Aboriginal Peak Organisations Northern Territory

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

APO NT Submission to the

House of Representatives Standing Committee on Indigenous Affairs

Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait communities

17 APRIL 2014

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Aboriginal Peak Organisations of the Northern Territory (APO NT) welcomes the opportunity to make a submission to the House of Representatives Standing Committee on Indigenous Affairs' Parliamentary Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait communities. The Northern Territory has the second highest alcohol consumption in the world.1 Misuse of alcohol has devastating health and social consequences for Aboriginal communities in the Northern Territory.

Formed in 2010, APO NT is an alliance between the Northern Land Council (NLC), Central Land Council (CLC), Aboriginal Medical Services Alliance of the Northern Territory (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.

[1] Menzies School of Health Research, *Harms from and Costs of Alcohol Consumption in the Northern Territory* (September 2009). A copy of this report is available at: http://www.territorystories.nt.gov.au/handle/10070/222498

List of Attachments

ATTACHMENT A:	Communique – Outcomes of the Darwin Grog Summit
ATTACHMENT B:	Central Australian Aboriginal Grog Summit Final Report APO NT Media
ATTACHMENT C:	APO NT Submission on Alcohol Management Draft Minimum Standards
ATTACHMENT D:	APO NT Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder
ATTACHMENT E:	'Not Under the Influence of Evidence': A sober critique of the NT Alcohol Mandatory Treatment Bill, 2013. APO NT Submission on Mandatory Treatment Bill
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Summary of Recommendations

SOCIAL AND ECONOMIC DETERMINANTS

Recommendation 1: Approaches to addressing alcohol policy must encompass the social determinants of health.

PATTERNS OF SUPPLY

Recommendation 2: APO NT recommends reducing the supply of alcohol by removing cheap products (such as cheap cask wine and port) from sale, regulating the price of alcohol through a minimum or 'floor price' per standard drink or through a volumetric tax, enforcing restrictions on the right to drink through permits and reducing trading hours where alcohol is sold.

Recommendation 3: APO NT believes that licensees who serve patrons alcohol must be held responsible and accountable for the irresponsible service of alcohol.

FOETAL ALCOHOL SYNDROME DISORDERS (FASD)

Recommendation 4: APO NT recommends that FASD should be recognised as a disability in Australia (see **Attachment D).**

Recommendation 5: Australia has no specialised programs or facilities for FASD-affected offenders. As this is the primary obstacle to humane, appropriate care for FASD sufferers, it should be the focus of government investment. The Australian Government must commit to ongoing funding of specialised FASD programs and provide resources to ensure awareness is raised in the community, through initiatives such as the Anyinginyi FASD program.

Recommendation 6: It may also be possible to improve conditions for FASD-affected offenders by making better use of existing community supports. Professional education of police, probation officers, lawyers and judges and making diagnostic tools readily available is likely to produce higher rates of diagnosis of FASD. The benefits of diagnosis

include improved access to appropriate therapeutic and supervisory services and potential identification of at-risk family members.[2]

Recommendation 7: Clinicians and Health professionals should have the resources and assistance from international and national FASD professional to develop treatment plans.

Recommendation 8: There is scope for Australian legal profession associations to develop policies to enhance recognition of and responses to FASD-affected offenders.[3] .

BEST PRACTICES TO MINIMISE ALCOHOL MISUSE AND ALCOHOL RELATED HARM

Recommendation 9: APO NT recommends that the Committee refer to the complete outcomes of the APO NT Grog Summit Communiqué of 2012 **(Attachment A)** and APO NT Central Australian Grog Summit Final Report 2013 **(Attachment B).**

Recommendation 10: APO NT recommends that alcohol policy approaches must be based on evidence, must be holistic and must have a whole of community response.

Recommendation 11: APO NT recommends that all levels of Government provide on-going support and resources for Aboriginal Community Controlled Health Services (ACCHSs) to deliver Social and Emotional Well-being programs for Aboriginal people together with integrated SEWB, mental health and AOD services, as effective, evidence-based mechanisms to address harms caused by alcohol.

Recommendation 12: APO NT recommends more funding be diverted to culturally appropriate voluntary rehabilitation services, across all regions in the Northern Territory, as the least restrictive means of addressing alcohol dependence.

Recommendation 13: The Australian Government needs to sign the Alcohol Management Plans that have been drafted by Northern Territory communities to ensure that the plan's can begin to take effect (see **Attachment C**).

