# Submission to the Northern Territory Government

# Six Month Review of the *Alcohol Mandatory Treatment Act* (NT)

February 2014

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# 1 Executive Summary

This submission is endorsed by:

- The Central Australian Aboriginal Legal Aid Service (**CAALAS**);
- The North Australian Aboriginal Justice Agency (**NAAJA**);
- The Northern Territory Legal Aid Commission (**NTLAC**);
- The Central Australian Aboriginal Womens Legal Service (**CAWLS**); and
- Darwin Community Legal Service (**DCLS**).

Together, we have serious concerns about the operation of the *Alcohol Mandatory Treatment Act* (**AMT Act**) and the related scheme of mandatory treatment. We also raise concerns relating to the review process and the transparency of the scheme.

We believe the scheme would be significantly improved if the Government were to:

1. Repeal the criminal penalty provisions that apply to individuals who abscond from treatment;
2. Ensure access to legal representation for all individuals who come before the Alcohol Mandatory Treatment Tribunal; and
3. Commit to conducting a thorough, transparent evaluation of the scheme and the medium- and long-term health outcomes for those who receive treatment.

We make a number of specific recommendations to protect the rights of clients interacting with the scheme and to address the grossly disproportionate number of Aboriginal people entering treatment. We also address the need to improve communication with, and accountability to, both clients and the public.

Many of the issues raised in May 2013 in the detailed joint submission of NAAJA, CAALAS and NTLAC on the then *Alcohol Mandatory Treatment Bill* continue to apply.

Our responses to the issues raised by NT Government representatives during the consultation process for the six month review are set out below, followed by a series of additional discussion points.

# 2 Issues raised in the consultation process

| Question | Response |
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| **Assessable persons (Part 2, s 8)** | |
| 1. Is this entry point to AMT targeting the right or only group requiring treatment?<br><br>2. Could the system be made available via other referral avenues? | • Data released to date by the Department of Health indicates that this approach disproportionately targets Aboriginal people. Given the criminal penalties that potentially stem from referral to treatment, this amounts to a de facto criminalisation of public drinking by Aboriginal people, contrary to the recommendations of the |

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| | Royal Commission into Aboriginal Deaths in Custody.[1]<br>• Recent data released by the Productivity Commission indicates that alcohol misuse is prevalent across the community in the Northern Territory, and that non-Aboriginal people are at greater risk of alcohol-related harm than Aboriginal people.<br>• While we are reluctant to suggest changes that would expand the scope of the scheme, the Government may wish to consider adopting health-based criteria for referral for treatment rather than the current entry point. Similar models can be found in Victorian and NSW legislation.<br>• The Government may wish to consider repealing s 9(2)(a), to allow for referral of individuals who have committed low level offences under the influence of alcohol. If this position were adopted, it may also be appropriate to allow for referral by judicial officers. |
| **Timing of assessment (s 17)** | |
| 3. Should the 96 hour assessment period be extended? Or<br><br>4. Should there be a provision to enable the Senior Assessment Clinician (SAC) to apply to the Tribunal to extend the assessment period if, in their clinical opinion, the client is not able to be properly assessed within 96 hours?<br>• On what grounds should the SAC be able to apply to the Tribunal to extend the assessment period and for how long?<br><br>5. Should the 96 hour period be specified as business days only? | • We strongly oppose any extension of the assessment period. The current 96 hour period already imposes a significant incursion on personal liberty, and increases the amount of time that Aboriginal people (in particular) spend in a custodial setting.<br>• Similarly, the 96 hour period should not be specified as business days only, as this would effectively extend the period for those clients who are referred for treatment on Friday evenings and weekends. While no data is available on the proportion of clients this would affect, it could be expected to include a relatively large proportion of admissions to assessment.<br>• According to the October–December 2013 Quarterly Report released by the NT Government, only one person was released from assessment as a result of the time period for assessment running out. No information is available to indicate why this assessment exceeded the available time. However, this figure does suggest that in the vast majority of cases the current 96 hour period allows adequate time for assessment.<br>• If the Government is committed to |

[1] Royal Commission into Aboriginal Deaths in Custody (1991) *Final National Report*, Recommendations 79–85.

