

Aboriginal Peak Organisations Northern Territory

An alliance of the CLC, NLC, CAALAS, NAAJA and AMSANT

APO NT Submission on the Alcohol Mandatory Treatment Act

February 2014

Contents

| | |
|---|----|
| Recommendations | 3 |
| About APO NT | 5 |
| Not under the influence of evidence: a sober critique of the AMT Bill | 5 |
| Reviewing the AMT Scheme | 6 |
| Transparency and data collection | 6 |
| APO NT Comments on the AMT Act | 7 |
| 1. Specific provision for review by the NT Government | 8 |
| 2. Treatment services..... | 14 |
| 3. Programs for alcohol and drug dependent offenders | 15 |
| 4. Interpreter services..... | 16 |
| 5. Culturally appropriate service delivery..... | 17 |
| 6. Aftercare plans..... | 19 |
| 7. Legal representation | 20 |

Recommendations

Recommendation 1: NT Government review legislation in order to ensure rights protections are in line with similar contemporary legislation in Australia, for example the *Severe Substance Dependence Treatment Act 2010* (Vic) and *Drug and Alcohol Treatment Act 2007* (NSW) (page 5).

Recommendation 2: That the referral avenue for the system is reviewed so it is based on health criteria, rather than referral by Police and that the NT Government look at other similar schemes in Victoria, or NSW as a model (page 7).

Recommendation 3: APO NT also recommends that the threshold contained in the AMT Act criteria under section 10(d) be raised to *extreme, immediate or severe* risk to the health, safety or welfare of the person. We also recommend that the criteria be included to ensure that all voluntary treatment options have been exhausted before resorting to mandatory treatment (page 8).

Recommendation 4: The 96 hour assessment period should not be extended or specified business hours only. We recommend referral and assessment come through medical pathways (see Recommendation 2) (page 9).

Recommendation 5: We recommend that the default length of an order imposed by the Tribunal be reduced to 14 days with any further extension only being possible if there is another full Tribunal hearing and there are special circumstances such as an alcohol and other drug brain injury or other medical complications that makes it difficult for the person to make a fully informed choice (page 9).

Recommendation 6: We recommend that funding for legal representatives, interpreters, Aboriginal liaison officers and Aboriginal health workers be provided (see below sections 4, 5 and 7) (page 10).

Recommendation 7: The time left on an order should not pause automatically rather treatment should be reviewed on basis of whether less restrictive treatment could be offered, and the capacity of the patient to make their own choice (page 10).

Recommendation 8: APO NT recommends that the provisions in section 72 relating to offences for absconding from mandatory treatment centre be removed (page 10).

Recommendation 9: We recommend that sections 131 and 133 be amended to provide that senior assessment clinicians and senior treatment clinicians must be both a prescribed medical practitioner *and* have relevant expertise in severe substance dependence and its treatment (page 11).

Recommendation 10: We recommend that there be adequate funding for legal representation, aftercare planning process, and interpreters for Aboriginal people at the AMT Tribunal (see sections 4,6 and 7 below) (page 13).

Recommendation 11: The NT Government consider additional safeguards contained in the Victorian and NSW legislation as outlined above (page 13).

Recommendation 12: That the NT Government provides additional health and other services through Aboriginal outreach services, such as those provided by Larrakia Nation, Kalano, Tangentyere Council (among others), and by Aboriginal community controlled health services to

reduce numbers of Aboriginal people accessing services through the AMT scheme, including but not limited to:

- additional night and day-time patrols;
- return to country programs;
- disability support services; and
- social and emotional wellbeing, alcohol and other drug and trauma programs, incorporated into primary health care There are SEWB and AOD services available to people in urban towns (although they are under resourced to met demand _ but very little available for people in remote communities particularly around alcohol and other drug problems. A minority of communities have residential AOD workers but many communities have no services at all (page 15).

Recommendation 13: The AMT Act should also stipulate that effective treatment will be provided to patients and that detention will not continue if effective treatment is not being provided (page 15).

Recommendation 14: That diversionary AOD treatment services be made available to people who are found to have committed their offences under the influence of alcohol, including by referral by the courts (page 15).

Recommendation 15: That there be training for all staff on how to properly use interpreters, particularly for staff who have no experience using interpreters (page 17).

Recommendation 16: We recommend that the AMT Act is amended to include a provision which recognises language and culture as special needs of a person which must be taken into consideration in delivery of treatment and preparation of aftercare plans (page 17).

Recommendation 17: We recommend that clients exiting the Alcohol Mandatory Treatment system be provided with an exit survey to obtain a picture of whether they understood the process which they have just been through (page 17).

Recommendation 18: We recommend that Aboriginal staff, in particular Aboriginal health workers, be employed in mandatory treatment centres wherever possible (page 19).

Recommendation 19: We recommend that Aboriginal liaison officers are employed in all mandatory treatment centres, similar to services in NT hospitals, to support Aboriginal people under the AMT scheme (page 19).

Recommendation 20: That the NT Government to ensure adequate funding for coordination with in ACCHSs to arrange for provision of after-care for persons detained under the AMT Act post-release (page 21).

Recommendation 21: It is recommended that the NT Government fund legal representation for Aboriginal people going before the AMT Tribunal (page 21).

