than particular items.


**Q9. How do you recognise a solvent user?**

- A. Sometimes it is not easy to distinguish solvent users from other genuine customers. This makes it difficult for retailers to know if an individual wants a particular solvent product for legitimate purposes or for sniffing.

**Q10. What are some clues in identifying a possible solvent user in the store?**

- A. Watch out for groups of young people standing around counters or areas where solvents are displayed. Frequent purchase of solvents by the same individual. An obvious indicator of solvent use is the strong chemical smell on the users breath or clothing as well as a drowsy, vacant or glazed expression in the eyes. Requests for plastic bags at the same time as solvent-based products should raise your suspicions.

# Appendix 5b – Sunshine Chroming Awareness Program Traders’ Resource Kit



**TRADERS RESOURCE KIT**  
to address solvent use in the Sunshine shopping area.

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*Developed by the*  
Sunshine Chroming Awareness Group  
Salvation Army Crossroads  
Galaxy Project

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*Funded by the:*  
Commonwealth Government’s National  
Illicit Drug Strategy Community  
Partnerships Program.

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*Information drawn from the:*  
**Retailers Acting Against Solvent Abuse.**  
Resource Kit funded by the  
Western Australian Drug Abuse Strategy Office.

**SUNSHINE CHROMING AWARENESS GROUP**

The Sunshine Chroming Awareness Group was formed in November 1999, and includes representatives from:

- Sunshine Police (Youth Liaison Officer)
- Sunshine Youth Housing
- Sunshine Traders Association
- Salvation Army Westcare Alcohol and Drug Consultant
- Good Shepherd Youth & Family Services
- Westcare Residential Units
- Youth Outreach Team (Alcohol & Other Drug Program)
- IMYOS - MHSKY
- Rotary Club
- Department of Education Employment & Training
- Brimbank City Council
- ESCOR - Smorgon family

The group is coordinated by the Galaxy Project Worker in conjunction with Westcare.

The group has met regularly during 2000, and has spent time discussing the issue of chroming and developing ways to tackle the problem. This is one of the initiatives decided on by the group.

**AIM**

- to form a group with representatives from local community agencies and traders to develop an action strategy / pilot program to address chroming issues in the Sunshine Shopping areas.
- Document a best practice model for other communities to use when dealing with chroming and other commonly misused substances in their local areas.

## BENEFITS FOR RETAILERS IN MANAGING THE SALE OF SOLVENTS

- Reduced theft of solvents
- Deter intoxicated individuals from entering your store.
- Improve staff safety in the management of the sale of solvents.
- Improve compliance with occupational health and safety requirements.
- Customers do not feel threatened in the store.
- Positive public view of store as being community minded and socially responsible.

A RESPONSIBLE AND ETHICAL APPROACH TO  
REDUCING DRUG RELATED HARM IN THE  
COMMUNITY.



## WHAT CAN RETAILERS DO?

THERE ARE A NUMBER OF ACTIONS THE RETAILER CAN TAKE TO DETER POTENTIAL USERS FROM VIEWING THE SHOP AS A PLACE TO OBTAIN THE PRODUCTS THEY WANT.

RETAILERS CAN DEVELOP A VOLUNTARY CODE OF PRACTICE.

By developing a voluntary code of practice retailers can provide a service to their communities by limiting the opportunities for materials to be obtained for the purpose of solvent abuse. The code refers particularly to all solvents, glues, butane and other aerosols, particularly chrome paint.

The code encourages retailers to take reasonable steps to limit the likelihood of these materials being obtained for solvent abuse by such actions as appropriate to their circumstances, which may include any of the following:

- Identifying sensitive products in your store is the first important step.
- Educate and train yourself and your staff about solvent use, safety and management precautions.
- Keep local emergency numbers near the phone and / or programmed into the phone, and call from a visible point in the store.
- Displaying these materials in sight of shop staff, near tills, on high shelves, under the counter, or in locked display cabinets.
- Avoiding sale of products to children unless accompanied by adults.
- Identification of the purpose of frequent or large sales of product.
- Display of signs indicating your right to refuse sales.
- Politely refusing sale of these substances to those you suspect of being a solvent abuser.
- Undertake a signage program highlighting the fact that these products will not be sold to minors (Under 18)
- Network with retailers on a regular basis to keep informed about solvent users and the products they are seeking.

