Aboriginal Peak Organisations Northern Territory

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

Not under the influence of evidence:

A sober critique of the Alcohol Mandatory Treatment Bill

APO NT Submission on the NT Alcohol Mandatory Treatment Bill

May 2013

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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 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.

Introduction

APO NT does not support passage of the Alcohol Mandatory Treatment Bill (the Bill). Our organisations do not agree with key assumptions which underpin the Bill. We do not agree that mandatory treatment as provided for in this bill is an effective way to assist in reducing alcohol related harm in the NT. The mandatory rehabilitation scheme outlined in the Bill is not based on the best available evidence about what is effective to address alcohol dependence. The measures contained in the Bill will not be cost-effective and will not work.

The Bill in its current form would be a de facto re-criminalisation of public drunkenness which is contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody. APO NT believes detaining problems drinkers will lead to unnecessary tensions between Aboriginal people and police, and is likely to result in more Aboriginal people entering the criminal justice system. Prisons in the NT are already overflowing with Aboriginal people.

We also believe that the Bill indirectly discriminates against Aboriginal people in the NT, particularly those Aboriginal people living remotely who are often more likely to drink in public places when they visit service centres or towns.

APO NT believes that there may be a limited role for involuntary treatment in extreme circumstances where individuals are at very high risk of harm and unable to manage their circumstances, where clinically effective and culturally appropriate methods of engaging the patient into treatment have been tried and failed, and where strong safeguards and protections are in place, including that it does not criminalise, either directly or indirectly, the behaviours it seeks to address.

The NT is a small jurisdiction with a finite amount of resources for programs and services. The budget allocation for the mandatory rehabilitation scheme is $45 million to set up and run the scheme for a year, which works out to an average spending of approximately $80,000 per problem drinker. APO NT believes that the NT Government could make a better investment to address alcohol-related harm in the NT, by investing in existing voluntary rehabilitation and other alcohol treatment programs including AOD treatment provided in Aboriginal primary health care, as part of a holistic suite of reforms which includes population supply reduction measures.

We believe that the proposed Bill will not only be extremely costly, but will be ineffective and worse, discriminatory. We call for evidence-based, holistic and community-led solutions to alcohol problems in our communities. We call for the withdrawal of the AMT bill and a review of current and

previous policies including the raft of measures enacted by the previous government, such as the Banned Drinkers Register.

Structure of the submission

The APO NT submission is divided into five parts.

Part One of our submission outlines our overarching theoretical perspective including background on the social determinants of health, and human rights concerns with the bill.

Part Two of our submission:

- outlines the need for evidence to support any alcohol treatment scheme, including the evidence on health aspects of alcohol addiction, the role of trauma, and the need to ensure physical safety;
- discusses comparative mandatory treatment schemes including the Volatile Substance Abuse Prevention Act and legislation in other jurisdictions;
- criminal penalties and link to increased crime and imprisonment;
- the need for appropriate after-care; and
- concerns about reduced access to voluntary rehabilitation for alcohol dependent persons.

Part Three of our submission outlines APO NT's serious concerns about the process for consultation and timeframes for developing the mandatory rehabilitation scheme; and the Alcohol Protection Order scheme.

Part Four calls on the Government to recognise the complexity of alcohol dependence and the need for a holistic and multi-pronged approach to solving these problems, including treatment and rehabilitation services; services for the homeless; trauma targeted programs, reducing the availability of alcohol and the need for voluntary treatment.

Part Five makes specific recommendations about key operational components of the scheme and highlights the need for culturally appropriate treatment. Recommendations for amendments to the bill and new provisions to be inserted into the bill are also provided.

Recommendations

We call on the Government to scrap the current Bill and immediately commission appropriate research to thoroughly review and scope the issues and alternative solutions with regard to chronic drinking problems; and to initiate a proper process of community consultation involving all stakeholders.

Should the Government proceed with this bill, we strongly recommend that the date for implementation be extended in order to allow time for elements of the scheme to be properly considered by all affected stakeholders.

We recommend that the NT Government abandon its plan to introduce Alcohol Protection Orders amendments. If it decides to go ahead with the scheme then we recommend they release the

proposed legislative amendments for public comment prior to introduction, and that they consult widely on the amendments before introducing them.

We reiterate the recommendations we sent to NT Government following the 2012 Grog Summit and ask that the Government review the draft Bill in light of this evidence and community concerns.

We recommend that a system, such as the Banned Drinker Register (BDR), be introduced to restrict the supply of alcohol to problem drinkers *without* resorting to criminalisation.

We recommend more funding be diverted to culturally appropriate voluntary rehabilitation services as the least restrictive means of addressing alcohol dependence, and in conjunction with other evidence-based measures which do not criminalise alcohol dependence.

1 A social determinants of health perspective

APO NT believes that tackling the plight of our communities can only be achieved through coordinated, evidence-based action across a broad range of policy areas: in housing, employment, education and health; but equally importantly in ensuring that the right conditions are in place for creating strong, resilient communities.

The task of improving health and social outcomes requires empowering individuals through developing self-esteem and strong cultural identity that can underpin educational achievement, enhanced capacity to obtain and remain in employment, and to avoid destructive behaviours such as substance misuse and interpersonal violence that all too often lead to contact with the criminal justice system.

And it requires strong action in tackling the scourge of alcohol and other drugs, its underlying causes and the accompanying burden of unresolved and ongoing intergenerational trauma in our families and communities.

Addressing the significant human and social costs of the unacceptably high numbers of Aboriginal people in the NT with alcohol and other drug addictions must be based on a balanced approach that recognises these complex dimensions of causality and action.

These understandings are based on the strong evidence on the social determinants of health (WHO 2008) that shows that our health and wellbeing is profoundly affected by a range of interacting economic, social and cultural factors, including:

- poverty, economic inequality and social status;
- housing;
- employment and job security;
- social exclusion, including isolation, discrimination and racism;
- education and care in early life;
- food security and access to a balanced and adequate diet;
- addictions, particularly to alcohol, inhalants and tobacco;
- access to adequate health services including services for alcohol and other drugs and social and emotional well being services; and
- control over life circumstances.

Research further indicates the importance of key determinants for Indigenous peoples generally and Aboriginal peoples in Australia in particular. These include:[1]

- the fundamental importance of control and empowerment;
- the debilitating impacts of social exclusion, racism and discrimination; and
- the protective role of culture, language and land.

APO NT believes that any policy or legislation aimed at tackling alcohol addiction will ultimately be ineffective without simultaneous action to address other relevant social determinants of health. Reports by the World Health Organisation (WHO) and National Drug Research Institute (NDRI) found that social deprivation and associated factors such as income and education are clearly linked to the

[1] Cooper, David, 2011, *Closing the gap in cultural understanding: social determinants of health in Indigenous policy in Australia,* Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), Darwin.

risk of dependence on alcohol.[2] Inadequate housing, infrastructure, job prospects and opportunities for recreation have been identified as areas in need of attention in order to help combat alcoholism.[3]

Further, policies targeting a particular area of alcohol addiction need to be based on careful assessment of the circumstances and needs of those targeted. For example, "Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice" states:

> *The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualized by the legacy of colonization, racism and marginalization from dominant social institutions. International and Australian research clearly demonstrates that health in general; mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks.*[4]

The cohort that this legislation targets includes individuals with severe alcohol addiction and complex social problems and individuals who engage in harmful binge drinking. Those drinking at very harmful levels will have high rates of associated mental health and chronic health conditions. They will be overwhelmingly Aboriginal, and will present with high rates of homelessness, low formalised education levels, histories of incarceration, and exposure to trauma, both past and present. A significant number will have neurodevelopmental and cognitive impairment as a result of exposure to Foetal Alcohol Spectrum Disorders (FASD) or Early Life Trauma (ELT) and/or from the effects of long-term alcohol and other drug misuse, including volatile substance abuse. As a group they are also heavily stigmatised, experiencing high levels of racism and social opprobrium.