[2] Douglas, H, 'Sentencing and FASD' (2010) 15.
[3] Douglas, H; Hammill, J; Russell, A and Hall, W 'The importance of Foetal Alcohol Spectrum Disorder for criminal law in practice: Views of Queensland lawyers' (2012), 9.

Recommendation 14:	APO NT recommends strategies like the CREDIT Court and SMART Court, should be re-instated to break the cycle of physical and social harm attributed from the misuse of alcohol and the rising rate of incarceration.
Recommendation 15:	APO NT recommends that in regards to the effectiveness of the mandatory treatment of alcohol in the NT, the Committee refer to the recommendations in the APO NT Submission "Not under the influence of evidence: a sober critique of the Alcohol Mandatory Treatment Bill" **(Attachment E)** and the Legal Services Submission to the Northern Territory Government on the six month review of the Alcohol Mandatory Treatment Act **(Attachment F).**
Recommendation 16:	APO NT does not support Alcohol Protection Orders in the NT. APO NT recommends that comprehensive measures be used to address alcohol in the NT that is evidence-based, will reduce alcohol harm, is culturally relevant and which will not apply criminalisation for a health problem (see **Attachment G**).

1. Background

Alcohol is a well-documented problem that disproportionately impacts on Aboriginal families and communities. APO NT and all of APO NT's members have been involved over many years in trying to achieve coordinated action in relation to alcohol issues affecting our communities. Alcohol abuse is devastating the lives of too many Aboriginal people and families in the Northern Territory. It is a central driver of community and family violence, and makes it difficult or impossible to hold down or get a job, or get kids to school. It destroys health and families. It has other devastating impacts, such as alcohol related deaths at three times the national average, and alcohol-related hospital admissions more than double the Australian average including 60% of assaults in the NT.[4] 81 per cent of Aboriginal people in police custody in the Northern Territory have self-reported they had consumed alcohol within the first 48 hours prior to their arrest. The national rate is 63.8 per cent.[5]

It should be noted however, that alcohol is not just an Aboriginal problem. The average consumption of alcohol for non-Aboriginal people in the NT was reported at almost 14 litres per person per year in 2007, compared with a national average of less than 10 litres, while the mean for Aboriginal people in the NT is 16 litres. With a thinly populated region occupying one sixth of the Australian landmass, the Northern Territory is one of the heaviest drinking regions in the world.

In the NT, 35 per cent of the adult population drink either at a risky or high risk rate in terms of long term harm, or at a rate which risks short term harm on at least one occasion per month.[6]

In May 2011, Delia Lawrie the then Labor Attorney General acknowledged that "alcohol is the biggest cause of crime in the Territory with 60 per cent of all assaults and 67 per cent of all domestic violence incidents involving alcohol, costing our community an estimated $642 million a year."[7] This figure represents $4,197 for every adult Territorian, almost four and a half times the national figure of $944 per adult, and includes costs incurred by health and medical emergency services, police, the courts and corrective services, and loss of workplace productivity.[8] This figure does not include the social cost of alcohol abuse's contribution to intergenerational poverty and disadvantage. It also does not include the substantial ongoing costs of Foetal Alcohol Spectrum Disorder (FASD), perhaps this is because, at this stage it is difficult to pinpoint the impact it is having on society.

[4] Sharp, J. 'Mandatory Treatment in the NT: Is it really about health and wellbeing?' *Precedent* (Issue 118 September/ October 2013) and See: 'Get in the Know' http://thatsenough.com.au/get-in-the-know/
[5] NIDAC Report p 5.
[6] Ibid, above n 9.
[7] Hogan, E, 'The "right to drink" in Alice Springs', *Inside Story*, 9 May 2013 http://inside.org.au/the-right-to-drink-in-alice-springs/
[8] Ibid.

2. Introduction

APO NT believes that addressing alcohol and drug misuse, along with the many health and social consequences of this misuse, can only be achieved through a multi-tiered approach. APO NT supports evidence based alcohol policy reform, including supply reduction measures; harm reduction measures, and demand reduction measures. Without addressing the social determinants of health, policy makers are only continuing the disadvantage of Aboriginal people.

APO NT urges the Australian Government should support policies and programs which reduce alcohol related harm to Aboriginal families and communities; are based on best available evidence; have the informed consent of local communities and is based on the provision of sufficient information, evidence and expert advice.