About APO NT

Aboriginal Peak Organisations of the Northern Territory – APO NT – is an alliance comprising the Central Land Council (CLC), Northern Land Council (NLC), Aboriginal Medical Services Alliance of the NT (AMSANT), North Australian Aboriginal Justice Agency (NAAJA) and Central Australian Aboriginal Legal Aid Service (CAALAS). The alliance was created to provide a more effective response to key issues of joint interest and concern affecting Aboriginal people in the Northern Territory, including through advocating practical policy solutions to government. APO NT is committed to increasing Aboriginal involvement in policy development and implementation, and to expanding opportunities for Aboriginal community control. APO NT also seeks to strengthen networks between peak Aboriginal organisations and smaller regional Aboriginal organisations in the NT.

Not under the influence of evidence: a sober critique of the AMT Bill

APO NT made a submission on the Alcohol Mandatory Treatment Bill in May 2013. The submission contained a number of concerns about how the scheme would operate. Our submission outlined concerns about the process for developing the legislation and we believed it had been rushed through without proper consideration of the evidence-based underpinning the scheme. The majority of these concerns with the then Bill related to the lack of evidence informing the scheme. These concerns included the following:

- The need to have an approach informed by the underlying social determinants of health;
- The need to recognise health aspects of alcohol dependence;
- The need to recognise the role of trauma in alcohol misuse;
- Criminal penalties associated with mandatory rehabilitation will increase crime and imprisonment rates in the NT;
- The need for appropriate aftercare post release when people return to their community; and
- The desirability of promoting voluntary access to alcohol rehabilitation.

A copy of our submission on the AMT Bill “*Not under the influence of evidence: a sober critique of the AMT Bill*” ([Attachment 1](#)).

Alcohol dependence is recognised as a disease and is a complex problem that requires multi-pronged solutions in order to be addressed effectively. There is no quick fix. Our previous submission made a number of recommendations about alternatives to mandatory rehabilitation, and including increasing services for the homeless and reducing alcohol supply. APO NT held the Central Australian Grog Summit on 30-31 July 2013 in Alice Springs. The Summit heard from community members and experts on the best ways to address alcohol related harm. The Summit participants agreed on a number of priority areas for action including: reducing supply as a critical ‘circuit breaker’ in the fight against alcohol harm; focusing on holistic approaches in treatment, including addressing underlying causes; the need to act now to address FASD; and building stronger community-based approaches to addressing alcohol related harm. A report containing the outcomes from the Central Australian Grog Summit was prepared. A copy of the report is attached ([Attachment 2](#)).

Reviewing the AMT Scheme

Aboriginal Peak Organisation NT (APO NT) welcomes review of the Alcohol Mandatory Treatment Act (the AMT Act). It is imperative to continuously monitor and evaluate unprecedented schemes such as the AMT scheme, to ensure that they are meeting their objectives.

The AMT Act review documentation states that *“It is not the intent of this review to evaluate the AMT program or client outcomes; rather the review will focus on the legislation and its practical application in order to identify areas for improvement.”* The legislation itself was design to facilitate execution of the AMT program. The AMT program outcomes and the legislation are inextricably linked. It appears therefore to be an arbitrary distinction to make between the legislation which facilitates the scheme, and the scheme itself.

Further, section 3 of the AMT Act contains the Objects of the AMT Act:

The objects of this Act are to assist and protect from harm mis-users of alcohol, and other persons, by providing for the mandatory assessment, treatment and management of those mis-users with the aim of:

- (a) stabilising and improving their health; and*
- (b) improving their social functioning through appropriate therapeutic and other life and work skills interventions; and*
- (c) restoring their capacity to make decisions about their alcohol use and personal welfare;*
and
- (d) improving their access to ongoing treatment to reduce the risk of relapse.*

We believe that with no in-built system of evaluation against these objectives, it is difficult to assess to what degree the AMT Act is meeting its function. APO NT believes that ‘operationalising’ the AMT Act should mean implementing it in a way that can be measured.

Further, the AMT Act is not in line with similar contemporary legislation in New South Wales and Victoria, nor with similar legislation in the Northern Territory, such as the *Mental Health and Related Services Act*. The rights protections offered in those schemes are greater than those offered under the scheme in place under the AMT Act currently.

Recommendation 1: NT Government review legislation in order to ensure rights protections are in line with similar contemporary legislation in Australia, for example the *Severe Substance Dependence Treatment Act 2010 (Vic)* and *Drug and Alcohol Treatment Act 2007 (NSW)*.

Transparency and data collection

APO NT considers that the NT Government has an obligation to provide greater public access to data in relation to the AMT scheme. As mentioned above, the review documentation states that *“the review will focus on the legislation and its practical application in order to identify areas for improvement.”* There is currently a lack of transparency in relation to a number of aspects of the scheme which means it would be difficult for anyone other than the NT Government and providers of the mandatory treatment services to assess its practical application.

Further, we understand that the NT Government intends to undertake an evaluation of the AMT program which will consider broader client outcomes later in 2014. Similarly, this evaluation will only

be meaningful if there is appropriate public reporting on the scheme. At present there is no information about:

- Types of treatments available;
- Numbers of people absconding from mandatory rehabilitation;
- Numbers of people who have been through the mandatory rehabilitation process more than once;
- The number of people who were represented by an advocate or legal practitioner before the Tribunal;
- The number of people who received access to an interpreter to prepare for, and appear before, the Tribunal;
- The average number of days a person was detained pending a Tribunal decision;
- Numbers of Aboriginal staff employed by mandatory rehabilitation centres;
- Proportion of staff employed who have formal qualifications in AOD treatment or related fields; and
- Number of staff employed with specific expertise (clinical psychologists, social workers, Aboriginal AOD workers etc).