A study of those staying in Darwin's Long Grass showed that the dominant reason for leaving home communities was family problems, mostly involving violence or other conflict.[5] Other significant reasons included a desire to access alcohol, lack of housing, and trouble with authorities.[6] Some also come to centres to access medical treatment or for other purposes, or to accompany spouses or other family members. Those with alcohol addiction or harmful binge-drinking behaviours are more likely to come into contact with police.

A social determinants analysis of the proposed legislation indicates that the mandatory treatment regime will not only provide little to no benefit in addressing these circumstances but has the potential to exacerbate them and cause additional avoidable harm because it will:

- do nothing to solve issues such as homelessness and problems in home communities that are significant determinants of chronic alcoholism;
- fail to address the significant underlying trauma issues and co-morbid mental health conditions that are associated with alcohol misuse;

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2 Gray, Dennis, Sherry Saggers, Edward Wilkes, Steve Allsop, and Coralie Ober. 2010. "Managing Alcohol-related Problems Among Indigenous Australians: What the Literature Tells Us." *Australian and New Zealand Journal of Public Health* 34 (July 8): S34–S35.

3 Gray et al. (2010). op cit.

4 Wilkes E, Gray D, Saggers S, Casey W and Stearne A. "Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice" In: Purdie N, Dudgeon and Walker R. (Eds). 2010. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. AIHW.

5 Holmes, C, and E McRae-Williams. 2009. An Investigation into the Influx of Indigenous "Visitors" to Darwin's Long Grass from Remote NT Communities: Phase 2: Being Undesirable: Law, Health and Life in Darwin's Long Grass. Monograph Series No. 33. Hobart: National Drug Law Enforcement Research Fund.

6 Ibid.

- further disempower and entrench the stigmatisation, discrimination and social exclusion of this group;
- expose individuals to risk of avoidable harm through the stress of being subject to the processes of involuntary confinement, including the risk of death or serious injury in custody or whilst being apprehended and the risk of a lack of appropriate medical and supportive care whilst in custody (particularly whilst waiting for assessment and entry into a secure facility);
- interfere with basic human rights of Aboriginal people and people with disabilities;
- expose individuals with a medical condition of alcohol addiction to criminal prosecution when, as will inevitably occur, they abscond to seek access to alcohol;
- deprive individuals of peer, kin, cultural and spiritual support and place them in conditions that are culturally unsafe and likely to cause trauma or re-traumatisation;
- reduce the availability of treatment and rehabilitation services to those voluntarily seeking treatment; and,
- do nothing to reduce the ready accessibility of alcohol or place effective controls on alcohol purchasing and consumption.

Moreover, mandatory treatment will, on the evidence available, have very limited success in treating alcohol addiction and achieving long-term change for those subject to it (see below), and will result over time in many individuals simply being re-cycled back into treatment for little or no benefit.

The huge cost of the scheme imposes an unacceptably high opportunity cost to the community that significantly reduces the capacity and support for more effective, evidence-based responses to this challenging and urgent issue.

1.1 Human rights concerns

The Bill in its current form may also lead to breaches of Australia's human rights obligations under the International Covenant on Civil and Political Rights (ICCPR)[7]:

- the right to liberty (Article 9);
- the right to freedom from arbitrary detention (Article 9);
- the right to freedom of movement (Article 12);
- the right to life (as the Bill is likely to lead to increased deaths in custody) (Article 6).

We also believe that the Bill may also lead to breaches of rights contained in:

- the Convention on the Rights of Persons with Disabilities; and
- the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment; and,
- the *Optional Protocol on the Convention Against Torture,* which seeks to prevent mistreatment of people who are held in detention.

APO NT also believes that the Bill indirectly discriminates against Aboriginal people in the NT, particularly those Aboriginal people living remotely or who live in alcohol restricted areas in towns

[7] International Covenant on Civil and Political Rights, UNHS, 16 December 1966, (entered into force 23 March 1976)., http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

(e.g. town camps) who are often more likely to drink in public places when they visit service centres or towns, thus breaching the Convention on the Elimination of All Forms of Racial Discrimination (CERD) and the *Racial Discrimination Act 1976*, and the NT *Anti-Discrimination Act*.

2.0 Evidence relating to selected aspects of the Bill

2.1 Lack of scoping of the problem (and solutions)

One of the deeply concerning aspects of the Bill is the lack of an underpinning evidence-based analysis of the problem, alternative solutions, and the needs of its target population, in particular.

The Bill is targeted at "people with chronic drinking problems in public areas"[8] in the Northern Territory. There is little research relating to circumstances and drinking behaviours of this target group. The most detailed research comprises two research reports commissioned by Larrakia Nation Aboriginal Corporation on Darwin's Long Grass Community (referred to as the NDLERF report[9] and *Message in a Bottle* report[10]). The *Message in a Bottle* report surveyed the drinking patterns and attitudes amongst Darwin's homeless.

Of 101 homeless people surveyed, 15% did not drink at all and 20% drank on average only one day per week. Almost a third (31.1%) reported drinking every day, many heavily. Nearly 50% drank on six days per week or more. In the survey, alcohol free days spent in a dry community were not counted in the statistics. Port was the most commonly consumed alcohol at 72% of all alcohol consumed. More than a third of drinkers surveyed indicated that they would like to stop drinking.[11] The *Message in a Bottle* report also confirmed the findings of the NDLERF report of high levels of trauma and grief amongst the homeless population of Darwin (see below).

While only a snapshot of the data from this research and notwithstanding that drinking patterns will not be exactly the same across all public areas in the Territory, these results suggest that those drinking at very harmful levels include both alcohol addicted individuals and those who engage in binge drinking at various intervals.

Importantly, the finding that over a third of those surveyed wanted to stop drinking indicates a high potential for voluntary rehabilitation. By focussing only on mandatory treatment, the NT Government not only ignores the opportunity this presents, but is likely to reduce the capacity for voluntary rehabilitation by swamping capacity with mandatory patients.

The data from *Message in a Bottle* also confirms the long-held understanding that cheap, bulk alcohol products are associated with very harmful drinking. This provides an opportunity to significantly reduce the harms and impacts of very heavy drinking by banning or restricting such products, or by instituting a 'floor price' on alcohol (see below).

Finally, the findings around trauma and grief experienced by the target population underline our understanding of the psychosocial and cultural complexities that must be negotiated in assisting and treating these individuals and that short-term mandatory treatment will not provide.

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8 Second reading speech, Alcohol Mandatory Treatment Bill 2013, at http://www.austlii.edu.au/au/legis/nt/bill_srs/amtb2013299/srs.html

9 Holmes & McRae-Williams 2009, op cit.

10 Taylor, Penelope, Sandy Japanardi Walker, and Barry Marawi. 2011. "Message in the Bottle: A Survey of Drinking Patterns and Attitudes About Alcohol Policy Amongst Darwin's Homeless". Darwin: Larrakia Nation Aboriginal Corporation.