APO NT supports reducing supply as a critical 'circuit breaker' in the fight against alcohol harm. We need to stop the flow of cheap grog through sales restrictions, a floor-price and/or volumetric tax, banning alcohol advertising/sponsorship in sport, stronger enforcement of licensing conditions, and encouraging individuals to take a personal stand against grog running. APO NT also supports building stronger community-based approaches to addressing alcohol related harm. There is an urgent need to support local community responses; ensure Alcohol Management Plans are representative of the whole community and driven by the community; investing in prevention rather than prisons; and engaging children and young people in education and solutions.

APO NT therefore welcomes the Committee's focus on best practice strategies and treatments for dealing with alcohol misuse and alcohol-related harm. We are long-overdue for rigorous, evidence-based policy in this area.

3. Northern Territory Alcohol Policy

Given the high rates of alcohol misuse and alcohol related harm, the Northern Territory Government (NT Government) has not provided solid, consistent policy on alcohol. Instead they have implemented a somewhat 'mish-mash' of government policies.[9]

The Northern Territory's Living with Alcohol program, ran from 1992 to 2000. It was funded by the revenue raised from the Territory excise on heavy beer and wine. The Living with Alcohol program was a whole-of-government approach to combat the considerable harm experienced by the community as a result of alcohol. The program was nationally recognised as being highly successful, because firstly, the increased cost of heavy beer led to a shift to light beer, a substantial reduction in

[9] Ibid, above n 4.

the total amount of alcohol consumed, and a concomitant reduction in the amount of harm caused and secondly, the revenue raised was dedicated to pay for prevention and treatment programs.[10] In the first four years, a total of $18 million of the levy raised paid for a broad range of new prevention and treatment programs in the Territory. As a result, 129 lives were saved and 2,100 alcohol-related hospital admissions were prevented, with an associated cost saving of $124 million.[11] Traffic accidents dropped and the number of alcohol fatalities dropped by 21%.[12] The High Court Case of *Ha v the State of New South Wales and Others*[13] ruled against State and Territory revenue raising which in turn stopped the Living with Alcohol program.

The Enough is Enough reform commenced on 1 July 2011, which included:

- Turning problem drinkers off tap through banning notices for the purchase, possession or consumption of alcohol across the NT;
- Compulsory treatment provisions for Problem Drinkers and people with a drug dependency;
- Establishment of a Banned Drinkers Register
- Establishment of an Alcohol and Other Drugs Tribunal with the power to make orders for the benefit of people who misuse alcohol or drugs, including mandatory treatment;
- Referral for assessment for income management of people who are misusing alcohol or drugs.[14]

The Banned Drinkers Register (BDR) was a central database that collected information on the identity of banned drinkers. The BDR enforced court and prohibition orders preventing sales of takeaway alcohol to banned drinkers throughout the NT. According to the NT Coordinator General's Report for Remote Services 2012:

> As at the end of March 2012, there were 2,369 people on the BDR: 54% of those for protective custody incidents and 38% for alcohol related crimes such as assault and driving under the influence. During the first nine months of operation, 12,288 total BDR Point of Sale refusals were recorded, 5,136 of these for prohibition and 7,152 supply restriction

[10] Goldflam, R, 'Damming the Rivers of Grog: Taking the hard decisions to stop the violence', 11.
[11] National Drug Research Institute, 'Preventing Harmful Drug Use in Australia' (2000) and Ibid.
[12] Crundall, I A, 'Living with alcohol in the Northern Territory', (2008) Northern Territory Health.
[13] (1997) 189 CLR 465 and Ibid, above n 12.
[14] Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Bill 2011, Enough is Enough Reform Package, NT Government, 2011.

> refusals, the rollout of the infrastructure to support the BDR commenced in March 2011, by 31 December 2011, was installed in 190 takeaway liquor outlets across the NT.[15]

The Credit Court commenced operation under the *Bail Act 1992* (NT) in May 2003 in Alice Springs and Darwin. The Court was primarily given to drug-related offending but consideration was given to alcohol-related crime. Through this model of court, the Magistrate was able to refer court-based clinicians for assessment and referral to treatment and rehabilitation programs provided by particular agencies. The client had regular monitoring through court reviews. The duration would last somewhere between 12 weeks and 5 months.[16] The court was seen as diversionary operator and case monitor and the aim of this court was to reduce crime, reduce drug use, improve health, improve social function and to reduce offending.[17] The CREDIT Court was replaced by the Substance Misuse Assessment and Referral for Treatment Court (SMART Court). The SMART Court offered rehabilitation services other than punitive measures, and prevented people from accessing the court if they were charged with aggravated assault or a sex offence.[18] Funding for the SMART Court was discontinued, the court was wound down, and no alternative was put in its place.[19] Full details of the CREDIT and SMART courts will be discussed under the heading 'Therapeutic Jurisprudence: CREDIT and SMART Courts'.