APO NT looks forward to the outcomes based evaluation of the AMT Act later in 2014.

APO NT Comments on the AMT Act

APO NT has stated its ongoing concerns with the scheme, and with the current process for review. However, as the NT Government has decided to proceed with the AMT scheme and the review under the current process, we would like to make the following recommendations in relation to:

1. Specific provisions for review by the NT Government;
2. Treatment services;
3. Programs for alcohol and drug dependent offenders;
4. Interpreter services;
5. Culturally appropriate services delivery;
6. Aftercare plans; and
7. Legal representation before the Tribunal.

1. Specific provision for review by the NT Government

This submission will address the considerations for the AMT Act Review as outlined in the NT Government submission package and additional specific provision which APO NT considers should be reviewed.

| Section | APO NT Comments |
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| <p>1. Assessable persons (Part 2, Section 8)</p> | <p>APO NT believes that there should be other avenues to enter the AMT scheme which are more appropriate than via contact with the Police. Currently, the AMT scheme disproportionately targets (almost solely) Aboriginal people. We believe this reflects the tendency of police to target Aboriginal people in public spaces. APONT is concerned that the current entry point to the scheme and assessment process is not sufficiently targeted to those with alcohol dependence. This may mean that people experiencing homelessness or who drinking in public places may unnecessarily be caught up in the scheme.</p> <p>Under other similar schemes referrals to treatment are made by health professionals rather than police. We recommend that the NT Government consider provisions in similar schemes in Victoria and New South Wales (NSW) substance abuse legislation which provides for health based referrals.¹</p> <p>Both Acts include substance dependence from alcohol but also other drugs. Neither the <i>Severe Substance Dependence Treatment Act 2010</i> (Vic) (the Victorian Act) nor the <i>Drug and Alcohol Treatment Act 2007</i> (NSW) (the NSW Act) is based on being apprehended by the police for public drunkenness.</p> <p>It should be noted that allowing more avenues of referral should not mean sending greater numbers to mandatory rehabilitation, rather there should be strict criteria along with wider catchment of appropriate referrals.</p> <p>APO NT notes that the amendment to allow for medical referral pathways rather than referral through apprehension by Police will reduce the resource pressures currently placed on NT Police through the AMT scheme.</p> <p><u>Recommendation 2:</u> That the referral avenue for the system is reviewed so it is based on health criteria, rather than referral by Police and that the NT Government look at other similar schemes in Victoria, or NSW as a model.</p> |
| <p>Criteria (section 10)</p> | <p>The threshold for becoming subject to involuntary detention on the basis on substance dependence is also much lower under the AMT Act criteria than in Victoria and NSW.</p> <p>The Victorian Act requires that a person has severe substance dependence and that treatment is required immediately because of an urgent severe threat to the person’s life or to their health; that all other</p> |

¹ *Severe Substance Dependence Treatment Act 2010* (Vic) section 12 and *Drug and Alcohol Treatment Act 2007* (NSW) sections 6 and 9

| Section | APO NT Comments |
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| | <p>treatment options have been exhausted; and there is no less restrictive means of providing treatment.² The NSW Act also requires that the person has a severe substance dependence with care required to prevent <i>serious</i> harm to the person; the person is likely to benefit from the treatment and has refused voluntary treatment; and there is no other less restrictive means of receiving treatment.³ The words such as ‘immediate’, ‘urgent’, ‘severe’ and ‘serious’ are not included in the AMT Act, which means the threshold for detaining someone is lower than in Victoria or NSW. Further, the AMT Act does not require that other voluntary treatment options be exhausted, and this is probably largely due to the fact that people enter the scheme through interactions with Police rather than health professionals.</p> <p>Recommendation 3: APO NT also recommends that the threshold contained in the AMT Act criteria under section 10(d) be raised to <i>extreme, immediate or severe</i> risk to the health, safety or welfare of the person. We also recommend that the criteria be included to ensure that all voluntary treatment options have been exhausted before resorting to mandatory treatment.</p> |
| <p>2. Timing of assessment (section 17)</p> | <p>The scheme deprives vulnerable individuals of their liberty for extended periods. According to comments made by Department of Health staff during consultations on the Act, assessment frequently does take the full 9 days permitted under the Act.</p> <p>Section 6 of the AMT Act provides for the principles underpinning the legislation. This section states that involuntary detention and involuntary treatment of a person are to be used <i>only as a last resort when less restrictive interventions are not likely to be effective or sufficient to remediate the risks presented by the person</i>; and the <i>least restrictive interventions</i> are to be used when a person is being treated or dealt with under this Act. The principle that the Government has an obligation to explore all other less restrictive options before detaining someone against their will is based on fundamental human rights principles.</p> <p>Detaining someone for the purposes of treatment against their will is the most restrictive intervention possible for individual, and should therefore be limited to the shortest possible timeframe.</p> <p>In Victoria the Magistrates Court considers the order to detain a person within 72 hours of filing of an application for a detention and treatment order.⁴ This shorter time period in recently reviewed legislation in Victoria is in line with rights protections for persons detained.</p> <p>We note that management of acute withdrawal requiring medical intervention would be easier if the Act allowed for a new referral pathway through medical practitioners.</p> |