11 Ibid.

It is hard to imagine how such an important piece of public policy could be developed and implemented without the rigour of an evidence-based assessment of the problem and consideration of alternative solutions.

We call on the Government to scrap the current Bill and immediately commission appropriate research to thoroughly review and scope the issues and alternative solutions with regard to chronic drinking problems; and to initiate a proper process of community consultation involving all stakeholders.

2.1 Need to recognise health aspects of alcohol dependence

Alcohol dependence is a relapsing chronic disorder. An Australian government review quoted relapse rates of 60% at one year for people undertaking residential rehabilitation.[12]

Those who are less likely to benefit from treatment include those with cognitive damage and those living in poor social circumstances and/or who have limited social/family support from people who do not have alcohol problems. People with co-morbidities may also have a lower success rate especially if these are not addressed with ongoing comprehensive support.[13] People referred to mandatory rehabilitation are more likely to fall into these categories because the criteria (apprehended 3 times in two months for public drunkenness) is likely to catch a high proportion of people with severe alcohol problems and complex social problems. When combined with evidence that mandatory treatment is less effective than voluntary treatment, relapse rates at one year are likely to be significantly higher than 60%.

Risk of relapse is also related to the behaviours and attitudes to alcohol consumption within communities. In some Indigenous communities, drinking has become normalised, with undertones suggesting 'the choice is simple: drink and belong, or abstain and remain outside'.[14] When removed from these situations, many alcohol users are able to moderate their intake.[15] Interventions that target the individual in this scenario are of limited assistance, as upon return to the community, the prevailing culture acts to undermine any progress gained.

2.2 Need to recognise the role of trauma in alcohol misuse

Alcohol and substance misuse is associated with intergenerational and other types of trauma, including childhood trauma. Alcohol and other drugs are often used as a coping mechanism for dealing with unresolved trauma and its resulting psychological distress.[16] A recent study of alcohol and substance-addicted participants found over half were PTSD symptomatic and over 80% had experienced traumatic events.[17] This concords with a recent study of Darwin's Long Grass residents

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12 Department of Health and Ageing (2010). Australian Treatment Guidelines for Alcohol problems.

13 Adamson S, Douglas J, Frampton C, (2009). Patient predictors of alcohol treatment outcome: A systematic review. *Journal of Substance Abuse*, Volume 36, Issue 1, January 2009, Pages 75cie.

14 Gray, D and Saggers, S. (2002) 'Indigenous Australian alcohol and other drug issues: research from the National Drug Research Institute', National Drug and Alcohol Research Centre

15 Gray, D and Saggers, S. (2002) 'Indigenous Australian alcohol and other drug issues: research from the National Drug Research Institute', National Drug and Alcohol Research Centre

16 Atkinson, J. (2002). *Trauma Trails Recreating Song Lines – The Transgenerational Effects of Trauma in Indigenous Australia*, North Melbourne: Spinifex Press.

17 Dore, Glenys, Katherine Mills, Robin Murray, Maree Teesson, and Philippa Farrugia. 2012. "Post-traumatic Stress Disorder, Depression and Suicidality in Inpatients with Substance Use Disorders." *Drug and Alcohol Review* 31 (3) (May): 294–302.

(the NDLERF report) that found that around 20% were PTSD symptomatic and that the vast majority had experienced "an extraordinary number of trauma events".[18]

Rehabilitation programs are likely not to have long lasting positive effects if they do not address the underlying issues associated with histories of trauma and loss. The growing evidence base in relation to working with individuals and communities with issues relating to trauma and loss has identified that effective programs rely on genuine community engagement, principles of empowerment and long-term work.[19] The principles for treatment implied in this Bill are antithetical to the principles known to be effective in addressing substance misuse issues relating to current and historical trauma.

The association of alcohol misuse and complex histories of trauma and abuse[20] suggests that the harsh and inappropriate regime of mandatory treatment may serve to exacerbate the underlying causes of substance abuse, and cause re-traumatisation.

A diagram outlining the cycle of trauma and substance abuse following colonisation is outlined at Appendix A.

2.3 Ensuring safety

The Northern Territory Government has a clear ethical responsibility to ensure the physical and mental safety of patients is not put at risk by mandatory rehabilitation given that the state has chosen to deprive people of their liberty. People detained in mandatory rehabilitation will require high quality medical and psychological services, along with cultural and family support to deal with:

- alcohol withdrawal;
- physical trauma (such as subdural haematoma or other undetected injuries);
- illness due to alcohol such as pancreatitis and liver disease;
- exacerbation of pre-existing chronic diseases such as diabetes, heart disease and renal failure (all very common in Aboriginal people);
- depression, anxiety, post-traumatic stress, despair and psychosis - all risk factors for suicide attempts;
- exacerbation of pre existing psychological trauma- also a risk factor for both suicide and non-suicidal self harming behaviours; and
- loneliness and sadness at being separated from their families and communities.

Alcohol withdrawal is a frequent and dangerous feature of cessation of drinking in heavy alcohol users. The spectrum of symptoms vary widely, from insomnia and tremulousness to severe complications such as withdrawal seizures and delirium tremens. These symptoms can manifest anywhere from 6 to 72 hours after cessation of alcohol use (Baynard et al 2004). Benzodiazepines, thiamine (needed intramuscularly or intravenously for the first 3-5 days), and vitamins are the mainstay of treatment. For any patients with significant alcohol use, Royal Darwin Hospital protocols recommend nursing observations and assessment for alcohol withdrawal between 4 hours to 30 minutely depending on stability and severity of symptoms with prompt treatment. Diazepam doses are often needed in high enough quantities to achieve sedation (RDH ED: Management of Alcohol

[18] Holmes & McRae-Williams, 2009. op cit.

[19] Purdie, N, P. Dudgeon and Walker R. (Eds). 2010. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice.* Australian Institute of Health and Welfare. Canberra.

[20] Atkinson, J. (2002). *Trauma Trails Recreating Song Lines – The Transgenerational Effects of Trauma in Indigenous Australia*, North Melbourne: Spinifex Press.

withdrawal). To give an indication of likely symptom frequency in this cohort, a study in patients undergoing public detoxification and residential alcoholism treatment programs found rates of shaking affected between 29-70% of patients, delirium tremens 11-29% and withdrawal seizures affecting 8-16% (Caetano et al. 1998). The high levels of medical co-morbidities in the population who will most likely to come under a mandatory treatment order, adds to the complexity of their medical needs.

There are several implications of alcohol withdrawal and mandatory rehabilitation. Firstly, those detained will require frequent nursing and medical oversight to avoid preventable suffering. This will require a significant medical workforce from a pool that is already overstretched and difficult to recruit to. There is a real danger the implementation will go ahead without provision of adequate medical care. Secondly, those withdrawing at the severe end of the spectrum will require hospitalisation. It is uncertain if the mandatory nature of rehabilitation extends to medical treatment of withdrawal and other co-morbidities, which complicates issues of patient autonomy and consent.

We believe that the Government should set out how it is going to provide these services and that it should be a legal obligation to provide them to a minimum standard. If the Government cannot afford to provide all these services to those in mandatory rehabilitation services, then the bill should not be pursued.

2.4 Comparative involuntary treatment schemes

Involuntary treatment regimes, by nature of the restrictions placed on an individual's rights and liberty, are reserved for cases where individuals are putting themselves at very high risk and who lack the capacity to make informed decisions about their welfare. In other jurisdictions involuntary treatment for those with serious substance dependence is very narrowly applied. For example, under the Victorian *Severe Substance Dependence Treatment Act 2010*, the criteria for involuntary treatment includes that "immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health". In the Northern Territory two examples of mandatory regimes are provided under the *Mental Health Act* and the *Volatile Substance Abuse Prevention Act* (the VSAP Act).