<table>
<tr><td></td><td>permitting an extension of time for assessment, we recommend that an extension of time should be made available only:
<ul><li>By application of the SAC to the Local Court; and</li>
<li>Where the SAC can demonstrate that there are exceptional circumstances justifying the extension.</li></ul>
<ul><li>Exceptional circumstances should be defined to exclude cases where a delay is the result of administrative or resourcing issues not relating to the assessed person.</li>
<li>In addition, express provision should be made for an individual to be released to the community pending a hearing if the SAC does not recommend that a treatment order be made.</li></ul></td></tr>
<tr><td colspan="2">AMT Tribunal (Part 3)</td></tr>
<tr><td>6. Are the functions and powers of the Tribunal adequate / appropriate?<br><br>7. Is 96 hours sufficient time for the Tribunal to hear and decide an application?<br><br>8. Should this 96 hour period be specified as business days only?<br><br>9. Should there be a provision for the Tribunal to defer making a decision and on what grounds should this occur?</td><td><ul><li>The Tribunal’s power to appoint an advocate should be revised to require the appointment of a legal representative (s 113(2)) by the President (or his or her delegate) if an affected person is not represented before the Tribunal, unless the person expressly refuses representation.</li>
<li>To safeguard transparency and accountability of decision making, s 48 of the Act should be amended to require the Tribunal to provide written reasons to the affected person, including reasons for the term of any income management order. In the event that Government decides this is not practicable in every case, the affected person should be given the option of requesting written reasons.</li>
<li>Given that an individual remains in custody at an assessment facility while the Tribunal deliberates, we oppose extending the time available for the Tribunal to hear and decide an application. Nor should the 96 hour period be specified as business days only.</li>
<li>In the event that the Government is committed to extending the time available for the Tribunal to hear and decide a matter, we recommend that this be permitted only:
<ul><li>On application by the President to the Local Court; and</li>
<li>Where the President can demonstrate that there are exceptional circumstances justifying</li></ul></li></ul></td></tr>
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| | the extension.<br>• Exceptional circumstances should be defined to exclude cases where a delay is the result of administrative or resourcing issues not relating to the assessed person. |
| **Appeals to Local Court (s 51)** | |
| 10. What are your views on these provisions? | • The scheme should provide for merits review of a decision of the Tribunal by an external decision-maker, such as the Local Court or an Administrative Decisions Tribunal should such a Tribunal be established. This would significantly improve the scheme.<br>• When conducting a merits review, the relevant decision making body should have an explicit power to obtain and consider all the information and material that was before the Tribunal when the initial decision was made, and to obtain and consider any further information or evidence that may be relevant, including information or evidence that was not before the Tribunal at the time it made its decision.<br>• In addition, if a treatment order is challenged on any basis, the decision making body should have discretion to stay the order pending review. |
| **Leave of absence (authorised s 76 / unauthorised s 72)** | |
| 11. Under what circumstances, if any, should a period of absence (permitted/ not permitted) during the 96 hour Tribunal or treatment order period:<br>• 'Pause' the clock and resume again when the person returns (eg, if client is absent after 48 hours of the Tribunal period, the remaining 48 hours is available when the person returns); OR<br>• Cause the time period to restart when the person returns? | • We strongly recommend that s 72 be repealed in its entirety, as discussed in greater detail at 3.1 below.<br>• The assessment period should not be allowed to 'pause'.<br>• As noted above, if the Government is committed to allowing an extension of the assessment period, this should only be permitted in exceptional circumstances and on application by the SAC to the Local Court. |

| Aftercare plans (ss 65–6) | |
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| 12. Do you think provisions for aftercare should be in the AMT Act?<br><br>13. Follow up treatment must be received for a minimum of 3 months, maximum of 6 months after completion / revocation of the mandatory treatment order. What are your thoughts on this? | • We support the provision of aftercare and believe that it should be available to all clients of the scheme, including those who live remotely.<br>• The scheme should be independently evaluated by health professionals, with reference to adequacy of the 3–6 month time frame for care.<br>• The Government should release public figures on the availability of aftercare and the outcome of its evaluation. |
| **Offence provision – absconding (s 72)** | |
| 14. Is it the view that the current offence provision and associated penalties is the most effective mechanism for responding to those clients not adhering to the treatment order / program in this way?<br><br>15. What other strategies can be used to strengthen the clients' compliance with the treatment order? | • As noted above, we would strongly support the repeal of s 72. We believe that it is entirely inappropriate to attach criminal sanctions to a health problem.<br>• We support the development of positive incentives to comply with treatment. In particular, treatment should be engaging and rewarding for clients.<br>• We would suggest that provisions may be enacted in the relevant legislation whereby affected people can offset their time undergoing mandatory treatment or community treatment against any money recoverable under the *Fines and Penalties Act*. |
| **Protection of rights** | |
| 16. Are [the current] measures sufficient?<br><br>17. Should other measures be in place to protect the rights of those in the AMT system? | • We recommend the repeal of s 70. Charging a person for food and medication in a detention environment is contrary to human rights principles as well as the therapeutic objects of the Act.<br>• Based on experiences reported by clients of our service who have been subject to the AMT scheme, we believe that the current rights provisions are inadequate. While we commend the express inclusion of certain rights in the Act, we have heard of numerous cases in which these rights have not been protected in practice. A case study examining several of these issues is set out at 3.9 below.<br>• Our primary concerns relate to the provision of legal advice and interpreters for vulnerable individuals. These matters are discussed in greater detail at 3.2 and 3.3 below. |

**Recommendations arising**

- The period for assessment and Tribunal hearings and decision making should not be extended.
- If the Government is committed to permitting an extension of time for assessment or Tribunal decision making, we recommend that an extension of time should be made available only:

  a. By application to the Local Court; and

  b. Where the applicant can demonstrate that there are exceptional circumstances justifying the extension.