Since the abolition of the Banned Drinkers Register and the CREDIT and SMART Courts the Northern Territory has seen harsh punitive measures to deal with alcohol problems in the Northern Territory. The NT Government has implemented the Alcohol Mandatory Treatment legislation and Alcohol Protection Orders where the legislation is counter-therapeutic, criminalises drinking for vulnerable individuals, is not evidence based and is contrary to fundamental recommendations of the Royal Commission into Aboriginal Deaths in Custody. This legislation leads to greater contact between Aboriginal people and police, and more Aboriginal people entering the criminal justice system and our jails. The NT's average daily imprisonment rate is already among the highest in the world. Locking more people up is not the answer to the Territory's alcohol problem.

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[15] Northern Territory Coordinator General for Remote Services Report 2012, 115-16.
[16] Australian Institute of Criminology, 'Specialty courts in Australia: Report to the Criminology Research Council' July 2005, 27.
[17] Ibid.
[18] Hind, R, 'Lawyers brand SMART Court changes as dumb' ABC News, July 21 2011, http://www.abc.net.au/news/2011-06-02/lawyers-brand-smart-court-changes-as-dumb/2742862
[19] Pyne, A 'Ten Proposals to Reduce Indigenous Over-Representation in Northern Territory Prisons' (2012) 16 *Australian Indigenous Law Review* 2, 6.

4. Social and economic determinants

Social determinants are the 'environmental' or 'societal' factors that influence the health outcomes of populations. These include the economic environment, the physical environment and the socio-cultural environment.[20] APO NT shares an understanding that tackling the plight of our communities can only be achieved through coordinated 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. It 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 interpersonal violence that all too often lead to contact with the criminal justice system. It also requires strong action in tackling the scourge of alcohol and other drugs, its underlying causes and accompanying burden of unresolved and ongoing intergenerational trauma in our families and communities.

The World Health Organisation provides evidence that Indigenous health and wellbeing is profoundly affected by a range of interacting economic, social and cultural factors: poverty, economic equality 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 for alcohol and other drugs and social and emotional well being services; and control over life circumstances.[21]

APO NT believes that any policy or legislation aimed at tackling alcohol addiction will not have lasting effects if policy makers do not also address other social determinants of health including housing, education, health and control. 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 risk of dependence on alcohol, thus these factors need to be addressed.[22] Inadequate housing, infrastructure, job prospects and opportunities for recreation have

[20] Marmot, MG. Multilevel approaches to understanding social determinants. In: Berkman LF, Kawachi I, editors. *Social epidemiology*. New York: Oxford University Press, 2000:349-367 and Spooner, C and Hetherington, K. *Social Determinants of Drug Use Technical Report* Number 228, National Drug and Alcohol Research Centre, University of New South Wales, 2004, 21.
[21] World Health Organisation. (2007) *The World Health Report 2007 – A Safer Future: Global Public Health Security in the 21st Century.*
[22] 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.

been identified as areas in need of attention in order to help combat alcoholism.[23]

The Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice expresses that:

> *The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised by the legacy of colonisation, racism and marginalisation 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.*[24]

Research further indicates the importance of key determinants for Aboriginal people in the Northern Territory which include: 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.[25] APO NT believes that strategies to address the broader structural and social determinants of health must accompany strategies to address the ill effects of alcohol consumption.

APO NT also recognises the importance of Aboriginal people being in control of their own actions and services and the need to engage Aboriginal people in the planning and development of strategies to address the misuse of alcohol.