The NT *Volatile Substance Abuse Prevention Act* (the VSAP Act) provides a useful point of comparison and contrast to the current Bill. The VSAP Act deals with mandatory treatment and provides greater safeguards than is provided for those receiving treatment under the Bill. It provides also for treatment without resorting to criminalisation, unlike the Bill.

The VSAP Act provides a comprehensive and systematic approach for the prevention, intervention and treatment of volatile substance abuse in the NT. There are a number of lessons directly relevant to the Bill:

- initial treatment interventions are not just initiated by Police, but could also be initiated by health professionals and community members which provides a more therapeutic and community driven approach;
- treatment orders can only be ordered by a court which provides an additional legislative safeguard for persons subject to the scheme;
- there is an important focus on aftercare, other appropriate therapies and health, diversionary and educational interventions;
- a warrant is able to be issued for a person absconding, but there is no criminal penalty for failing to participate or absconding;
- the VSAP Act involves measures at both an individual and a community level;

- community control is also central to the VSAP Act, in providing legislative support to local programs that have been in place for many years, and assisting individuals and communities to combat volatile substance abuse; and
- the VSAP Act criminalises the supply of volatile substances, which acts as a disincentive to suppliers and places the onus on the person supplying substance not the person with the dependence.

The current Bill falls far short of the kinds of minimum standards, processes and safeguards contained in the VSAP Act and on this basis alone, the Bill should not proceed.

The Alcohol and Other Drugs Tribunal, discontinued by the Northern Territory Government, had the capacity to require treatment for people who were assessed by the Tribunal, and to apply the non-criminal sanction of rolling alcohol banning orders for those who did not attend treatment. An amendment of adding income management as a further optional sanction was not implemented. The AOD Tribunal remains unevaluated.

2.5 Criminal penalties associated with mandatory rehabilitation will increase crime and imprisonment rate in the NT

The Bill creates a number of offences connected with mandatory treatment, and excludes those charged with a criminal offence from being sent to mandatory treatment. Contrary to the Government's stated aim of providing an alternative to prison, the Bill creates new pathways into the criminal justice system for vulnerable individuals. There is a dire risk that the interaction between a punitive and restrictive regime and new criminal offences will in fact increase the rate of crime and imprisonment in the Northern Territory.

The Northern Territory is already facing a crisis of over incarceration some stark statistics about NT justice system are below[21]:

- The Northern Territory's incarceration rate is 5 times the national average and is increasing faster than that of any other state or territory: in the ten years from 2002 to 2012, the NT imprisonment rate rose a staggering 72% (from 480 prisoners per 100,000 adult population to 826 prisoners per 100,000 adult population). In the twelve months to December 2012, the Northern Territory recorded a 9% proportional increase in imprisonment rate, the largest in Australia.
- It was reported that as at December 2012, the NT had 1452 people in full time custody. This figure is now well above 1500. With a new 1000 bed prison to be opened in 2014, it is projected that it will be more than 100 beds short when it opens its doors. On current trends, the NT will need another 1000 bed prison by 2016.
- The scandal in the Northern Territory is not just that we are locking up so many people; it is that we are locking up so many Aboriginal people. Over 30% of the Northern Territory's population is comprised of Aboriginal people. Yet of the1452 people in custody in December 2012, only 239 were non-Aboriginal. Aboriginal people comprise close to 85% of the jail population. Of the 64,000 Aboriginal people in the NT, 1213 are in prison.

[21] Sharp, Jared (2012) "The Justice James Muirhead Churchill Fellowship to investigate strategies for increasing the cultural integrity of court processes for Aboriginal young people and their families in the Northern Territory Youth Justice System - USA, Canada, New Zealand", p.7

- Aboriginal incarceration rates are even worse for young people. On 31 January 2013, there were 65 juvenile detainees held across three NT detention centres in the Northern Territory. 62 (96%) identified as Aboriginal or Torres Strait Islander.

It is clear that Aboriginal people, and particularly young people, come into contact with Police and the criminal justice in disproportionate numbers. The Bill will exacerbate this problem.

One of the most concerning aspects of the Bill is that person who "intentionally absent" themselves from a mandatory treatment centre will face criminal sanctions (clause 72 of the bill). These include a maximum 3 months imprisonment. It is inconceivable that where the Government has publically claimed:

> "This is not a punitive response; this is an attempt to bring people into an environment where they can attend to their alcohol and drug problems".[22]

That they have included a provision that so blatantly applies a punitive sanction to individuals who require a therapeutic response. This is all the worse in the Northern Territory where the Government should be especially cognisant about applying criminal sanctions to criminals, not alcoholics and where the Government ought to be especially concerned about introducing provisions that will disproportionately impact on the numbers of Aboriginal people in jail.

As outlined in greater detail in the NAAJA, CAALAS and NTLAC joint submission on the Bill, which APONT endorses, the operation of the mandatory treatment scheme would have a number of serious implications for access to justice in the Northern Territory.

The bill and scheme will increase the negative interactions between Aboriginal people and Police. This mandatory rehabilitation model outlined in the bill identifies Police rather than health professionals as the point of entry to the scheme. Coupled with the Alcohol Protection Orders (see reference below) and the increased monitoring by police of take-away alcohol premises, it is likely that this scheme will increase the interface and negative interactions between Aboriginal people, Police and the justice system. APO NT asserts that this will deteriorate an already fragile relationship between Police and Aboriginal people and their community or communities.

2.6 Need for appropriate after-care post-release when people return to their community

A 2002 review of residential rehabilitation programs targeting Aboriginal people found that there was a lack of suitable post rehabilitation support and that this is a factor in poor outcomes.[23] Since 2006, a remote AOD workforce has been growing throughout government and community controlled primary health care centres, with 30 specified AOD positions throughout 19 communities in 2013. There is considerable evidence and support for the effectiveness of AOD programs as part of comprehensive primary health care. However, there is also a recognised need for the expansion of this workforce to adequately address the AOD service needs throughout remote communities.

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[22] http://www.abc.net.au/news/2013-05-29/mick-gooda-on-nt-mandatory-alcohol-rehab-law/4719976?section=nt

[23] 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

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 services. Alternatively, if they stay in a regional town to access services, they are much more likely to relapse given easy access to alcohol in towns and limited access in remote communities. After-care post rehabilitation needs to be:

- properly planned, and based on a strong, culturally appropriate evidence base;
- available on remote communities as well as urban centres; and
- adequately staffed and financed.

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 Territory Government clinic. However, the majority of remote ACCHSs and Government clinics do not have either resident or visiting AOD staff. Indeed, it is of concern that ten additional AOD positions in remote communities were to be provided but have now been put on hold whilst the mandatory treatment scheme is implemented.

The requirement for clinicians to report regularly to the CEO of the Health Department on the progress of people on community orders will make it difficult for counsellors to maintain rapport and trust of their clients – which will in turn reduce the effectiveness of support. For instance, lapses (short periods of drinking after a period of sobriety) are common and can be used by counsellors as an opportunity to review with the patient the triggers for drinking and thus support them to deal better with these triggers in the future. If the counsellor is forced to report a lapse this in turn might mean the patient has their order extended or has to return to residential rehabilitation, and that the trust between the patient and counsellor is likely to be significantly damaged.