² *Severe Substance Dependence Treatment Act 2010* (Vic) section 8

³ *Drug and Alcohol Treatment Act 2007* (NSW) section 9

⁴ *Severe Substance Dependence Treatment Act 2010* (Vic) section 15

| Section | APO NT Comments |
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| | <p><u>Recommendation 4:</u> The 96 hour assessment period should not be extended or specified business hours only. We recommend referral and assessment come through medical pathways (see Recommendation 2).</p> |
| <p>3. Default length of orders</p> | <p>The Victorian Act allows for 14 days for a detention and treatment order without further review.⁵ Whilst the NSW Act allows for 28 days with extension only possible if the person has a brain injury due to alcohol and /or drug use. The NSW Act requires review by a Magistrate as soon as practicable.⁶ Both Acts require review of the case in the Magistrates Court.</p> <p>Rather than starting with a longer period such as three months outlined in section 49 of the Act, and then allowing for exceptions to this, we recommend that the default period for AMT orders should be of a shorter duration.</p> <p>As it should be clear within 14 days if the person is likely to benefit from mandatory treatment and /or if the person would engage voluntarily in treatment as opposed to having involuntary treatment, then the 14 day order should be the default order made. This order should be able to be extended in special circumstances such as an alcohol and other drug brain injury or other medical complications that makes it difficult for the person to make a fully informed choice.</p> <p>By providing for an order of shorter duration with an option to extend, this would allow for the AMT Act to offer greater rights protections for those detained under the Act.</p> <p><u>Recommendation 5:</u> We recommend that the default length of an order imposed by the Tribunal be reduced to 14 days with any further extension only being possible if there is another full Tribunal hearing and there are special circumstances such as an alcohol and other drug brain injury or other medical complications that makes it difficult for the person to make a fully informed choice.</p> |
| <p>4. AMT Tribunal (Part 3)</p> | <p>The challenges in relation to finding interpreters, advocates and Tribunal panel members within this time, may be overcome if other recommendations made in this submission are adopted by the NT Government.</p> <p>As outlined above, we believe that given the seriousness of detaining someone against their will, it is important that people are brought before the Tribunal as soon as possible. This is in accordance with the principles in the Act relating to least restrictive treatment.</p> <p>The recommendation below in relation to funding of legal representatives, interpreters, Aboriginal liaison officers and Aboriginal health workers will reduce the time needed to set up a hearing. If the NT Government wants to maintain a scheme which is human rights compliant, they will need to ensure adequate funding of components</p> |

⁵ Substance Dependence Treatment Act 2010 (Vic) section 20

⁶ Drug and Alcohol Treatment Act 2007 (NSW) section 14

| Section | APO NT Comments |
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| | <p>complementary to the scheme.</p> <p>Recommendation 6: We recommend that funding for legal representatives, interpreters, Aboriginal liaison officers and Aboriginal health workers be provided (see below sections 4, 5 and 7).</p> |
| <p>5. Leave of absence</p> | <p>There needs to be flexibility in the legislation to allow for leaves of absence as assessed by a clinician on a case by case basis.</p> <p>Most people with alcohol dependence benefit from longer term treatment but that does not mean that the <i>mandatory</i> treatment needs to be long term. Treatment should be reviewed on the basis of whether less restrictive treatment could be offered, and the capacity of the patient to make their choice. The treatment time should be determined for the individual and on the principle that coerced treatment should only continue if the criteria for involuntary treatment are still met, and not for an arbitrary three month period. Such criteria include: that the patient would not consent to voluntary treatment; they are at high risk of severe harm to their health and/or death without treatment; and the patient has the capacity to benefit from mandatory treatment.⁷ For the same reasons, stopping and starting the term of an order when a patient is away from a facility is also baseless.</p> <p>Recommendation 7: The time left on an order should not pause automatically rather treatment should be reviewed on basis of whether less restrictive treatment could be offered, and the capacity of the patient to make their own choice.</p> |
| <p>6. Offence provision – absconding (section 72)</p> | <p>There are other ways to ensure participation in mandated schemes without criminalising absconding behaviour. The <i>Volatile Substance Abuse Prevention Act</i> (the VSAP Act) provides a system to compel people to attend treatment without criminalising behaviour, an approach consistent with the NSW and Victorian Acts. Under the VSAP Act, where a person fails to participate in a court ordered treatment program or absconds, a warrant can be applied for to compel the person to attend.⁸ There is no criminal penalty for failing to participate or absconding.</p> <p>Under the Victorian and NSW Acts a person may be apprehended if they leave the treatment centre without permission, however the act of leaving the centre without permission does not attract a penalty of any kind.⁹ The AMT Act provisions criminalising absconding is therefore not in line with similar legislation in other jurisdictions.</p> <p>Recommendation 8: APO NT recommends that the provisions in section 72 relating to offences for absconding from mandatory treatment centre be removed.</p> |

⁷ *Drug and Alcohol Treatment Act 2007* (NSW) section 9; *Severe Substance Dependence Treatment Act 2010* (Vic) section 8;

⁸ Sections 41A, 41B, 41C VSAP Act: Persons authorised to seek a warrant include VSA assessors, police officers, authorised officers, the Chief Health Officer, or a legal representative of the above mentioned persons.