Recommendation 1: **Approaches to addressing alcohol policy must encompass the social determinants of health.**

5. Patterns of supply

Supply reduction measures are critical in the fight against alcohol misuse and the harm induced by alcohol. Alcohol restrictions are seen as a mechanism to fight this, but government's need to play their part in reducing the supply of alcohol by removing cheap products (such as cheap cask wine and port) from sale, regulating the price of alcohol through a minimum or 'floor price' per standard

[23] Ibid.
[24] Ibid.
[25] APO NT, (2013) '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. 'http://www.naccho.org.au/download/aboriginal-health/130531%20-%20APO%20NT%20Submission%20on%20Alcohol%20Mandatory%20Treatment%20Bill.pdf Retrieved 20 March 2014.

drink or through a volumetric tax, enforcing restrictions on the right to drink through permits and reducing trading hours where alcohol is sold.

Governments' also need to ensure that licensees are responsible for the sale of alcohol to their patrons. At the Top End Grog Summit in 2013 David Woodroffe, a lawyer from NAAJA also explained, usinf the example of a remote NT Alcohol outlet, why a licensee should have responsibility in serving alcohol:

> "It's surrounded by a couple of cattle stations and 4 main Aboriginal communities. In just one day, a carload of 4 persons rocked up. In half an hour they were sold 11 cartons of grog and 4 – 1L bottles of spirits. So that's 652 cans of beer and 3.125L of spirits so basically a swimming pool of grog. Now you can connect the dots, what's going to happen when you have a sale of that amount of alcohol. A couple of hours later 200 km down the road there was a rollover and a person was killed and the person who was driving went to court and went to jail – but some of the questions I would like to pose to the group in fact even to a wider audience is how is it that we have such ease of alcohol – why is that we have people who can sell as I say 652 cans - a swimming pool of grog to 4 people. We know the mayhem, we know what's happening but there is responsibility."

There are a number of communities that are struggling to stop the illegal importation of alcohol into their communities, even with an Alcohol Management Plan in place. In Nhulunbuy, for example, traffickers avoid the usual routes via planes and use dinghies to ferry the alcohol instead. To contain this, people in this community felt that there should be more compliance and enforcement measures in the region, even though the police already undertake good surveillance in the Nhulunbuy area.

There is also an over-policing when it comes to buying alcohol. There are concerns that the intensive policing of liquor outlets may even be discriminatory in some circumstances. In the first edition of the Law Society's *Balance* in 2014, Russell Goldflam said:

> "The woman ahead of me in the line as middle aged, neatly dressed, and unremarkable in her demeanour. Like me. Unlike me, she was Aboriginal. And unlike me, as we exited the bottle shop, she was stopped by the police officer stationed at the door, who conducted a mini-interrogation. Name? Address? Where are you taking this carton? And then laboriously checked the woman's particulars against a long list on a clipboard, before waving her on. All of course in full, humiliating view of the passing shoppers"[26]

[26] Goldflam, R. 'Grog. Again.' *Balance* Law Society Northern Territory, 1, 2014.

APO NT has serious concerns about the discriminatory nature of policing approaches such as that described above. We also have concerns as to the legality of this type of approach. Under Northern Territory law, Police must reasonably suspect that a relevant offence is likely to be committed before they can take actions such as seizing a 'thing' related to a relevant offence. Police appear to be equating the fact that a person is a resident of a restricted or alcohol protected area with a reasonable suspicion that they will consume alcohol in that area (i.e. commit an offence). In addition, police are requiring a person who is a resident of a restricted or alcohol protected area to prove that they will consume the alcohol in a lawful place. This reverses the onus of proof and arguably breaches the right to silence. A photograph of the public sign used by the Northern Territory Police can be viewed in **Attachment H**).

APO NT supports a whole of community approach in tackling the scourge of alcohol. Alcohol Management Plans are essential in the community and the plans need genuine input from the local Aboriginal community, which should then be integrated into regional and state/ territory and national frameworks. A further discussion of Alcohol Management Plans occurs in this submission under the heading of 'best practices to minimise alcohol misuse and alcohol related harm. The NT Government's Living with Alcohol Program, which will be discussed below, was a model that worked and should be considered when adopting a harm minimisation approach.