## SOLVENTS

There are numerous commercially available products containing potentially intoxicating inhalable solvents and aerosols. They are found in everyday products and as propellants in aerosols. Solvents and aerosols belong to a group of substances known as 'inhalants' because of the manner in which they are used. Other substances in this group include nitrites (amyl & butyl nitrite). Solvents and aerosols are described as 'volatile substances' because they are gases or give off fumes at room temperature.

### WHO USES SOLVENTS

Research indicates that individual solvent use is generally an experimental or temporary phenomena among some young people aged 7 - 18 years. There are three broad categories of young people who sniff chrome, glue or other solvents:

1. **The experimenter**  
The majority of young people fall into this category. They try it once or twice then stop by themselves.
2. **Social user**  
Usually done with a group of friends. The amount of using varies, depending on what else is going on in their lives.
3. **The long term / dependent user**  
A small number of people go on to use on a regular basis over a long time. These users usually have other major problems in their lives. They may sniff alone or with other people who use regularly.



## CHROMING

**Chroming means sniffing chrome based paint. Most users do this by spraying the paint from an aerosol can into a plastic bag then putting their face or entire head into the bag to inhale the vapors.**

### IMMEDIATE EFFECTS

- \* Erratic behavior, unsteady gait, slurred speech, sensitivity to light, sneezing, coughing, impaired judgement, nausea and vomiting.
- \* Unpleasant breath - after inhaling inhalants people often have the smell of the product on their breath.
- \* Nosebleeds and sores - Inhalants may also cause nosebleeds, bloodshot eyes and sores around the mouth and nose.
- \* Reckless behaviours - sometimes people do reckless or dangerous things after inhalants. This can cause serious accidents.
- \* Depression of body functions such as breathing and heart rate.
- \* Feelings of relaxation.
- \* These effects are usually followed by drowsiness. Repeated inhalation over a period of minutes or hours may lead to disorientation, loss of control, fits and unconsciousness.
- \* Afterwards the user may experience a hangover.

### LONG TERM EFFECTS

- \* Some studies have linked the heavy use of chrome and other certain solvents to liver, kidney and nerve damage.
- \* Temporary and permanent interference with brain functions has been reported, although permanent cases of brain damage are rare.
- \* A small number of people have died from using inhalants, and the associated behaviours that place them at high risk...

### GUIDELINES TO RETAILERS

**1. Is it illegal to sell solvents?**

At this stage there is no law against selling, buying or possessing solvent products in Australia. This is because many solvents have a legitimate use (i.e. petrol, glues, paint thinner, paint etc.) which them difficult to restrict to any member of the community.

**2. As a retailer do I have responsibility to not sell solvents to an individual whom I believe may be using them for purposes other than their intended use?**

Yes. Retailers and their staff are called upon to develop a moral and responsible approach to the sale of volatile substances. If the retailer and / or staff have reasons to believe that a particular compound is likely to cause harm or to be used for the purpose of intoxicification, then the decision not to sell should be supported.

**3. Is there any legislation that states that a shop owner has to sell solvents to customers?**

No. Retailers are often concerned that, if they do not sell particular products that they will be taken to court for discrimination or such. There has not been any recorded case of this happening. However, a retailer has the right to withdraw a particular item from sale if they so choose.

**4. Do retailers have the right to evict any individual from the store?**

Yes. The store manager has the right to ask any individual to leave the store. Particularly if an individual appears to be demonstrating unusual behaviour and / or has been known to cause problems or steal from the shop in the past.