⁹ Section 22 *Drug and Alcohol Treatment Act 2007* (NSW) and section 34 *Severe Substance Dependence Treatment Act 2010* (Vic)

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| <p>7. Senior Assessment and Treatment Clinicians (sections 131 and 133)</p> | <p>The Victorian and NSW Acts provide clear criteria about the qualifications of senior clinicians who provide recommendations about involuntary treatment. In both the NSW and Victorian Acts, this person must be a prescribed medical practitioner and have relevant expertise in severe substance dependence and its treatment¹⁰.</p> <p>The AMT Act currently provides that a senior assessment clinician and senior treatment clinician be either: a medical practitioner; or a person who, in the CEO's opinion, holds a qualification and has qualification or experience appropriate for the assessment or treatment of persons for misuse of alcohol. This means that in the NT the senior clinician is not held to an objective standard of expertise or training in assessment or treatment of persons for alcohol misuse. The person may also be someone other than a medical practitioner.</p> <p>APO NT members are concerned that these provisions do not ensure an adequate level of both qualification and experience, about that assessments may be conducted by a person who is either a medical practitioner or has the relevant expertise or qualification but does not have both. This position is clearly not in line with other similar schemes in Australia.</p> <p><u>Recommendation 9:</u> We recommend that sections 131 and 133 be amended to provide that senior assessment clinicians and senior treatment clinicians must be both a prescribed medical practitioner and have relevant expertise in severe substance dependence and its treatment.</p> |
| <p>8. Protection of rights</p> | <p>There are a number of rights protections in the AMT Act which APO NT is concerned may not be adequately funded. Without adequate funding there are components of the existing right protections, such as legal representation, aftercare plans, and interpreters, which are not available in practice. These concerns are outlined in more detail below.</p> <p>There are also a number of additional rights protections in similar legislation in Victorian and NSW which are not contained in the AMT Act. The Human Rights Law Resource Centre made a number of recommendations in relation to the Severe Substance Dependence and Treatment Bill (later the <i>Severe Substance Dependence and Treatment Act 2010</i> (Vic)). These recommendation are intended to ensure that the limitations on human rights imposed was reasonable and proportionate including that:</p> <ul style="list-style-type: none"> • if the Bill is to be compatible with the Charter, the Minister must provide strong empirical evidence to support the effectiveness of involuntary detention and treatment; • the Government should substantially improve access to voluntary drug treatment programs; • individuals must not be made subject to a detention and treatment order in instances where they retain legal capacity and |

¹⁰ See for example section 7 *Severe Substance Dependence Treatment Act 2010* (Vic)

| Section | APO NT Comments |
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| | <p>choose to refuse treatment;</p> <ul style="list-style-type: none"> • all persons subject to a detention and treatment order must have effective access to legal representation and advocacy support; and • the Bill should be amended to guarantee that persons made subject to a detention and treatment order can access voluntary treatment services once the order has expired.¹¹ <p>Whilst the NT does not have a human rights Charter, all of the above recommended safeguards would be of assistance in providing greater rights protections under the AMT scheme. We would recommend that the NT Government consider all of the above recommendations in relation to the AMT Act. Both the Victorian and the NSW Acts provide stronger protections for patients' rights than the NT Act. These protections include:</p> <ul style="list-style-type: none"> • Capacity to ask for a second opinion from a suitably qualified medical practitioner with experience in severe substance dependence (Victoria);¹² • Public Advocate to be involved in all cases (Victoria); • Review of all cases by a Magistrates court (Victoria and NSW); • Client able to ask for early review of their case; • Clear criteria about the qualifications of senior clinicians who provide recommendations about involuntary treatment. In both the NSW and Victorian Acts, this person must be a prescribed medical practitioner with experience in severe substance dependence or, in the case of Victoria, a nurse practitioner delegated by the prescribed medical practitioner; and • A clear complaints mechanism. While one channel of complaint exists in the NT through the community visitors scheme, there should be an alternative clear mechanism if the patient does not wish to use the community visitors scheme. <p>Recommendation 10: We recommend that there be adequate funding for legal representation, aftercare planning process, and interpreters for Aboriginal people at the AMT Tribunal (see sections 4,6 and 7 below).</p> <p>Recommendation 11: The NT Government consider additional safeguards contained in the Victorian and NSW legislation as outlined above.</p> |

¹¹ Human Rights Law Resource Centre (2010) "Severe Substance Dependence and Treatment Bill 2009 Submission to the Scrutiny of Acts and Regulations Committee", <http://www.hrlrc.org.au/files/HRLRC-Submission-Substance-Dependence-Bill.pdf> accessed 11 February 2014

¹² Section 31 *Severe Substance Dependence Treatment Act 2010* (Vic)

2. Treatment services

APO NT is concerned about the range of treatment options available outside of the AMT treatment centres. We understand that Addictive Medicine Specialist Lee Nixon, who resigned from working with the AMT program in December 2013, expressing concerns about the effectiveness of the scheme. He was quoted as saying that: "I fail to see how it can possibly have any long-term effects as long as there is no attention being paid to changing the drivers of drinking."¹³

APO NT believes these 'drivers' of change include wider factors such as underlying trauma, and without addressing these factors through treatment the scheme is unlikely to have any lasting effects in terms of rehabilitation of alcohol dependent persons.