2.7 Less access to rehabilitation for voluntary patients

A concerning aspect of the mandatory treatment scheme is its likely impact on reducing capacity for voluntary mandatory treatment. Those with alcohol dependence who are forced to enter rehabilitation programs will "clog up the system". Individuals who voluntarily seek treatment will endure longer waiting times before acceptance into rehabilitation centres. The dynamics of treatment centres may also be negatively affected as some move towards a "secure" system similar to incarceration.

It is also likely that given the limited number of medical professionals and qualified counsellors with alcohol treatment experience in the NT, that the limited resources will be diverted to the mandatory treatment scheme rather than providing services for voluntary patients.

It is also likely that resources will be further diverted from other critical primary care services, including hospitals, emergency rooms, and community treatment providers. As discussed further in section 4 below, appropriately trained medical professionals are best placed to address the complex needs of alcohol abuse and to refer individuals to appropriate rehabilitative treatment. Instead of requiring police to manage alcohol issues, the Government should invest in strengthening the health and community sectors, and by increasing resources for voluntary rehabilitation.

As mentioned previously, the findings from *Message in a Bottle* of over a third of those surveyed wanting to stop drinking, is evidence of a substantial potential demand for voluntary rehabilitation that should be pursued.

3 Process for developing legislation

APO NT is very concerned that a proper process for development of legislation has not been followed in development of the Bill.

There is concern about the consultative process that preceded the Bill:

- Over what period did consultation take place?
- Who was consulted?
- On what expert evidence is it based?
- Who was not consulted?
- What research was done on the problems that the Bill purports to address?
- Was the research reviewed by an appropriate Human Research Ethics Committee?
- Were the Australian Medical Association, the Chapter of Alcohol and other Drug Specialist Medical Practitioners, and other medical authorities consulted?

It is of particular concern that advice does not seem to have been sought on prevailing medical views on treatment for alcohol abuse.

To date there has been a piecemeal consultation process with key stakeholders. Consultation with important stakeholders who will be involved in operationalising and implementing key aspects of the Bill is crucial, yet this has not occurred.

There needs to be adequate consultation with the medical profession and others such as clinical psychologists, and there needs to be an understanding of how the Bill may require medical and other professionals to behave and whether this may breach significant professional standards, including ethical relationships with their patients.

We consider that a scheme as important and far-reaching as this should be based on the best available evidence. In calling for the scrapping of the current Bill, APO NT also calls for the commissioning of research to properly scope the issues and alternative solutions with regard to chronic drinking problems and that a proper process of community consultation involving all stakeholders be initiated.

3.1 Timeframes for consultation

We are also very concerned about timeframes for consultation on the Bill, passage of the Bill and introduction of the scheme. Proper process for development of complex legislation such as this Bill requires extensive and detailed input from key stakeholders to ensure that the Bill can be properly enacted and operationalised.

Should the Government proceed with this bill, we strongly recommend that the date for implementation be extended in order to allow time for elements of the scheme to be properly considered by all affected stakeholders.

3.2 Proposed Alcohol Protection Orders scheme

In May 2013 the Deputy Chief Minister David Tollner announced the government plans to introduce Alcohol Protection Orders purportedly aimed at reducing crime across the NT.[24] The Alcohol

[24] New alcohol powers for police, 10 May 2013 http://www.abc.net.au/news/2013-05-10/new-alcohol-powers-for-police/4683052

Protection Orders will be introduced under the NT *Liquor Act* and will be used to attempt to meet the NT Government's target of a 10 per cent reduction in crime.

An Alcohol Protection Order will prevent a person from possessing or consuming alcohol or attending licensed premises. It can be issued to any person who is charged with an offence carrying a minimum penalty of six months imprisonment or more, where alcohol was a factor (including offences under the Traffic Act). These orders can be issued for three, six or 12 months. If a person breaches an order he/she can be charged with an offence and fined or put in jail.[25]The Police will be able to issue the order on the spot where they are charging a person with a serious offence involving alcohol abuse. It will not be issued by the court. Police will have a list of people on Alcohol Protection Orders and monitor this. Police will be able to breathalyse someone on an order randomly at any time whilst on the order, even in their home.[26]

We are very concerned that the proposed Alcohol Protection Orders will discriminate against Aboriginal people and would appear to be contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody in 1991. APO NT believes the Alcohol Protection Orders will lead to unnecessary tensions between Aboriginal people and police. This is exacerbated by the fact that the government removed ID scanners from take-away licenses in 2012, so people on Alcohol Protection Orders can only be identified by police. It is likely to result in more Aboriginal people entering the criminal justice system. As we have outlined, prisons in the NT are already overflowing with Aboriginal people.

Minister Tollner claimed that this proposal is "nothing to do with the mandatory rehabilitation proposal".[27] However, we would like the NT Government to clearly outline the interactions between the two schemes, which will ostensibly be targeting a similar cohort.

We recommend that the NT Government abandon its plan to introduce Alcohol Protection Orders amendments. If it decides to go ahead with the scheme then we recommend they release the proposed legislative amendments for public comment prior to introduction, and that they consult widely on the amendments before introducing them.

4 Alternatives to mandatory rehabilitation

As outlined at the beginning of this submission, addressing the serious problem of high levels of chronic alcohol misuse must take a balanced approach that recognises the many dimensions of causality and evidence-based options for action that are available. We believe that such an approach should include the following elements.

4.1 Recognition of the complexity of the problem

There is a need for honest recognition that this is a complex problem that has reached the current crisis point through decades of neglect of the many factors that have driven its growth; particularly failure to provide essential housing, services and infrastructure in communities, lack of proper education and employment opportunities, and the failure to address the problems of over consumption of alcohol across the Territory.

[25] Ibid.
[26] Id.
[27] Id.

There is no quick fix.

There will continue to be significant numbers of homeless, including those with unstable or overcrowded housing. There will continue to be individuals who by choice or lack of resources will be living rough or in the Long Grass in the NT's major centres. Some of these people will continue to consume dangerous amounts of alcohol.

Reducing these numbers over time will require both short-term strategies to minimise immediate harm and long-term strategies to address the broader determinants of alcohol misuse and chronic addiction. Effective policy recognises that these issues impact on the Aboriginal community as well as substantial numbers of non-Aboriginal people living on the margins of society.

4.2 Tackling the harms of chronic alcohol misuse

There is a need to provide more effective responses to address the acute harms that are occurring to those who are chronically alcohol addicted or engaged in very harmful binge drinking and those around them.

Where individuals are at very high risk of harm and unable to manage their circumstances there may be a limited a role for involuntary intervention if clinically effective and culturally appropriate methods of engaging the patient into treatment have been tried and failed. It would also require authorities to assess whether the patient had a significant cognitive or other impairment which made it difficult for the patient to benefit from conventional treatment. The capacity for involuntary treatment in limited circumstances is currently available under the Mental Health Act and the Volatile Substances Act for severe mental illness and use of volatile substances. Such legislation requires strong safeguards and protections, including that it does not criminalise, either directly or indirectly, the behaviours it seeks to address. The current Bill does not contain such elements and should not be proceeded with. If such legislation were to be contemplated in the NT, a review of the effectiveness of civil commitment should be undertaken including the effectiveness of more recent Australian legislation such as the Victorian Act (*Severe Substance Dependence Treatment Act 2010*). It is noteworthy that this Victorian Act contains much stronger safeguards than the NT legislation but has still raised considerable concerns about human rights and effectiveness.[28]

A significant gap in the proposed mandatory treatment regime is a mechanism to effectively restrict and police the supply and access to alcohol to affected individuals.