**5. Should I display a sign indicating that solvent products will not be sold to any person under suspicious circumstances?**

Yes. A sign can state "We reserve the right to refuse the sale of certain harmful substances if we believe they are going to be used in a way other than the purpose for which they were intended."

### GUIDELINES TO RETAILERS

**6. Should shop assistants be trained in how to deal with incidents?**

Training of all staff members is an important part of addressing the issues of solvent abuse and the stealing of these products. Each staff member should receive training in how to recognise and communicate with individuals who they suspect are solvent abusers. Each staff member should also receive training in their rights and responsibilities regarding the sale of solvents. Situations are best handled calmly and without fuss.

**7. What products are being used to sniff?**

It is difficult for retailers to keep track of the entire range of solvents used. It is important for retailers to keep the whole shop or property safe rather than particular items.

**8. What are some clues in identifying a possible solvent abuser in the store?**

Watch out for individual or groups of young people standing around counters or areas where solvents are displayed.

Frequent purchase of solvents by the same individual.

An obvious indicator of solvent use is the strong chemical smell on the users breath or clothing as well as a drowsy, vacant or glazed expression in their eyes.

Requests for plastic bags at the same time as solvent based products should raise your suspicions.

**9. What should I do if an individual becomes threatening?**

**Call the Police.** Retailers and staff should not put themselves or customers in danger trying to prevent the sale or stealing of volatile substances from the shop. If an individual becomes agitated or angry, do not engage him / her in an argument, call the police first and then call the manager, or follow individual store protocols.

## WHAT TO DO IN A CRISIS:

If someone has an adverse reaction while using inhalants it is very important that they receive professional help as soon as possible. Quick responses can save lives.

- \* Immediately remove the plastic bag if one has been used.
- \* Call an ambulance. Dial 000. Don't delay.
- \* Stay with the person until the ambulance arrives. Ask for the nearest person in the shop, or at the scene who knows mouth to mouth resuscitation or cardiopulmonary resuscitation (CPR)
- \* Ensure adequate air by keeping the crowds back and opening windows where possible. Loosen tight clothing
- \* If the person is unconscious, don't leave them on their back - they could choke. Turn them on their side and into the recovery position. Gently tilt their head back so their tongue does not block the airway.
- \* If breathing has stopped, give mouth to mouth resuscitation if there is no pulse, apply CPR.
- \* Provide the ambulance officers with as much information as you can - what inhalants were taken, how long ago, other medical conditions if known.

This information is taken from the Australian Drug Foundation pamphlet - Inhalants - How Drugs Affect You, and is a guide only.

You must seek professional medical assistance immediately if someone has had an adverse reaction whilst abusing inhalants.