As outlined in our previous submission on the AMT Bill, the Northern Territory currently does not offer sufficient access to alcohol treatment and complementary services which could provide less restrictive options to persons now falling within the scope of the AMT Act. The criteria as they are currently worded apply to a fairly small group of people – many of whom sleep rough and make use of public spaces whilst in towns. APO NT has also outlined previously that the reality of continuing numbers of homeless and those living rough or in the Long Grass requires a response by government to provide additional services to reduce avoidable harms and to provide basic facilities, including access to health care and other services.

The current criteria for treatment also apply to a fairly small group of people, many of whom may experience hearing loss, cognitive impairment or other physical and mental health problems. The number of persons who may be entering the system with some form of disability is not known as this data is not available, however we understand that this number may be quite high. Persons entering the AMT scheme some forms of disability, such as a cognitive impairment, would have limited capacity to benefit from mandatory alcohol treatment. There is therefore a need to ensure that alternative sources of long term support are available for clients who will not benefit from mandatory rehabilitation.

Further, section 6 of the AMT Act provides that "involuntary detention and involuntary treatment of a person are to be ***used only as a last resort when less restrictive interventions*** are not likely to be effective or sufficient to remediate the risks presented by the person." The criteria for a mandatory treatment order set in section 10 of the AMT Act states that the order must only be made where "*there are no less restrictive interventions reasonably available.*" In practice, for some Aboriginal people from remote communities, treatment at a mandatory treatment centre would be the *only* treatment option. There are currently voluntary residential treatment options available in Darwin, Katherine, Alice Springs, Tennant Creek and Nhulunbuy, however there are no spaces in these services. This means that without Government funded treatment services and complementary programs available in many parts of the NT, mandatory treatment becomes the default option.

The AMT Act should also stipulate that effective treatment will be provided to patients whilst they are detained under the AMT Act and that detention will not continue if effective treatment is not being provided. This should encompass treatment which is both culturally and clinically effective.

¹³ Coggan, Michael (2013) "Specialist doctor quits NT alcohol rehabilitation program in protest", *ABC News*, Friday 6 December 2013, <http://www.abc.net.au/news/2013-11-29/nt-doctor-quits-alcohol-rehab-program/5123996> accessed 31 January 2014

The Victorian Act¹⁴ refers to ensuring effectiveness of treatment in the provision of treatment. At present, the AMT Act does not currently make reference to the need to ensure treatment is effective.

Recommendation 12: That the NT Government provides additional health and other services through Aboriginal outreach services, such as those provided by Larrakia Nation, Kalano, Tangentyere Council (among others), and by Aboriginal community controlled health services to reduce numbers of Aboriginal people accessing services through the AMT scheme, including but not limited to:

- additional night and day-time patrols;
- return to country programs;
- disability support services; and
- social and emotional wellbeing, alcohol and other drug and trauma programs, incorporated into primary health care There are SEWB and AOD services available to people in urban towns (although they are under resourced to met demand _ but very little available for people in remote communities particularly around alcohol and other drug problems. A minority of communities have residential AOD workers but many communities have no services at all.

Recommendation 13: The AMT Act should also stipulate that effective treatment will be provided to patients and that detention will not continue if effective treatment is not being provided.

3. Programs for alcohol and drug dependent offenders

In July 2013, the then Chief Magistrate Hilary Hannam pointed out that after the scrapping of the SMART Court:

“We have now nothing in the court system, not a single program, not for drugs, not for illicit drugs, not for alcohol, not for mental health, not for Indigenous people.”¹⁵

As the Chief Magistrate lamented this puts us behind all other states and territories. Last year, APO NT called on the NT Government to include more diversionary options for courts. We call on the NT Government to introduce properly resourced, evidence based programs to help people break the cycle of offending and reoffending.

People charged with an offence are not able to be referred to any treatment program, including mandatory treatment under the AMT scheme, and this applies even to non-violent offenders.¹⁶ APO NT considers that there should be therapeutic or treatment options available to courts in the NT.

Recommendation 14: That diversionary AOD treatment services be made available to people who are found to have committed their offences under the influence of alcohol, including by referral by the courts.

¹⁴ Section 28 *Severe Substance Dependence Treatment Act 2010* (Vic)

¹⁵ Timms, Penny (2013) “Chief Magistrate Takes Aim at NT Justice System” *ABC New*, 1 July 2013, <http://www.abc.net.au/news/2013-07-01/outgoing-chief-magistrate-takes-aim-at-nt-justice-system/4792056>

¹⁶ Section 9(2)(a) *Alcohol Mandatory Treatment Act NT*

4. Interpreter services

APO NT is concerned about the access to and use of interpreters under the operation of the AMT Act. We understand from statistics released by the NT Government that all but one client of the AMT has been Aboriginal. This highlights the need to be pro-active in making sure that interpreters are being used effectively under the AMT scheme.