We therefore support the need for the re-introduction of mechanisms, such as the BDR that is able to track and prevent alcohol purchases by banned individuals, and an AOD Tribunal that is able to properly consider referrals, provide pathways to treatment and supports, and is also able to apply non-criminal sanctions to encourage the take up of voluntary treatment options.

4.3 Treatment and rehabilitation services

It has long been recognised that there is a shortage of appropriate alcohol treatment and rehabilitation services, particularly in regional and remote areas of the Territory.

Resources are required to expand the capacity and number of services, including sobering-up shelters, dying out facilities, and voluntary treatment and rehabilitation services. The NDLERF report

[28] Fitzroy Legal Service, 2009. Submission to the Scrutiny of Acts and Regulations Committee regarding the Severe Substance Dependence Treatment Bill 2009.

identified a need "for respite care for individuals who have alcohol addiction and the need to detoxify, both in centres and in home communities. The availability of respite services may lead to an increasing number of clients who choose to enter more structured rehabilitation programs".

Culturally appropriate voluntary residential treatment services need to be expanded. As mentioned previously, the findings from *Message in a Bottle* of over a third of people living in Darwin's Long Grass surveyed wanting to stop drinking, is evidence of a substantial potential demand for voluntary rehabilitation that needs to be responded to (see below).

In addition, there is a need for the expansion of the Remote AOD Workforce, which provides AOD services as part of comprehensive primary health care throughout remote communities (see 2.6 above).

4.4 Increased services for the homeless and those staying in the Long Grass

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 and health and other services.

Experience has shown that improved access to health and other services should be provided through Aboriginal outreach services, such as those provided by Larrakia Nation, Kalano, Tangentyere Council (among others), and by Aboriginal community controlled health services. This should include, for example:

- additional night and day-time patrols;
- outreach health services;
- return to country programs; and
- social and emotional wellbeing and trauma programs, including programs incorporated into primary health care.

These services also play an important role of reducing contact with police, and diverting people in unsafe situations to more safe places. Outreach services also assist in identifying those individuals who are at most risk and linking them with services or interventions where required. They can also act to encourage individuals into voluntary treatment programs.

Other needs that have been identified include:

- specialist aged care and supports outreach services;
- a variety of short-term and long-term supported shelter and accommodation; and
- multiple designated safe drinking areas.

4.5 Need for more programs and services targeting trauma and social and emotional wellbeing

Particular focus also needs to be provided on programs dealing with the prevalence of trauma experienced by those with chronic alcohol addiction. Evidence shows that effective programs rely on genuine community engagement and principles of empowerment. Increased support is required for community-based recovery strategies, eg, Fitzroy Valley and the Kimberley Healing and

Empowerment Program, [29] Social and Emotional Wellbeing programs offered as part of comprehensive primary health care, and healing initiatives, such as We Al-li,[30] Marumali and the Family Wellbeing Program.[31]

4.6 Reducing the availability of alcohol

A critical component of a broader approach to addressing the problem of alcohol related harm is the need for population level measures to control to reduce the supply of alcohol.

Reducing harm requires strong action to reduce the supply of alcohol fuelling dangerous levels of drinking. We believe that this requires a number of coordinated actions.

At the Grog Summit held by APO NT in November 2012, APO NT and other key Aboriginal organisations, service providers and communities called on both levels of government to:

- base alcohol policy on evidence not politics;
- ensure that Police work with communities rather than engaging simply in law enforcement and develop strategies to ensure better relationships with Aboriginal people;
- bring back a system to effectively restrict the supply of alcohol (such as the Banned Drinker Register) to problem drinkers *without* resorting to criminalisation;
- implement population level supply reduction measures as a 'circuit breaker' for problems in our communities;
- provide significant new resources into evidence-based and culturally appropriate early childhood programs as an absolute priority;
- expand government support for community-based recovery strategies, similar to strategies used in Fitzroy Crossing; and
- expand and invest in existing rehabilitation programs and in alcohol and other drug treatment in primary health care, including in remote areas.

We reiterate the messages we sent to NT Government following the Grog Summit last year. We ask the Government to review the draft Bill in light of evidence and community concerns.

4.6.1 Restricting supply of alcohol

APO NT supports bringing back a system, such as the Banned Drinker Register (BDR), to restrict the supply of alcohol to problem drinkers *without* resorting to criminalisation.

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[29] Dudgeon, P., K. Cox, D. D'Anna, C. Dunkley, K. Hams, K. Kelly, C. Scrine, and R. Walker. 2012. *"Hear Our Voices: Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal People Living in the Kimberley, Western Australia. Final Research Report"*. Perth W.A.: Centre for Research Excellence Aboriginal Health and Wellbeing Telethon Institute for Child Health Research.

[30] Atkinson, Judy. 1994. "Recreating the Circle with We Al-li: A Program for Healing, Sharing and Regeneration." *Aboriginal and Islander Health Worker Journal* 18 (6): 8–13.

[31] McCalman, J., A. McEwan, K. Tsey, E. Blackmore, and R. Bainbridge. 2010. "Towards Social Sustainability: The Case of the Family Wellbeing Community Empowerment Education Program." *Journal of Economic and Social Policy* 13 (2): 8.

We consider that restrictions on purchasing alcohol will provide a serious, social, but non-criminal consequence for people with alcohol dependence, and will prevent an increase in incarceration of Aboriginal people associated with measures that try to address alcohol dependence.

Without a system which monitors the purchase and sale of alcohol there will be no practical way in which to implement prohibition orders. A photo identification system, similar to the BDR, is less stigmatising than some other measures as it applies to all people purchasing alcohol.

We reiterate the recommendations we sent to NT Government following the 2012 Grog Summit and ask that the Government review the draft Bill in light of this evidence and community concerns.

4.6.2 Population level supply reduction measures

Restricting the availability of alcohol is the most effective means of reducing alcohol consumption and related harm. There is extensive research from both Australia and overseas which demonstrates the effectiveness of alcohol supply reduction measures. APO NT believes that evidence-based supply reduction measures should continue to be introduced until per capita population alcohol consumption has reduced by at least one third of the current level, which would see the NT drinking at about the same level as the national average.

Price is the single-most important determinant of consumption and harm. The availability of cheap alcohol products results in increased consumption at risky levels. Banning such products such as 4 litre wine casks and 2-litre port, has shown to reduce levels of over-consumption and related harms. It is essential to ensure the comprehensive removal of such products to prevent chronic users from substituting with other cheap alternative products. In order to prevent product substitution, the NT should introduce a minimum price benchmark for alcohol products based on a price of $1.30 per standard drink. This would ensure that as a benchmark, the cheapest form of alcohol would be full strength beer as sold in half or full cartons. Contrary to popular belief the price of spirits would not change, and only cheap wines would be affected in price.

Takeaway outlets are the main source of alcohol for chronic and dependent users. Provision must be made for the outright banning of takeaways in communities supporting such a measure. There is also the need to develop a set of minimum Territory-wide standards for restricted takeaway trading hours.

Effective measure for reducing alcohol consumption and related harm including:

- reducing takeaway sales hours, for example opening at 2pm;
- reducing on-site sales hours, for example by limiting trading hours to 12noon to 2am; and
- adopting restricted alcohol sales days, for example Thursdays and Sundays where no alcohol sales are permitted or take-away sales are banned.