  Exceptional circumstances should be defined to exclude cases where a delay is the result of administrative or resourcing issues not relating to the assessed person.
- Express provision should be made for an individual to be released to the community pending the hearing of an application for an extension of time if the Senior Assessment Clinician does not recommend that a treatment order be made.
- Section 113(2)–(3) (right of appearance and representation – appointment of advocate) should be revised to require the appointment of a legal practitioner if an affected person is not represented before the Tribunal, unless the person expressly refuses representation.
- To safeguard transparency and accountability of decision making, s 48 of the Act should be amended to require the Tribunal to provide written reasons to the affected person, including reasons for the term of any income management order. In the event that Government decides this is not practicable in every case, the affected person should be given the option of requesting written reasons.
- The scheme should provide for merits review of a decision of the Tribunal by an external decision-maker. When conducting a merits review, the relevant decision making body should have an explicit power to:

  a. obtain and consider all the information and material that was before the Tribunal when the initial decision was made; and

  b. obtain and consider any further information or evidence that may be relevant, including information or evidence that was not before the Tribunal at the time it made its decision.
- If a treatment order is challenged on any basis, the decision making body should have discretion to stay the order pending review.
- Section 72 should be repealed.

- The aftercare scheme should be independently evaluated by health professionals, with reference to adequacy of the 3–6 month time frame for care.

- The Government should release public figures on the availability of aftercare and the outcome of its evaluation.

- Section 70 should be repealed.

# 3 Additional concerns and recommendations

## 3.1 Criminal penalty provisions

Section 72 of the AMT Act should be repealed. As noted in the 2013 submission, and in several other submissions made to the NT Government, it is inappropriate to apply a criminal penalty to an individual who fails to comply with health treatment. This is particularly so in the case of individuals suffering from alcoholism, given that the desire to obtain and consume alcohol is a feature of addiction and outside the control of the individual.

Based on our experiences as legal services assisting individuals who have absconded from treatment, and the views of expert medical practitioners, we believe that the threat of a criminal sanction does not create an incentive for individuals to remain in treatment, and does not compel compliance by individuals who strongly wish to leave treatment.

Instead, it appears that those who feel most positive about treatment are those who believe they are making a choice to participate, and those who are most likely to engage are those who perceive the treatment provider to be helpful to them. Emphasis should therefore be placed on ensuring that mandatory treatment providers offer engaging, culturally appropriate programs in order to create a positive incentive for clients to comply with, and participate in, treatment.

We note that no data is available about the number of people who have absconded from treatment three times and thus been charged under s 72, and we urge the NT Government to make this information publicly available.

## 3.2 Access to legal advice and representation

Although the AMT Act provides that an individual may be represented before the Tribunal, and grants the President power to appoint a representative, the Department of Health has confirmed that no individual appearing before the Tribunal in Alice Springs has been represented by a legal representative or independent advocate of any kind. While some individuals in Darwin and Katherine have been represented by lawyers from NAAJA, this has been on an ad hoc basis, not by appointment of the Tribunal, and NAAJA does not have the resources to continue to represent people in this position. We also understand that no individual appearing before the AMT Tribunal has had the benefit of a legal representative appointed by the Tribunal. We understand that a social worker advocate has now been appointed to assist those appearing in Darwin only. The advocate is not available to people appearing before the tribunal outside of Darwin. We also understand that this advocate does not always have a right to question witnesses or make submissions on behalf of the affected person.

This situation is unacceptable.

Given the potential impact of a mandatory treatment order on individual liberty, and the limited capacity of some vulnerable individuals to represent themselves and the potential for criminal sanctions on absconding, it is critical that individuals be afforded legal representation. Based on the limited demographic data released by the NT Government, and our experience providing advice to individuals undergoing assessment or treatment, it appears that a large number of individuals affected by the scheme have a limited understanding of the process to which they are subject.

Many individuals speak English as a second, third or fourth language (and some only at a very basic level), and many cannot read or write. They experience the process as foreign and confusing, and have little understanding of their rights. In some cases individuals undergoing treatment have reported that they do not understand what type of order they have received. Without assistance, most clients would be unable to make a complaint or to seek that an order be varied or revoked.

While the appointment of an independent advocate is preferable to a situation (such as that in Alice Springs) in which individuals are entirely unrepresented, we believe that legal advice and representation should be available as a matter of course, unless expressly refused by an individual.