There is academic research conducted in the NT that suggests that there are often difficulties in communicating with Aboriginal people in the health and legal system. A study from the Alice Springs hospital found that:

“Miscommunication and alienation frequently follow contact between Aboriginal patients and hospitals. In the present study, the hospital environment trouble many patients and few understood the reasons for admission suggesting that doctors were often unable to impart even basic medical concepts to their Aboriginal patients.”¹⁷

The only mention of interpreters in the AMT Act is in relation to the AMT Tribunal hearing. There needs to be recognition of the importance of language and culture as special needs of a person which must be taken into consideration in the delivery of treatment and aftercare planning under the AMT scheme. For instance under the Victorian Act¹⁸:

The following principles apply to the provision of treatment to the person and the preparation of a discharge plan for the person under this Act—

- (e) the person must be involved in decisions about his or her treatment and discharge planning and must be given sufficient information and supported where necessary, to enable this to occur;*
- (f) the age-related, gender-related, religious, cultural, language, and other special needs of the person must be taken into consideration;*
- (g) the role of families and other persons who are significant in the life of the person must be considered and respected.*

We recommend that the provisions in the Victorian legislation be used as a guide for inclusion of additional provisions relating to culture and language as they relate to *treatment* in the AMT Act. We also recommend that the provisions in the Victorian legislation be used as a guide for additional consent provisions in the AMT Act. The AMT Act should ensure that patients detained under the AMT scheme are required to be involved in decisions about their treatment and care. Given the fact that most people detained under the AMT scheme are Aboriginal and that there are many Aboriginal languages spoken the NT, involving a person in decisions about their treatment and care would necessarily involve adequate access to interpreters.

We understand anecdotally that people are being discharged now because no interpreter is available to assist. There needs to be adequate support offered to people who are discharged due to language difficulties. This may include referral to culturally appropriate voluntary alcohol rehabilitation services, or to other appropriate services.

¹⁷ Einsiedel, Lloyd et al. (2013) “Self-discharge by adult Aboriginal patients at Alice Springs Hospital, Central Australia: insights from a prospective cohort study”, *Australian Health Review*, 37, p.244

¹⁸ Section 28 (3) *Severe Substance Dependence Treatment Act 2010* (Vic)

Recommendation 15: That there be training for all staff on how to properly use interpreters, particularly for staff who have no experience using interpreters.

Recommendation 16: We recommend that the AMT Act is amended to include a provision which recognises language and culture as special needs of a person which must be taken into consideration in delivery of treatment and preparation of aftercare plans.

Recommendation 17: We recommend that clients exiting the Alcohol Mandatory Treatment system be provided with an exit survey to obtain a picture of whether they understood the process which they have just been through.

5. Culturally appropriate service delivery

In our previous submission in May 2013, APO NT suggested that the AMT scheme needed to accommodate the needs of Aboriginal clients. We understand from statistics released by the NT Government that all but one client of the AMT has been Aboriginal. This highlights the need to be pro-active in making sure the services provided as part of the AMT scheme are culturally appropriate.

This problem can be overcome by putting in place important cultural safety practices which recognise the problems associated with providing health services to Aboriginal people whose first language may not be English:

“Aboriginal Liaison led to significant reductions in the self-discharge rates and enhanced institutional cultural safety more generally may also increase service utilisation by a population that has little confidence in hospitals.”¹⁹

It has also been noted by Dunbar that:

The need for improvement to services at the structural and systemic levels, and how the institution supports staff to provide culturally secure quality health and family services, is critical in the NT... Staff power, miscommunication and lack of cultural knowledge have been identified as central to disparities of quality health and family service outcomes experienced by Aboriginal people...²⁰

The Aboriginal Liaison services provided at hospitals in the NT need to also be provided in the mandatory rehabilitation centres in the NT to prevent miscommunication and to supplement cultural knowledge.

Dunbar et al. have undertaken a study in the NT to examine better ways to allow for culturally secure delivery of health care services to Aboriginal people in the NT.²¹ We recommended that the NT Government review this study as an example of culturally safe treatment service design.

There are a number of alcohol residential treatment programs in the NT which have adopted a culturally appropriate approach in treatment, including:

¹⁹ Einsiedel, Lloyd et al. (2013) op cit, p. 244

²⁰ Dunbar, Terry (2011) “Aboriginal People’s Experiences of Health and Family Services in the Northern Territory”, *International Journal of Critical Indigenous Studies*, Volume 4, Number 2, p.12

²¹ See T Dunbar et al. *Cultural Security: Perspectives from Aboriginal people*

- Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD)²²
- Council for Aboriginal Alcohol Program Services (CAAPS)²³
- Central Australian Aboriginal Alcohol Programs Unit (CAAAPU).²⁴

This is an important aspect of the scheme, as studies have shown that interventions that are effective in reducing substance misuse in the wider population do not necessarily translate similarly amongst Indigenous Australians.²⁵ This may be attributed to the fact that Indigenous healing is based on a much more holistic plane as compared to Western biomedicine.²⁶ It is therefore unsurprising that a large factor behind the success of these programs is attributed to their holistic approach. A good example of holistic treatment is CAAPS. The family orientated treatment program provides stability within the family, whilst also encouraging intergenerational healing to take place.

The treatment scheme as outlined in the AMT Act does not have any explicit link to culturally supported models of treatment, although we note that some treatment providers (such as CAAAPU) do adopt culturally appropriate strategies. There are a disproportionate number of Aboriginal people being treated under the AMT Act, and as such the scheme must incorporate support for Aboriginal peoples' culture and language.

The benefits for Aboriginal Health Workers in health care for Aboriginal people are well known in the NT. In his speech launching the Year of the Aboriginal Health Worker, AMSANT CEO John Paterson stated that²⁷:

For over three decades, Aboriginal Health Workers have been at the heart of the Aboriginal Primary Health Care system as registered health practitioners. Uniquely in Australia, Territory Aboriginal Health Workers are professional clinicians as well as providing other health system roles.