A significant reduction in alcohol-related harm and community disruption in remote and regional communities could be achieved by aligning Centrelink payments to a single day per week (Thursdays) on which no takeaway sales are permitted.

The NT has the highest density and diversity of liquor outlets in Australia. Strong evidence exists showing a relationship between outlet density and alcohol-related harm. The number of NT liquor outlets should be reduced by buying back take-away licenses from petrol stations, corner stores and roadhouses. This has occurred since an AMSANT paper was developed in Alice Springs where the licenses for Gap BP and Hoppy's have been bought back. Appropriate population-based outlet densities should be established through evidence-based research.

We recommend that a system, such as the Banned Drinker Register (BDR), be introduced to restrict the supply of alcohol to problem drinkers *without* resorting to criminalisation.

4.7 Voluntary treatment

APO NT supports the least restrictive measures to address alcohol related harm and alcohol dependence. APO NT supports greater funding of existing and new voluntary treatment programs.

There are already alcohol treatment programs in the NT which have adopted a culturally appropriate approach in treatment outlined above (see Culturally appropriate treatment at 5.2 below). Services already operating in the NT such as FORWAARD, CAAPS and CAAAPU operate on a voluntary treatment basis. Individuals are not coerced into participating in treatment programs; rather, they opt to partake in rehabilitation, because they have accepted that their alcohol abuse is a problem that needs to be healed. Rehabilitations which enforce treatment on individuals may cause negative effects. Negative perceptions of treatment may affect client motivation in a way that may cause future relapses, and reluctance to accept that alcoholism is a significant issue.

These services are also able to delivery culturally appropriate alcohol rehabilitation service to Aboriginal people in the NT, however at present are not adequately funded to meet the need for voluntary rehabilitation.

There are insufficient alcohol treatment and rehabilitation services to cope with current levels of demand in the NT. There is a need for increased alcohol treatment and rehabilitation services, including detoxification and residential treatment facilities, based on need and comprehensive regional coverage. Such services need to be supported to implement quality improvement systems and be accountable through reporting on key performance indicators so that outcomes can be assessed.

There is a need for improved integration and coordination of alcohol and other drug services and community mental health services with the primary health care sector. The primary health care sector should be funded to provide community-based treatment and rehabilitation, including screening, brief interventions, assessment, care planning, support for home based and supported withdrawal programs, provision of pharmacotherapies and community-based structured therapies.

A recent report published by Dr Ronald Donato notes the importance of Aboriginal community controlled health services in delivering comprehensive primary health care in order in addressing health outcomes:[32]

> *There is a considerable body of international evidence which highlights that disparities in health owe much to contemporary structural and social factors embodied in what are termed the 'social determinants' of health, such as dispossession, racism, income, employment, education, community capacity and the physical environment. However, locating the causative factors of health and ill health outside the health system presents major challenges. Primary healthcare (PHC) is recognised as central not just to dealing directly with chronic disease but also for providing a multidisciplinary framework that can interface with other sectors and tackle Indigenous disadvantage.*

As outlined in the Closing the Gap Clearinghouse Resource sheet no. 3 "Reducing alcohol and other drug related harm" (Gray & Wilkes, 2010); Aboriginal community control, together with adequate

[32] Donato, Ronald (2013) "Reforms not closing the gap", *Australian Health Review*, 24 May 2013

resourcing and support and planned, comprehensive intervention, are integral to the effective provision of AOD services to Aboriginal Australians.

Some people unfortunately have sustained significant cognitive impairment from alcohol consumption or they may have permanently impaired capacity to make informed judgments for other reasons (for example, people with FASD or people with acquired brain injury from other causes). In these cases, people will require ongoing intensive case management and support and not a revolving door of mandatory rehabilitation which is unlikely to be effective. The Guardianship Board should be involved in the care and support of many people with significant cognitive impairment and requires adequate resourcing to provide this care.

We recommend more funding be diverted to culturally appropriate voluntary rehabilitation services as the least restrictive means of addressing alcohol dependence, and in conjunction with other evidence-based measures which do not criminalise alcohol dependence.

5 Proposed amendments to mandatory rehabilitation scheme

APO NT opposes the introduction of the bill. It creates a new pathway to prison in the Northern Territory, where the average daily imprisonment rate is already among the highest in the world. The underlining objectives of the policy to reduce alcohol related harm and crime are unlikely to be met. In fact, APO NT seriously thinks that mandatory rehabilitation scheme will increase tensions between police and those who are dependent on alcohol.

However if the NT Government does decide to proceed with the bill, we would like to make the following recommendations in relation to:

- Operational concerns about the entire mandatory rehabilitation scheme;
- Culturally appropriate treatment in relation to the entire mandatory rehabilitation scheme;
- Amendments to the bill; and
- Proposed additional provisions for inclusion in the bill.

5.1 Operational concerns

APO NT is also very concerned about how the Bill will be operationalised. We have considered the NT Government Department of Health document *Mandatory Treatment Service: Arrangements and Pathways*.[33] These concerns include:

Concern	Recommendation
It is unclear how people will enter the mandatory rehabilitation system. The process by which police decide whether to take a person to a Sobering-Up Shelter or into Police Protective Custody has not been clearly defined and we are concerned this decision may become arbitrary. It is important to clarify this process, as being taken into Police Protective Custody leads to mandatory rehabilitation.	**We recommend the criteria and process by police decide whether to take a person to a Sobering-Up Shelter or into Police Protective Custody has not been clearly defined, preferable in the Bill.**
If there is no available space for assessment at the Assessment and Treatment Centre a person remains in police custody. It is not clear how long people would be detained before space became available for assessment.	**We recommend the process for dealing with persons in protective custody when there is no space available at the Assessment and Treatment Centre be clearly articulated, including how long a person can be held when in protective custody when no space is available. This would preferably be prescribed in the Bill.**
The basis on which the Government has assessed that it will be a small number of people requiring intensive medical support to withdraw at this stage is unclear. We are concerned that once operationalised there may be large numbers of people suffering medical withdrawal and requiring intensive medical attention, and there may not be adequate resources to assist these people.	People detained in mandatory rehabilitation will require high quality medical and psychological services, along with cultural and family support to deal with alcohol withdrawal and rehabilitation. **We recommend that the NTG set out how it is going to provide these services and that it should be a legal obligation to provide them to a minimum standard.**
Besides alcohol withdrawal, a significant number of those detained will have serious medical problems/risk of undiagnosed trauma and it is not clear how these will be addressed.	People detained in mandatory rehabilitation will require high quality medical and psychological services, along with cultural and family support to deal with undiagnosed trauma. **We recommend that the NTG sets out how it is going to provide these services and that it should be a legal obligation to provide them to a minimum standard.**

[33] Department of Health, *Mandatory Treatment Service: Arrangements and Pathways* http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/82/63.pdf&siteID=1&str_title=Mandatory Treatment Service Arrangements and Pathways.pdf

Concern	Recommendation
It is concerning that the Tribunal will only sit in Darwin, and will assess detainees in other NT locations via videolink. It may be difficult to properly assess detainees via videolink, and the Tribunal should travel to all places where people are detained under the Act.	**We recommend that the Tribunal sit in every location where there is a mandatory alcohol treatment centre (Darwin, Nhulunbuy, Katherine and Alice Springs), and that this be prescribed in the Bill.**
We are concerned about the use of the Medi-Hotel in Darwin as a mandatory treatment facility. It was not designed with this purpose in mind, and we are concerned that there may be risk of harm to detainees in using a facility which is not purpose built (supported by the findings of the Royal Commission into Aboriginal Deaths in Custody in 1991).	**We recommend that the NT Government source appropriate, built for purpose accommodation for detainees under the mandatory rehabilitation scheme, and that the scheme not proceed until such accommodation is available.**

5.2 Culturally appropriate treatment

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

- Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD)[34]
- Council for Aboriginal Alcohol Program Services (CAAPS)[35]
- Central Australian Aboriginal Alcohol Programs Unit (CAAAPU).[36]

This is an important aspect, 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.[37]

This may be attributed to the fact that Indigenous healing is based on a much more holistic plane as compared to Western biomedicine.[38] It is unsurprising, thus, that a large factor behind the success of these aforementioned programs may be accredited to their innate holistic nature. 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.