A legal representative is uniquely placed to ensure that individual rights are protected, proceedings are understood, and complex matters are dealt with efficiently and effectively. The provision of legal representation would also assist the Tribunal to ensure that all relevant issues are considered, and that the appropriate order is made. Legal representation is also essential given the limited rights of appeal and the technical language (particularly relating to clinical assessment and income management) that is often used before the Tribunal.

The Central Australian Aboriginal Legal Aid Service (**CAALAS**) and North Australian Aboriginal Justice Agency (**NAAJA**) (two of the legal services endorsing this submission) both provide preliminary telephone advice to clients undergoing assessment. Unfortunately, neither has sufficient resources to provide ongoing representation of individuals before the Tribunal without impacting on other services they currently provide. The Northern Territory Legal Aid Commission (**NTLAC**) is not sufficiently funded to extend its service to representing individuals before the Tribunal.

To give effect to the provisions of the AMT Act that provide for representation, to protect the rights of individual clients, and to improve the efficiency and perceived legitimacy of the scheme, we strongly recommend that the NT Government commit to adequately funding legal services to enable them to appear before the Tribunal. Such representation should be provided on a fee for service basis, adopting the approach taken under the *Mental Health and Related Services Act*.

**Recommendations arising**

- The NT Government should provide funding to enable legal services to advise and represent individuals undergoing assessment and appearing before the AMT Tribunal.
- The Act should require assessment facilities to expressly notify clients of their right to contact a lawyer when they are first referred for assessment

## 3.3 Access to interpreters

The AMT Act currently provides for the use of interpreters when the rights statement is explained to a person (s 15(3)) and before the Tribunal (s 116) "to the extent that is reasonably practicable". In our experience, these provisions are inadequate. There is also no provision for the use of interpreters during clinical assessment.

Assessment centre staff should be equipped to undertake a rigorous assessment of whether an interpreter is necessary when a person is first referred to treatment. The test in s 15(3) and s 116 (that is, if a person "is unable to communicate adequately in English") does not reflect the need to undertake a thorough assessment in many cases. Service providers must be able to ensure that they are conveying all of the required information, and that it is being understood. Effective communication is a two way process, and treatment staff should not proceed without an interpreter unless they are confident that the client is able to fully express themselves in English.

As discussed at 3.2 above, many individuals undergoing assessment and treatment have a limited capacity to communicate in English. The use of appropriately trained interpreters is critical to ensure that individuals who do not speak English as a first language (or at all) understand the process to which they are subject, and are properly assessed. When combined with the absence of legal advice or representation, a failure to use an interpreter at a hearing of the Tribunal may also contribute to a denial of natural justice, as was held to be the case in the recent matter of *RP v Alcohol Mandatory Treatment Tribunal*.[2]

We have advised clients in a number of cases in which an interpreter has clearly been required, but has not been made available by assessment centre staff. For example, on one occasion, CAALAS was contacted by a staff member of the Alice Springs assessment centre and asked to 'explain what was happening' to a client who spoke very limited English. The staff member stated that no interpreter was available for the language spoken by the client, although it quickly became clear that the language was widely spoken in the Top End. CAALAS contacted the Aboriginal Interpreter Service in Darwin and secured the assistance of a highly qualified interpreter who was able to interpret by telephone shortly thereafter.

While recognising that challenges can arise when seeking to access an interpreter, this example highlights that in many cases these barriers can be overcome. The current provisions of the AMT Act are insufficient to ensure that staff take all possible steps to ensure access to an interpreter when needed. Our experience also points to the need to ensure that staff of the scheme are adequately trained in working with interpreters. The Aboriginal Interpreter Service has developed guides to working with an interpreter and for deciding whether an interpreter is necessary, and these standards should be adopted by assessment centre staff, tribunal members, and treatment providers.

Further, access to an interpreter should not be confined to the reading of a rights statement and Tribunal hearings. Interpreters should also be required to be used when an individual is preparing for a Tribunal hearing, and should be utilised during assessment. To ensure that treatment is delivered in a meaningful manner, interpreters should also be used throughout treatment when an order is made.

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[2] [2013] NTMC 32.

**Recommendations arising**

- The words "to the extent reasonably practicable" should be removed from s 15(3) and s 116.

- Section 19 should be amended to include a requirement that decisions about a person's decision making capacity and discussions about treatment options take place with the use of an interpreter (where necessary) and that any "explanations, descriptions or advice be given in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, literacy and any other factors which may influence the person's understanding", in line with s 7(5) and s 7(3)(k) of the *Mental Health and Related Services Act*.

- Any provisions in the Act relating to the use of an interpreter should be strengthened to state that where the clinician or the Tribunal is unable to ensure that that there is meaningful two way communication in English, an interpreter must be used.

- All AMT staff (including assessment clinicians, Tribunal members and treatment providers) should be required to undertake training to improve their ability to identify when an interpreter is required.

- When an interpreter is required, they should be present at all stages of assessment, before the Tribunal, and while undergoing treatment.