THE SUNSHINE CHROMING AWARENESS  
GROUP AND COMMUNITY THANK  
THOSE RETAILERS WHO  
HAVE ALREADY RESPONDED

- \* BUNNINGS WAREHOUSE - SUNSHINE
- \* SAFEWAY
- \* BIG W
- \* REJECT SHOP



**CONTACTS FOR FURTHER INFORMATION**

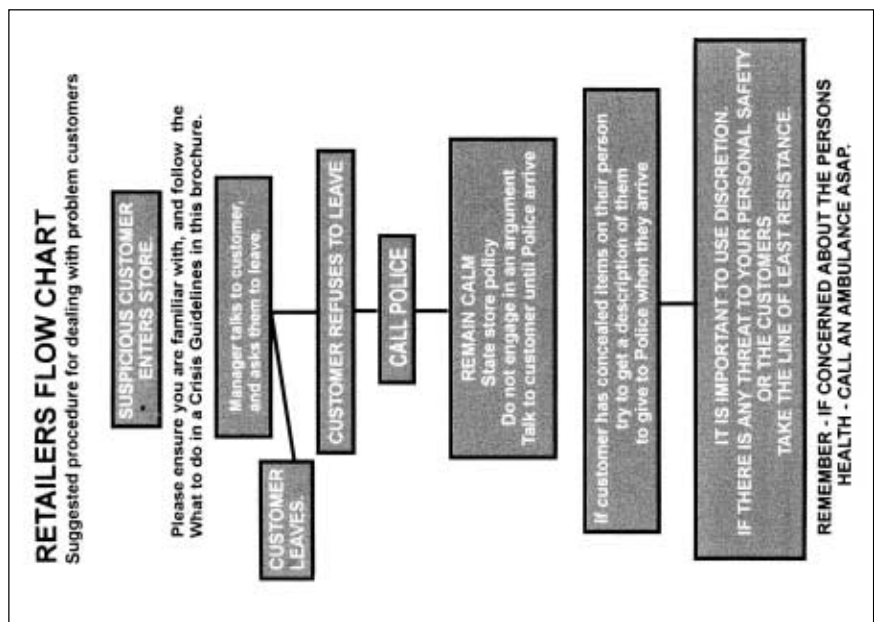
**TRAINING OR ASSISTANCE**

Sunshine Chroming Awareness Group.

- \* Salvation Army Crossroads Galaxy Project Coordinator - Lyn O'Grady (03) 9372 1877
- \* Salvation Army Westcare ICMS Alcohol & Other Drug Consultant - Steve Marchese (03) 9312 3544
- \* Youth Outreach Team - YOT. (Alcohol & Other Drug Program) Western Hospital - (03) 9317 2217
- \* Salvation Army Westcare Glenys Bristow (03) 9311 5261 Mobile: 0407 811 331.

For contact details for other Awareness Group members please contact the above.

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# Chroming alert

CHROMING in Swan Hill was an across the board problem for the city's young teenagers, according to drug and alcohol worker Al Mitton.

Working from the Swan Hill and District Aboriginal Co-operative, Mr Mitton said chroming, inhaling products such as paint to get high, was a cross-cultural practice.

Mr Mitton was responding to the announcement by

## Solvent abuse is highlighted

the State Government last week of an inquiry into chroming.

The Melbourne media reported that Swan Hill had a particular problem with chroming, and that paint had become "the drug of

choice among isolated and marginalised children, often Aboriginal".

"It's a problem here, but it's far from chronic," Mr Mitton said.

It was mainly done by teenagers who were

experimenting with different drugs, he said. He said teenagers from years seven to nine in school were the ones most often inhaling.

"That's when you become experimental and want to become part of a peer group."

He said the dangers of chroming included brain damage and death, and the effect it had on the central nervous system was irreversible.

Mr Mitton said chroming was a bigger problem in the western suburbs of

Melbourne, where he used to work, than here.

Because Swan Hill was a smaller city the problem was more visible, and became highlighted, he said.

Swan Hill District Hospital executive officer of clinical services Kathy Wright said the casualty department saw one or two cases resulting from chroming in a six month period.

"It is happening ... but it hasn't translated into appearances in Emergency" she said.

From the few cases the hospital does see, Mrs Wright said, "It is not something that is confined to the young Aboriginal population".

"Certainly that was the tone of The Age article, but our experience hasn't been that," she said.

Mr Mitton held a forum on the issue last month and is currently producing an education strategy on the matter, in consultation with health providers.

More reports – Page 3

*The Guardian (Swan Hill)* 21 May 2001, p. 1.



# Teens having fun

From — Page 1

With the help of local health officials, we have constructed the life of our fictitious Billy to illustrate how simply youth can fall into a pattern of abuse, an abuse which is eating out their brains.

Billy habitually skips a class after lunch.

He is neither black nor white, nor male or female — he can be any of these.

Billy meets up with friends who hide themselves from the public gaze.

Together they have discovered a cheap euphoria through abuse of readily-available solvents.



Warning poster

Billy starves his brain cells of oxygen and causes

irreversible damage.

He may feel less inhibited, excited, or drowsy.

Billy might also experience flu-like symptoms, sickness, nosebleeds and sores.

Up to an hour later the effect has worn off.