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34 Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties, (2010), http://www.forwaard.com.au/history.html, [Accessed 26 February 2013)

35 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]

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

37 Gray, D., Saggers, 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

38 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

Neither the Bill nor the supporting policy[39] appears to support a culturally supported model of treatment. APO NT believes that there will be a disproportionate amount of Aboriginal people being treated under the proposed mandatory treatment regime, and as such the scheme must incorporate support for Aboriginal peoples' culture and language.

The Barkly Work Camp in Tennant Creek provides reparation activities and educational programs for offenders, including the Elders Visiting Program. The Elders Visiting program allows members of the Council of Elders and Respected Persons (CERP) to visit offenders which assists with the prisoner's reintegration back into the community.[40] We recommend that a similar visiting program be incorporated into the proposed mandatory alcohol treatment scheme.

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 that[41]:

> *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 in any therapeutic approach to treatment of alcohol dependence.

Although we believe that suitable senior experienced Aboriginal staff will be critical to making mandatory rehabilitation as safe as it can be, there is only a limited pool of Aboriginal staff who are ready to work in AOD services. Establishing these schemes quickly will potentially draw qualified experienced Aboriginal staff (and other qualified staff) away from existing voluntary services into mandatory rehabilitation. In the long term, we can work towards more training but as the NTG is committed to establishing these services quickly, the mandatory services will be drawing on the same small pool of qualified Aboriginal staff and this will either leave other services short or you will not be able to recruit.

We also recommend that in order to detainees to benefit from the proposed treatment to be provided the NT Government will need to provide Aboriginal Liaison Officers. We recommend that the employment of Aboriginal Liaison Officers should either be enshrined in the Bill or in the supporting policy document.

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39 Department of Health, *Mandatory Treatment Service: Arrangements and Pathways* http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/82/63.pdf&siteID=1&str_title=Mandatory Treatment Service Arrangements and Pathways.pdf

40 http://www.correctionalservices.nt.gov.au/CorrectionalCentres/BarklyWorkCamp/Pages/default.aspx

41 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

5.3 Amendments to the Bill

We understand that CAALAS, NAAJA, NT Legal Aid Commission (NTLAC) are making a joint submission on the Bill. We have seen this submission and we support the specific legal comments made in their joint submission.

The Government has stated its commitment to the Bill, and we appreciate the opportunity to consult with the Department of Health (**the Department**) on the draft Bill. If the NT Government still intends to pursue passage of the Bill following community consultations, then we provide the following comments for the attention of the Department.

Concern	Recommendation
Clause 14, 17, 31 Problem drinker detained in custody for an excessively long period while they are assessed. People may be detained in assessment detention for up to 13 days, before they are can be released by the Tribunal as unsuitable for mandatory treatment.	**We recommend you amend clause to reduce the time taken before assessment to be in line with timeframes in modern mental health and alcohol treatment legislation.**
Clause 65 The Department has confirmed that the requirement to receive aftercare is not enforceable, and that aftercare is considered critical to the effectiveness of rehabilitative efforts. The Department understands that the Government is committed to funding this service. However, ongoing participation is not intended to be compulsory once the term of a mandatory treatment order is completed. The Department has stated that they will continue to consult with stakeholders concerning arrangements for aftercare.	**We recommend that this clause 65 be amended to define "aftercare", to identify matters that should be covered in an aftercare plan, and to establish what assistance will be provided post-release.**
Clause 70 Problem drinkers detained may have to pay for costs of their own incarceration including basic items such as medication and food. No other state/territory in Australia asks detainees to pay for basic necessities while detained.	**We recommend you remove this provision.**
Clause 72	**We recommend you remove this provision as it is counter-therapeutic, and will unnecessarily**

Concern	Recommendation
It will be a criminal offence to abscond from mandatory residential detention with a maximum penalty of 3 months jail.	**criminalise people who there are for therapeutic reasons.**
Clause 75 There are serious concerns about the 'reasonable force' that authorised persons will be able to use against people in treatment. A person may have force used in an improper and potentially dangerous way.	**We raised strong concerns about the breadth of the authorised officer appointment provision, and the scope of the powers that are granted to such an officer.** **We recommended that this provision be revised to include safeguards such as those contained in Part IIA of the Criminal Code.**
Clause 15, 19 It is not guaranteed that people requiring an interpreter or a rights statement in first language will be provided with these at all times.	**We recommend that there be a guarantee that people requiring an interpreter and a rights statement in first language will be provided with these at all times.**
Clause 104 The Tribunal membership is made up of two experience lawyers, but only one medical or health practitioner. Membership of the Tribunal should include more medical or health professionals, if the focus of the scheme is really to be medical or therapeutic.	In order to ensure that an appropriately qualified person is making decisions about a person's treatment whilst detained, the Bill needs to specify the qualifications for members of the Tribunal. **We recommend that the instead of 'medical or health practitioner' the Bill require that the medical/health representative on the Tribunal have the following experience/ expertise:** • **Alcohol and other drug medical specialists or other doctors with extensive experience (at least five years) in alcohol and other drug medicine whose practice and qualifications have been reviewed by a AOD medical specialist; or** • **Clinical psychologists with five years of AOD experience whose qualifications and experience have also been reviewed by an experienced AOD specialist.**
Clause 113	**We strongly recommend that representation by**

Concern	Recommendation
There are no provisions for increased resourcing of legal representation and it is set up that non-lawyers appointed by the Tribunal will represent people. The lack of legal representation will place already vulnerable people in grave jeopardy, for example in not having access to legal advice as to whether they might have grounds to appeal a decision made against them.	**a lawyer is made available to all people before the tribunal.**

5.4 Additional provisions

APO NT recommends a number of additional provisions be included in the Bill, outlined in the table below:

Proposed provision	Content
Transport following release	There is no requirement that a person be taken home following release from detention, which could mean that people are stranded hundreds of kilometres from home upon their release from treatment
Aboriginal liaison officers	Recommend that the Bill include mandating employment of Aboriginal liaison officers at treatment centres.
Mandatory qualifications for staff	The bill needs to stipulate the qualifications and experience of the senior clinician who is authorised to assess whether a person requires mandatory treatment. There are only a few alcohol and other drug medical specialists in the NT and many other doctors such as general practitioners would not necessarily have detailed knowledge of alcohol and other drug problems. Clinical psychologists with extensive experience in AOD assessment may be suitable to be senior clinicians but the person would definitely need to be seen by a medical practitioner to sort out general health problems. APO NT recommends that senior clinicians be limited to: • Alcohol and other drug medical specialists or other doctors with extensive experience (at least five years) in alcohol and other drug medicine whose practice and qualifications have been reviewed by a AOD medical specialist • Clinical psychologists with five years of AOD experience whose qualifications and experience have also been reviewed by an experienced AOD specialist.