## 3.4 Rights of appeal

The Northern Territory government seeks comments on the operation of the appeal mechanism under the Act. As outlined in our submission to the government on the Alcohol Mandatory Treatment Bill, the current appeal mechanism, which allows an appeal only on a 'question of law' is far too narrow.

We have real concerns about the integrity and transparency of the Tribunal process and the protection of the rights of affected persons within that process. While the strict appeal mechanism under s 51 of the Act is available to remedy these issues in some cases, such as where the Tribunal acts outside its jurisdiction, misconstrues the law or denies an affected procedural fairness (see, for example, *RP v the Alcohol Mandatory Treatment Tribunal)* the limited scope of the appeal mechanism means that, in many cases, there is no avenue for challenging the Tribunal's decision.

Given that the Tribunal has the power to deprive a person of their liberty for a period of three months to receive treatment against their will, it is critical that an affected person can challenge the Tribunal's factual findings and the legality of its findings. Accordingly, we strongly recommend that the Tribunal's decisions be subject to merits review by an independent, external decision-maker, and that the external decision-maker be granted explicit power to obtain and consider any information relevant to the decision.

In a consultation with Northern Territory government representatives in Alice Springs on 4 February 2014, legal stakeholders were informed that a merits review mechanism was considered unnecessary because an affected person subject to a Tribunal order may make an application to the Tribunal to have the order varied or revoked. This may be an

appropriate mechanism where circumstances change and the affected person or the treatment clinician considers that the order is no longer suitable. However, because the application for variation or revocation is heard by the Tribunal, not by an independent, external decision-maker, it does not provide affected persons with an appropriate avenue for challenging a flawed Tribunal decision or decision-making process. Nor is it adequately accessible, given the particular vulnerability of people undergoing treatment and the lack of easy access to legal representation.

To improve transparency and accountability in Tribunal decision-making, and to better safeguard an affected person's rights and interests, the government should introduce a right to seek merits review in the Local Court (or the Administrative Decisions Tribunal, should it be established), or it should amend the appeal mechanism to allow for a de-novo hearing based on all relevant information, including any relevant information not before the Tribunal when it made its decision.

The decision-maker with the jurisdiction to conduct a merits review or an appeal should have the power to stay the Tribunal's decision, pending determination of the proceedings. This is consistent with other merits review and appeal schemes.

## 3.5 Income management

We reiterate the comments we made in relation to the income management provisions in our submission to the government in response to the Alcohol Mandatory Treatment Bill. In particular, it is critical that the decision to make an income management order is a discretionary decision governed by criteria requiring a connection between income management and improved health outcomes for the affected person. The current 'automatic' income management order of 70% upon the making of a mandatory treatment order constitutes an unjustifiably arbitrary exercise of power.

It is deeply concerning that the Territory Government did not have the legislative power from the Commonwealth to income manage people for the first 4 months and 22 days of Tribunal's operation. A significant number of income management orders were made which could not be implemented by the service delivery agency, Department of Human Services (Centrelink). This would have caused confusion and uncertainty for participants. We are unsure if the Tribunal communicated this to participants in any or in any meaningful way.

We have been advised that the Tribunal is imposing 12 month income management orders in many of the cases it decides. This has the potential to impose significant hardship on participants, including on their freedom of movement. For example, a person who wishes to move to a different location in order to secure a job will find it difficult to save the money for moving expenses with access to only 30% of their Centrelink payment as cash. We note that there are still a number of outlets, including fuel and community stores, which are not BasicsCard merchants. It may also have an impact on a person's ability to pay child support.

While there is the ability for a participant to seek a review of an income management decision, a participant is unlikely to do so unrepresented. Remote participants face additional barriers to seeking review.

Per Recommendation 5, written reasons for the length of an income management order should be included in written reasons for the Tribunal's decision when an income

management order is made. The Tribunal needs to be clear about the reasons why it considers 12 months income management orders to be necessary and include this in the assessment report.

We also maintain that it is inappropriate for the purposes of the Tribunal to tie income management orders to the person's partner's eligibility for a welfare payment. The partner is not the subject of the proceedings before the Tribunal and so their status as an eligible payment recipient should not be relevant.

Practically, we do not consider that the Department of Human Services – Centrelink would be able to provide the Tribunal with information as to the affected person's partner's payment status, given Principle 11 of s 14 of the *Privacy Act 1998* (Cth) which restricts a record keeper from disclosing the information unless the person consents to the disclosure or there is a serious or imminent threat to the life or health of the individual concerned. Accordingly, s 119(b) should be repealed.

**Recommendations arising**

- The Tribunal should have discretion to determine whether or not to make an income management order, based on criteria requiring a connection between income management and improved health outcomes for the affected person.

- The Tribunal should have discretion to set the amount of income management at less than 70%.

- All members of the Tribunal should receive training regarding the income management provisions of the operation of the *Social Security (Administration Act) 1999* (Cth) and the practical operation of income management, so as to inform any decisions it makes regarding the suitability or term of any income management order.