He goes home, straight to his room.

Billy changes his clothes, maybe sprays some deodorant around.

His parents notice he is sniffing.

He doesn't do it every day.

If Billy keeps doing it, the brain damage he is causing will increase.

He could burst blood vessels in his eyes, making

them completely red, and eventually leading to blindness.

If he is stealing, it's likely he will get into trouble with the law at an early age.

He is not addicted, he just wants to fit in, or likes the buzz, or has nothing better to do.

Billy is in trouble.

There are a number of people who can help him, or help his parents.

The druginfo line is a free-call, 1800 136 385, so is Youth Substance Abuse Service, 1800 014 446.

Locally, there is Koorie Community Alcohol and Drug Worker Al Mitton 5032 2265.

## Billy likes fun

BILLY is in his early teens.

Like his mates, he likes fun, he likes pushing the boundaries "just to see what would happen".

In fact, Billy is probably not much different from his parents who snuck a fag behind the shelter shed when they were his age, or a quite nip of an uncle's forgotten beer glass.

But today Billy has ready access to some of the most poisonous toxins man has produced.

Tell him, it'll kill him, he'll want to test it for himself just to make sure those domineering adults don't want to share a tasty secret.

Continued — Page 3

## Drug experiments

CHROME paint is "burning the brains" of Swan Hill's Koorie children who are choosing to experiment with drugs, according to local police.

A spokesman from the Swan Hill police station said police continue to see alcohol and drug abuse within the local Aboriginal community as a problem.

Children as young as 10 are experimenting with "chroming", sniffing chrome paint, under the Swan Hill bridge and at local parks.

A ring of paint left on their face, lethargy and disorientation are some of the tell tale signs of the dangerous past time.

The police officer said reports of chroming had been "fairly quiet of late".

"I dare say it is happening but the police haven't had direct involvement." Because buying and smelling paint is not an offence there is little local police can do to stop chroming.

"We have fought long and hard

against it," the spokesman said.

"Traders have recently been requested to store paint more securely and only supply on demand."

While substance sniffing and marijuana were the drugs of choice for the young, heroin and amphetamines were seen as a problem for adults.

Poor role models were blamed for the continuing problem.

"It is a lack of supervision and role models"

"Nine out of ten of the children 'chroming' see their parents smoking marijuana or something harder," he said.

He agreed more Koori children were "chroming" compared with non-indigenous children.

Referring to recent reports in the media of sexual abuse police said they could not gauge the problem because it was common for the Aboriginal community to keep cases of abuse to themselves.

### Chroming concerns

SIR,

I am extremely concerned at the misrepresentation in the article "Chroming Alert" in *The Guardian* on Monday, May 21, 2001.

My concern is the angle your paper has taken in regards to "glorifying" this very sensitive and dangerous practice.

I have been endeavoring to adopt a uniform approach to dealing with this matter, by adopting 'harm minimisation' strategies.

Your paper has omitted the majority of my conversation with the reporter. There are several quotes, which made up a combination of my conversation.

I have never mentioned 'inhalants' as a drug, they are as labelled, a 'poison'.

I went to great lengths in explaining the misuse of Volatile Substances, the educational objectives and the 'go no's' of media reporting. I have given your paper a copy of the "Australian Drug Foundation" guide to inhalants as a reference. You have even gone against the National Guide Lines for Drugs.

Your paper has no regard for the victims of this behavior and the young community of this area.

The practice of Volatile Substance Abuse is extremely dangerous and does irreversible damage to the body.

To quote "it is the drug of choice" and "inhaling products to get high" is morally wrong and shows no regard for the community.

To edit a "Health Related" article provided by a national organisation in regards to "life threatening behavior" is extremely senseless and shows a total ignorance of the matter.

Al Mitton,  
Swan Hill and District Aboriginal Co-Operative,  
SWAN HILL.