Recommendation 2: **APO NT recommends reducing the supply of alcohol by removing cheap products (such as cheap cask wine and port) from sale, regulating the price of alcohol through a minimum or 'floor price' per standard drink or through a volumetric tax, enforcing restrictions on the right to drink through permits and reducing trading hours where alcohol is sold.**

Recommendation 3: **APO NT believes that licensees who serve patrons alcohol must be held responsible and accountable for the irresponsible service of alcohol.**

6. Foetal alcohol syndrome disorders (FASD)

6.1 Early childhood development and Aboriginal children in the Northern Territory

The Australian Early Development Index (AEDI) provides compelling evidence that the level of disadvantage in the early childhood Indigenous population in the Northern Territory remains high.[27] Bruce Wilson, in his draft report into Indigenous Education recently reported that Indigenous children are significantly behind their national counterparts on five different indicators: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills and communication skills and general knowledge.[28] The index shows higher rates of vulnerability in every developmental area compared to both non-Aboriginal people in the NT and Aboriginal children nationally.[29] Exposure to alcohol abuse and addicitions make children vulnerable to poor development, increase their risk of addiction when they reach adolescence and also increase their risk of getting into trouble with the law.[30]

Foetal Alcohol Spectrum Disorder (FASD) is an umbrella term describing a range of effects that can occur in an individual who has been exposed to alcohol during pregnancy. The effects include physical, mental, behavioural and learning disabilities with possible life-long implications.[31] Some of the consequences of FASD include brain damage, birth defects, poor growth, developmental delay, difficulty hearing, difficulty sleeping, problems with vision, high levels of activity, difficulty remembering, short attention span, language and speech deficits, low IQ, problems with abstract thinking, poor judgement, social and behavioural problems, and difficulty forming and maintaining relationships.[32]

The recent Commonwealth Inquiry into FASD outlined the following research findings:

- The Foundation for Alcohol Research and Education (FARE) and the previous Department of Health and Ageing (DoHA) and Families Housing, Community Services and Indigenous Affairs (FAHCSIA) report that recent research estimates the prevalence of FASD to be between 0.06 and 0.68 per 1000 live births. Other experts consider this to be a significant underestimation.

[27] Wilson, B 'Review of Indigenous Education in the Northern Territory Draft Report, p.11-12 and 24-47.
[28] Ibid. This was also noted in APO NT's Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder, December 2011, 15. http://apont.org.au/index.php/alcohol-and-other-drugs.html
[29] APO NT, Central Australian Grog Summit Report 2013, 19. http://apont.org.au/index.php/central-australian-grog-summit-2013.html
[30] Ibid.
[31] Foetal Alcohol Spectrum Disorder Project, Anyinginyi Health Aboriginal Corporation http://anyinginyi.org.au/programs-services/mens-health/foetal-alcohol-spectrum-disorder-project
[32] Ibid.

- FARE reports that among Indigenous Australians, the incidence of FASD is estimated to be 2.76 and 4.7 per 1000 births.
- A study in far north Queensland estimated FASD prevalence of 1.5 per cent in the Aboriginal child population, with one Cape York community having a prevalence of 3.6 per cent.
- A comprehensive and detailed incidence study of FASD in Fitzroy Crossing will soon be released; a recent media report suggested that half of the babies born in Fitzroy Crossing are born with disabilities from FASD.[33]

APO NT made a submission to this inquiry in 2011 and it has been attached to this submission **(Attachment D)**

6.2 Current community controlled FASD programs in the NT

6.2.1 Anyinginyi Health Aboriginal Corporation FASD Project

There needs to be greater support for Aboriginal people who are diagnosed with FASD. Anyinginyi Health Aboriginal Corporation commenced an FASD project in 2011 to raise awareness, educate, prevent and support people with FASD. The aim of the project was to raise awareness, educate, prevent and support people with FASD. The initial focus of the project was:

- To identify and partner/network with existing services and programmes;
- To develop a library of resources which can continue to be used by the community beyond the lifetime of the Project; and
- to consolidate and build on community knowledge and ownership of the FASD issues, as well as support of individuals, families and services dealing with FASD.

Some of the activities and strategies that the AHAC have implemented include: The development of Pregnancy Pamper Packs, currently being distributed via health professionals to all pregnant women with the aim of providing information and support to encourage them not to drink alcohol; The creation of a hip hop song with local young people, called “Strong Baby, Strong Life!”; The adoption of warning signage in local licensed premises; Various education and prevention sessions with different community groups; and, ongoing collection of resources and research.[34] It was reported in the NT News on 25 March that this “successful project in Tennant Creek” was stripped of Federal

[33] North Australian Aboriginal Justice Agency Response to the Australian Human Rights Commission Issues Paper: April 2013, Access to Justice in the criminal justice system for people with a disability, 5 and House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD: The Hidden Harm Inquiry into the prevention, diagnosis and management of Foetal Alcohol Spectrum Disorders* (2012), 2.94
[34] Ibid.