- Section 119(b) should be repealed.

## 3.6 Review and evaluation of the AMT scheme

We are concerned that the government is seeking comments on the operation of the legislative scheme without providing any detailed data evidencing how the scheme is in fact operating. It is insufficient to provide basic input and output data. We question the value of a review of the operation of legislation when there is no evidence of its *outcomes*.

Given our concerns about the discriminatory nature of the scheme, lack of transparency and accountability, the lack of safeguards to protect affected persons' rights and the significant funds expended on the scheme, at a minimum the input and output data should be better particularised to include:

- The number of people who were assessed as needing an interpreter;
- The number of people who received access to an interpreter both prior to the Tribunal hearing and during the Tribunal hearing;
- The number of people who received legal representation before the Tribunal;
- The number of people who received an advocate before the Tribunal;

- The number of people who were assessed, but were not the subject of a Tribunal order; and
- The average number of days a person was detained pending a Tribunal decision (assessment through to Tribunal decision).

Most importantly, we also urge the government to follow through with its commitment to evaluate client outcomes. We support APONT's submission outlining the matters which should be included in an evaluation framework, and we ask the government to continue consulting with key stakeholders in relation to the evaluation of client outcomes to ensure that the evaluation is fair, rigorous and delivered in a timely manner.

**Recommendations arising**

- The Government should commit to undertake a thorough, independent, health-based evaluation of the scheme and medium- and long-term client outcomes. Such information should be publicly released.

- The Government should commit to undertaking a further public consultation process upon release of evaluation data.

- The Government should provide a greater level of detail in the quarterly reports it publishes on the scheme.

## 3.7 Breadth of criteria for a mandatory treatment order

We are concerned about the breadth of s 10 of the Act, and the discretion that the Tribunal has when determining whether a person should be subject to a mandatory treatment order. We have been advised of instances where the Tribunal has used evidence of a person's status as a protected person on a Domestic Violence Order (DVO) to support a decision to place that person under a mandatory residential treatment order. Possession of a DVO against another person has absolutely no relevance to a person's alcohol abuse or whether that alcohol abuse will be appropriately addressed through mandatory treatment. Further, to use this as support for mandatory treatment is to suggest that being named as a protected person on a DVO justifies a deprivation of that person's liberty, and risks inappropriately conflating the issues of domestic violence and alcohol abuse.

## 3.8 Impact of the scheme on parents and children

We are also concerned about the impact of the scheme specifically on women, and parents more broadly. In the case where a parent is placed under a mandatory treatment order, they should be entitled to seek support and advice of an advocate relating to the care of and access to their children whilst in treatment. Division 2 of the Act details the community visitors program operating under the scheme. There are however no provisions in the Act to ensure parent-child contact is prioritised throughout the treatment period, and no requirement that approved treatment facilities be able to facilitate parent-child access or other family meetings during a treatment period.

A parent (particularly a single parent) who is subject to a treatment order may be at immediate risk of losing custody and responsibility of their child to the Department of Children and Families (DCF) due to that parent's detention and absence from the family

home. We are also concerned that the Tribunal may use evidence of open child protection files as a justification for placing a parent under a mandatory treatment order.

**Recommendation arising**

- The Act (or accompanying guidelines) should make clear provision for the consideration of children who have a parent that is subject to a mandatory treatment order, and referral to appropriate family services. That all approved treatment facilities be required to facilitate parent-child access as per appropriate cases.

## 3.9 Additional safeguards

The following case study highlights a number of the systemic issues that affect vulnerable individuals interacting with the scheme, which are discussed in greater detail below. This case study also raises issues about the use of interpreters, which is discussed above at 3.3.

**Case study: Ms G**

A senior assessment clinician had assessed a woman from a remote community, Ms G, as meeting the s 10 criteria for mandatory treatment. Ms G had had been apprehended three times in the previous two months under the protective custody provisions. There had been no other apprehensions in the previous 12 months. A year earlier she was reported to have been nearly hit by a car whilst walking home from the Social Club in her community. This was relied upon as evidence that her drinking had put her in danger. The assessment did not take place with an interpreter.

Ms G indicated that she would like a legal representative and a solicitor from NAAJA Katherine attended her at the hospital. The solicitor was able to talk with Ms G with the help of an interpreter and get the following background. Ms G told NAAJA that she was away from home in Katherine for her birthday and had been drinking. Her apprehension for one of her protective custodies was while she was waiting for a taxi to take her to her sister's place. Ms G usually lives in a dry community, although there is a Social Club which does not sell full strength beer. In relation to the incident where she had nearly been hit by the car she instructed NAAJA that she, and other pedestrians, had taken a popular short cut home from the club. The short cut is between two shire buildings and at the time was also used by vehicles. It is poorly lit. On the basis of these instructions it was clear that she was not the kind of drinker that the legislation is intended to target.