(Editor's note: We believe Mr Mitton's concerns are completely unfounded. Any reader

of our stories on Monday and last Friday's editorial will note our careful and cautionary approach to this sensitive issue. We did not identify Swan Hill as a chroming "hotspot" as other media have done, we have sought to alert parents that this horrifying abuse is not widespread locally, but is happening and we should be aware of it. We defend our right to alert parents to social and health issues which some professionals would prefer were swept under the carpet.)

*The Guardian* (Swan Hill) 23 May 2001.

# Appendix 7 – Chroming story, *The Wimmera Mail Times*

THE WIMMERA

# Mail-Times

MONDAY AUGUST 27 2001 VICTORIAN COUNTRY PRESS NEWSPAPER OF THE YEAR 90c inc GST



## Suicides spark city chroming warning

AN Aboriginal community justice worker has sounded an urgent warning about 'chroming' after linking the sniffing of inhalants to four suicides in Horsham this year.

Horsham-based Mary Moore said the potentially lethal practice of chroming — the inhaling of volatile substances including paint, petrol and glue — was becoming commonplace among Horsham's 15 to 25-year olds.

She told the Mail-Times that chroming was responsible for four suicides and an attempted suicide in the Wimmera capital in less than eight months.

And she issued an urgent plea for Horsham retailers to help address the problem by keeping a close check on items including spray paints and plastic bags.

Wimmera crime prevention officer Senior Constable Laurie Thomas supports her call for retailer vigilance and confirms that chroming is a problem among young people in the region and across Victoria.

Both Sen Const Thomas and Mrs Moore believe retailers must be aware of potential liability if someone injures or kills themselves by 'chroming'.

Mrs Moore said young people did not understand the lethal repercussions of using such potent substances.

She said chroming was an issue in both Aboriginal and non-Aboriginal communities.

"It's incredibly addictive. The fumes and toxins get into the brain making the users think they are able to fly," she said.

"I've come across people who have claimed they can fly and have tried to jump off roofs and walk in front of cars. This delirious state of mind gives

By JENNY SHAND and JANE MINTERN

users the unintentional ability to kill themselves."

Sen Const Thomas said police were concerned about spray products' availability and appreciated retailers' assistance in distributing products responsibly.

"But people should also be aware of the vicarious liability. It could be a matter of time before someone supplying these products to young people who hurt themselves are held responsible financially," he said.

"We advise retailers to put spray paint products out of

derived from petroleum, paint thinner and aerosol propellant. People found guilty of contravening the law face possible fines and jail.

Mrs Moore said young people had 'stolen' products for chroming from Horsham businesses for many years.

"They find it easy to steal products from Horsham businesses because there is limited surveillance. Retailers don't fuss about — can missing here and there, they don't realise it could be someone's life," she said.

Mrs Moore urged retailers to put surveillance systems in their stores, move paint products behind counters and keep a close watch on plastic bags in fruit and vegetable departments in supermarkets.

She asked retailers to be aware of potential chromers, saying the majority of users were unemployed.

"We need to crack down on this situation before it gets out of hand," Mrs Moore said.

She said symptoms retailers might notice among chromers included red eyes, facial abrasions and the smell of paint. Parents could watch for signs including red eyes, blood noses, confusion, poor concentration, insomnia and nightmares.

Horsham police first spoke out about the growing problem two years ago after the dangerous practice while not large scale, increased substantially in 12 months.

Police said at the time that youths sniffing inhalants risked death or brain damage, with users unable to control the 'dose' or its effects.

**'It's incredibly addictive'**  
Mary Moore

reach and behind sales counters to assist in preventing harm being done to young people. This would also assist in prevention of products being stolen."

Mrs Moore believes retailers must be aware of lost stock because they might be found liable if death or injury occurs by people using their products for chroming.

The Drugs, Poisons and Controlled Substances Act 1981 states that a person shall not sell a deleterious substance to another person if they know or believe the customer intends to drink, inhale, administer or otherwise introduce it into his body.

Deleterious substances include glue and volatile products

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