Government funding.[35] This is disappointing given that "prevention is the solution". As Professor Elizabeth Elliott commented at the APO NT Central Australian Grog Summit, that "FASD is 100 per cent preventable. We need to support expectant mothers to stop drinking."[36]

NT Minister Elferink told Lateline on Thursday 13 March 2014, that the NT Government were 'currently exploring the ante-natal rights of the unborn child', which 'could include prosecuting women who are drinking during pregnancy'.[37] Although, this is a proposal at this stage, an NT Parliamentary Inquiry is underway. APO NT opposes criminalising women drinking in pregnancy. APO NT believes that funding should be spent on education and prevention programs for pregnant women to raise awareness about the dangers of drinking while pregnant. There needs to be more support for Aboriginal people who are diagnosed with FASD. Government's should commit to providing long term funding to programs like the FASD project commenced by the Anyinginyi Health Aboriginal Corporation

6.3 FASD and the Justice System

FASD is particularly perilous in the legal context, especially, in relation to young clients appearing before the Children's Court, many of whom present with a number of complex social, psychological and health issues. We anticipate that FASD is often under identified. There are no Australian studies concerning the prevalence or incidence of FASD in the criminal justice system.[38] Canadian studies of youths in the justice system suggest a 20-40% FASD prevalence.[39] We assume that the Australian prevalence would be similar.

An example of the impact of FASD in young offenders was given in evidence before the Senate Committee Inquiry on Youth Suicide, highlighting the problems caused by a lack of diagnosis:

> For example, if you have a 14 year old or a 15 year old who is suffering from foetal alcohol syndrome, but no-one knows about that; they don't have the developmental capacity to meet the requirements of an order...and they don't report the next day to corrections, they come back to court...they are yelled at by the magistrate for not meeting that [the order]

[35] 'Funding blow for sobriety program' NT News, 25 March 2014.
[36] Ibid, above n 36.
[37] Kerin, L, 'NT Plans to punish heavy drinkers during pregnancy', ABC News, The World Today, March 14 2014, http://www.abc.net.au/worldtoday/content/2014/s3963318.htm
[38] Svetlana Popova, Shannon Lange, Dennis Bekmuradov, Alanna Mihic, Jurgen Rehm, 'Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: a Systematic Literature Review', *Canadian Journal of Public Health* vol. 102, no. 5, pp. 336-340.
[39] Bisgard, E.B., Carlso, S.S. & Louis, M., 'FASD in the juvenile court', Paper presented at the It's a Matter of Justice Conference, Vancouver, April 2012.

> but no-one has actually gone back a step and said actually developmentally are they even capable of meeting this?[40]

Evidently, issues affecting the health of young people have the capacity to have a profound negative impact on their interaction with the justice system.

In the Northern Territory, one barrier to diagnosing FASD relates to the difficulties diagnosing paediatricians experience in confirming prenatal maternal alcohol use. This constitutes an essential criteria in diagnosing FASD, but it is often not well-documented and doctors are unable to rely on hearsay evidence about alcohol consumption to make a diagnosis.[41]

Additionally, issues arise due to the absence of a multi-disciplinary team that can contribute to FASD diagnosis. Currently, FASD is primarily diagnosed in Central Australia by paediatricians, who generally work with children until a maximum age of fourteen. Intensive contact between paediatricians and young people ceases some time before adolescence. However, for those individuals who are at the lower end of the foetal alcohol spectrum, behavioural issues that may suggest FASD become more apparent as the young person becomes older and physically bigger, due to the more pronounced impact of their misbehaviour. Often, these young people will fail to be diagnosed,[42] even where they become involved in the criminal justice system.

Case Study 1:

A 15 year Aboriginal girl in the care of the NT Department of Children and Families (DCF) has a history of exhibiting difficult behaviour. As a result of her behaviour, she has been excluded from schooling for approximately five years. Over a period of 14 months, the girl has become involved in offending, primarily property damage, which has brought her before the courts on several occasions. Due to the girl's behaviour and concerns about her well being, DCF was ordered to provide a report to the Court about the girl's family support and access, accommodation, education and developmental issues. While the report stated that it has been identified that the girl is operating intellectually as a seven year old, no formal FASD diagnosis was referred to and there was no proposed FASD management plan.