Ms G instructed NAAJA that she wanted to return home to her community and take part in rehabilitation through the clinic. The solicitor was able to talk to family members and staff at the clinic and ascertain that they were willing to support her in her rehabilitation.

It was not possible for the Tribunal to make community treatment orders as the clinic is not a certified treatment provider under the regulations. However as it appeared that a more appropriate and less restrictive option for treatment was available, the solicitor, with the support of the senior assessment clinician after having reviewed the additional instructions that NAAJA obtained, was able to argue for release.

We are concerned that there are practical and legislative constraints which restrict peoples' chances of having access to the "least restrictive" option for treatment. The above case study highlights a number of these issues.

**The need for the person to understand and respond to the assessment process**. We are concerned about the lack of safeguards in the Act to ensure that the therapeutic objects in section 3 of the Act are met. There are parallels between the mental health and mandatory alcohol treatment jurisdictions, including the provision for involuntary detention and treatment, the requirements for consideration of the least restrictive options, and the overarching “therapeutic” objects of the regimes. Section 7 of the *Mental Heath and Related Services Act* (**MHRSA**) provides for a detailed and stringent process which must be undertaken before an assessment can be made that a person has given ‘informed consent’. These include advising the person about their treatment, the options, why it is necessary and checking whether the person understands that advice. There are specific provisions for the use of an interpreter (see s 7(5) MHRSA) and for the explanation to be in plain English and culturally appropriate (s 7(3)(k) MHRSA).

However in comparison, the AMT Act requires the use of an interpreter “if practicable” (s15(3)) and only for the purpose of having the rights statement explained. While it is commendable that people are given a rights statement, it is not an adequate safeguard to ensure that a person (and in particular an Aboriginal person with limited literacy and whose main language may not be English) understands the information in that statement, can apply that abstract information to their own situation and then advocate for him or herself. The Act is silent on the need for clinicians to assess whether an interpreter is necessary, to use plain English, to be culturally sensitive, to checking understanding during the assessment process of the s10 criteria. The Act would be greatly improved with the introduction of safeguards to ensure that the assessment clinician/medical staff thoroughly assesses a person’s decision making capacity and discusses all the treatment options and the person’s wishes before making a decision on s 10(c) and s 10(f).

We note that it was only after talking to her NAAJA solicitor that Ms G was able to put forward her whole story and her wishes that an appropriate treatment plan was developed.

**The lack of certified treatment providers.** The case study also highlights the limited range of treatment options which in turn are likely to result in more people being detained unnecessarily. In the Katherine region the only choice for mandated treatment is Venndale. Similarly, only one treatment provider, CAAAPU, is available in Central Australia. If Government intends to monitor treatment under the Act it should consider actively seeking out alternative treatment centres (including community clinics) and funding community based options for treatment.

We are also concerned that the Act does not provide sufficient flexibility around the need for ongoing assessment of an affected person’s treatment once an order is made. To further the principle of least restrictive intervention (s 6(b)) clinicians should be able to refer the person for treatment in their home community especially where that community is ‘dry’. The clinician may not feel that revocation of the order is appropriate. While it is arguable that the leave provisions in s76 may extend to leave for the remainder of the order for community based treatment, this argument has not been successful when raised at the Tribunal.

We note that the *Mental Health and Related Services Act* provides for doctors to change the nature of a person’s detention from involuntary to voluntary and to release a person without the need to return to the Tribunal. This recognises that a person’s attitude towards treatment (as well as their mental health condition) will change over a period of time. It also recognises

that the assessment as to the least restrictive treatment should be an ongoing one especially if the original order is for three months.

**Recommendations arising**

- Section 56 should be amended to specify that the assessment of the least restrictive treatment option is an ongoing one and that treatment plans include the investigation of community based options to determine whether a more appropriate treatment is available for the affected person.

- The leave provisions in s 76 should be amended so as to specify that senior assessment clinicians and senior treatment clinicians may grant leave for the person to be able to continue their rehabilitation with other (non designated) treatment services.

# 4 Conclusion

We commend the Government on honouring its commitment to undertake a legislative review following its first six months of operation. However, with the limited data available, it is impossible to determine whether the scheme is capable of achieving its stated goals.

On the information that is available, including anecdotal evidence gathered from our work advising individuals affected by the scheme, we believe that the AMT process has a discriminatory impact on Aboriginal people, fails to protect the rights of vulnerable people, and lacks transparency. For these reasons, we continue to oppose the scheme.

In addition to the human costs, the financial costs of running this scheme place a significant burden on the taxpayers of the Northern Territory. While we recognise that there is a pressing need to address the impact of alcohol related harm, including alcohol related offending, in our community, we submit that the NT Government should adopt a more holistic approach to addressing this issue. Such a system should target those across the whole community who most need help, not only Aboriginal people. Individuals should have basic rights protected, and access to interpreters and legal representatives must be assured. Finally, it is never acceptable to attach criminal penalties to a health problem, and the Government should develop appropriate, positive incentives to encourage people to engage in treatment.