Crucially, our Aboriginal Health Workers are the primary source of advice to non-Aboriginal health professionals, at the front line of cultural safety and with intimate knowledge of how communities work and therefore how to best deliver health services across our health system, from remote communities to hospitals.

But most importantly, Aboriginal Health Workers: you are our family, you are our friends, you are our leaders. You are us.

The benefits of receiving treatment from health workers who not only speak the language of Aboriginal people, but understand their community life and where they have come from cannot be underestimated. This approach should underpin any therapeutic approach to the treatment of alcohol dependence.

²² Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties, (2010), <http://www.forward.com.au/history.html>, [Accessed 26 February 2013]

²³ Council for Aboriginal Alcohol Services Inc (2013): CAAPS [Online] http://www.caaps.org.au/index.php?option=com_content&view=article&id=8&Itemid=8, [Accessed 15 February 2013]

²⁴ CAAAPU A Place of Health, Hope& Healing (2012), CAAPU, [online] <http://www.caaapu.org.au/>, [Accessed 25th February 2013]

²⁵ Gray, D., Sagers, S., Wilkes E., Allsop, S., Ober C. (2010) 'Managing Alcohol Related Problems Amongst Indigenous Australians: What the Literature Tells Us' Australian and New Zealand Journal of Public Health; 34; 34-35

²⁶ Ypinazar, V.A., Margolis, S.A., Haswell-Elkins, M., Tsey, K.(2007): Indigenous Australians' Understandings Regarding Mental Health and Disorders, Australian and New Zealand Journal of Pyschiatry, 41(6):467-478

²⁷ John Paterson (2011) "Closing the Gap Through Caring and Sharing for Our People", Aboriginal Medical Services Alliance of the NT, [http://amsant.org.au/attachments/article/95/110901-Speech-JP Launch%20of%20YAHW%202011.pdf](http://amsant.org.au/attachments/article/95/110901-Speech-JP%20Launch%20of%20YAHW%202011.pdf)

We also understand, anecdotally, that there have been difficulties contacting family of people detained under the AMT Act, and that this may mean that family members are not being told about family members being detained. This may be addressed through better use of interpreters and more culturally appropriate services delivery.

Recommendation 18: We recommend that Aboriginal staff, in particular Aboriginal health workers, be employed in mandatory treatment centres wherever possible.

Recommendation 19: We recommend that Aboriginal liaison officers are employed in all mandatory treatment centres, similar to services in NT hospitals, to support Aboriginal people under the AMT scheme.

6. Aftercare plans

Appropriate aftercare services are critical to ensuring that the AMT system does not become a revolving door. The level of funding for aftercare needs to be sufficient in order to allow for coordination and follow up between the mandatory treatment centres and the services in communities where a person may be returning.

A review of residential rehabilitation programs targeting Aboriginal people found that there was a lack of suitable support post rehabilitation which is a factor in poor outcomes.²⁸

Although no data is available on the scope and resourcing of aftercare, we are concerned that a lack of funding to support adequate aftercare may lead to high rates of re-admission. Without adequate support, there is a real risk that people may cycle back through the system. It is therefore critical to ensure that people receive adequate follow-up upon release, and transport home when exiting the system.

We also note that there is currently no public data available on the numbers of people who have been through the AMT system more than once, and we encourage the NT Government to include this as a factor in their public evaluation of system effectiveness.

There is a need for comprehensive and culturally appropriate after care plans, which take into account the individual needs of the person being released. For instance, a person may be released and sent back to a remote Aboriginal community where they are unable to continue to access AOD services.

The preparation of aftercare plans needs to be explicitly linked in with services available to that person in their community following time in mandatory rehabilitation. This may often mean relying on the local Aboriginal community controlled primary health care provider or the local government clinic. However, the majority of remote ACCHSs and Government clinics do not have either resident or visiting AOD staff.

The Aboriginal community controlled health care providers will often end up being responsible for care of the person once they have exited the scheme. If an ACCHS with no AOD or SEWB staff have

²⁸ Brady M 2002 Indigenous residential treatment programs for drug and alcohol problems: current status and options for improvement. Discussion paper no 236/2002 Canberra: Centre for Aboriginal Economic Policy Research, ANU

to support a client, then the service should receive an aftercare plan but the expectation is that it needs to be reasonable and negotiated with the ACCHS prior to release of the person.

Recommendation 20: That the NT Government to ensure adequate funding for coordination with in ACCHSs to arrange for provision of after-care for persons detained under the AMT Act post-release.

7. Legal representation

APO NT understands that at present people going before the Tribunal in Darwin may now be represented by a non-legal advocate.

Section 113 of the AMT Act provides that a person may be represented by a legal practitioner, however there is no corresponding funding to support a legal practitioner for persons detained under the AMT Act who want a lawyer. The AMT Act provides for a complicated legal regime which a lay-person would struggle to navigate. The NT Government should commit to providing adequate funding for legal services to assist people to prepare for and appear before the AMT Tribunal, adopting the model provided for under the Mental Health and Related Services Act. It is recommended that the NT Government similarly make ongoing funding available to allow Aboriginal people detained under the scheme to access legal advice throughout treatment, or to seek variation or revocation of an order.

Recommendation 21: It is recommended that the NT Government fund legal representation for Aboriginal people going before the AMT Tribunal.