# 5 List of recommendations

***Assessment and appearances before the Tribunal***

1. The Act should require assessment facilities to expressly notify clients of their right to contact a lawyer when they are first referred for assessment.

2. Section 56 (treatment – plan) should be amended to specify that the assessment of the least restrictive treatment option is an ongoing one and that treatment plans include the investigation of community based options to determine whether a more appropriate treatment is available for the affected person.

3. Section 76 (leave of absence) should be amended so as to specify that senior assessment clinicians and senior treatment clinicians may grant leave for the person to be able to continue their rehabilitation with other (non designated) treatment services.

***Timing of assessment and Tribunal decision making***

4. The period for assessment and Tribunal hearings and decision making should not be extended.

5. If the Government is committed to permitting an extension of time for assessment or Tribunal decision making, an extension of time should be made available only:

    a. By application to the Local Court; and

    b. Where the applicant can demonstrate that there are exceptional circumstances justifying the extension.

    Exceptional circumstances should be defined to exclude cases where a delay is the result of administrative or resourcing issues not relating to the assessed person.

6. Express provision should be made for an individual to be released to the community pending the hearing of an application for an extension of time if the Senior Assessment Clinician does not recommend that a treatment order be made.

***Appointment of legal representatives***

7. Section 113(2)–(3) (right of appearance and representation – appointment of advocate) should be revised to require the appointment of a legal practitioner if an affected person is not represented before the Tribunal, unless the person expressly refuses representation.

8. The Government should fund legal services to advise and represent individuals undergoing assessment and appearing before the AMT Tribunal.

9. Section 48 of the Act should be amended to require the Tribunal to provide written reasons to the affected person, including reasons for the term of any income management order. In the event that Government decides this is not practicable in every case, the affected person should be given the option of requesting written reasons.

***Appeals***

10. The scheme should provide for merits review of a decision of the Tribunal by an external decision-maker. When conducting a merits review, the relevant decision making body should have an explicit power to:
    a. obtain and consider all the information and material that was before the Tribunal when the initial decision was made; and

b. to obtain and consider any further information or evidence that may be relevant, including information or evidence that was not before the Tribunal at the time it made its decision.

11. If a treatment order is challenged on any basis, the decision making body should have discretion to stay the order pending review.

***Treatment, aftercare and criminal penalties***

12. Section 70 (charge for consumables) should be repealed.

13. The aftercare scheme should be independently evaluated by health professionals, with reference to adequacy of the 3–6 month time frame for care.

14. The Government should release public figures on the availability of aftercare and the outcome of its evaluation.

15. Section 72 (offence to be absent from treatment centre) should be repealed.

***Provision of interpreters***

16. The words "to the extent reasonably practicable" should be removed from s 15(3) and s 116.

17. Section 19 should be amended to include a requirement that decisions about a person's decision making capacity and discussions about treatment options take place with the use of an interpreter (where necessary) and that any "explanations, descriptions or advice be given in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, literacy and any other factors which may influence the person's understanding", in line with s 7(5) and s 7(3)(k) of the *Mental Health and Related Services Act*.

18. Any provisions in the Act relating to the use of an interpreter be strengthened to state that where the clinician or the Tribunal is unable to ensure that that there is meaningful two way communication in English, an interpreter must be used.

19. All AMT staff (including assessment clinicians, Tribunal members and treatment providers) should be required to undertake training to improve their ability to identify when an interpreter is required.

20. When an interpreter is required, they should be present at all stages of assessment, before the Tribunal, and while undergoing treatment.

***Income management***

21. The Tribunal should have discretion to determine whether or not to make an income management order, based on criteria requiring a connection between income management and improved health outcomes for the affected person.

22. The Tribunal should have discretion to set the amount of income management at less than 70%.

23. All members of the Tribunal should receive training regarding the income management provisions of the operation of the *Social Security (Administration Act) 1999* (Cth) and the practical operation of income management, so as to inform any decisions it makes regarding the suitability or term of any income management order.

24. Section 119(b) (eligible welfare payment recipient – person's partner) should be repealed.

***Provision for families***

25. The Act (or accompanying guidelines) should make clear provision for the consideration of children who have a parent that is subject to a mandatory treatment order, and referral to appropriate family services. All approved treatment facilities be required to facilitate parent-child access as per appropriate cases.

***Evaluation***

26. The Government should commit to undertake a thorough, independent, health-based evaluation of the scheme and medium- and long-term client outcomes. Such information should be publicly released.

27. The Government should commit to undertaking a further public consultation process upon release of evaluation data.

28. The Government should provide a greater level of detail in the quarterly reports it publishes on the scheme.