[40] Barson, R. Advocacy Lawyer, North Australian Aboriginal Justice Agency, Committee Hansard, (3 November 2011) 55, extracted in *Gone Too Soon: A Report into Youth Suicide in the Northern Territory, Select Committee on Youth Suicides in the NT* (March 2012), 136.
[41] Conversation with Rose Fahy, Head of Paediatrics at Alice Springs Hospital, 13 December 2011.
[42] Ibid.

Without a formal medical diagnosis of FASD, it is difficult for Magistrates to rely upon impaired functioning as a mitigating factor in sentencing, or to tailor the court process and sentencing options to better meet the particular needs of the offender. Where an offender does present with a formal diagnosis, the lack of legislative diversion mechanisms for offenders presenting with offending relating to a cognitive impairment combined with the dearth of specific management services or a centre to coordinate access to community services that may assist an individual with FASD, provide few appropriate diversion and sentencing options for Magistrates. There are currently no support programs specifically designed for FASD sufferers available in Australia, either in prisons or in the community.[43] Furthermore, there is no specific sentencing jurisprudence for cases involving FASD,[44] with the issue generally dealt with as a 'developmental problem'.[45]

Consequently, sentencing dispositions rarely reflect the difficulties experienced by FASD affected individuals and instead offenders with FASD are subject to the same sentences and punishments, such as imprisonment, as fully functioning offenders, despite this being inappropriate. APO NT maintains that there needs to be better resourcing of the criminal justice system and changes to criminal justice system legislation and practices to enable any person suspected of having developmental or cognitive impairments to be assessed and have access to appropriate case management that informs sentencing dispositions. Opportunities must be offered to divert people with FASD away from the criminal justice system and away from incarceration.

Case Study 2:

A 22 year old Aboriginal female who resided in Alice Springs had been diagnosed with Foetal Alcohol Syndrome. Despite this, the female has had repeated contact with the criminal justice system since 2008 and consequently experienced many periods of imprisonment. Magistrates in Alice Springs comment on the inappropriateness of imprisoning the woman but note the dearth of alternate options: *"The Northern Territory Government has chosen not to provide any services for people such as [X] .... The Northern Territory Government is well aware that there are people such as [X] in this community who need assistance, and they have chosen, at an executive level, to make a decision not to provide those services....I expect they're saying that the criminal justice system should be picking up and dealing with people who suffer as she suffers from an illness. In my opinion that's highly inappropriate....There are... few sentencing options available to this court....There is nothing to be*

[43] Heather Douglas, 'The sentencing response to defendants with foetal alcohol spectrum disorder' (2010) 34 *Criminal Law Journal* 221, 230
[44] Ibid, above n 4, 20
[45] see *R v Twaddle* [2008] (Unreported QDC, Durward J, 24 January 2008) 5 where this occurred despite expert reports identifying FASD

gained from giving consideration to specific deterrence, there is very little gained in giving consideration to ... rehabilitation."[46] The female was sentenced to a period of imprisonment.

Where the court considers it necessary to sentence an offender with FASD to a term of imprisonment, it is imperative that the specific needs of the offender are recognised. In *Doolan*, which involved a FASD sufferer who demonstrated increasingly violent behaviour, the judge found that there was 'no realistic and safe alternative' to a custodial supervision order in a correctional setting.[47] The judge requested that the Department of Health make special arrangements.[48] Aged and Disability Services personnel formed a Disability Management Team, whose plan included:[49]

- Face to face contact with Doolan three times per week
- Opportunities for Doolan to leave the correctional setting and have contact with family and the community

The Department of Justice consented to these conditions. The judge considered that the proposals achieved the correct balance between the twin objectives of public safety and provision of therapeutic services to Doolan.[50] Specifically designed prison programs can produce positive results for FASD offenders who must be sentenced to a term of imprisonment.[51] However, as demonstrated in *Doolan*, a successful outcome is contingent on:

- A highly motivated and well-informed judge
- Well-trained prison officials
- A multi-disciplinary team capable of designing and executing an appropriate treatment plan
- An acknowledgment that standard prison programs are unlikely to be of any utility to FASD offenders.[52]

Australian prisons vary in their capacity to provide tailored programs suitable for FASD-affected offenders and there are insufficient community resources and programs to compliment treatment, particularly in remote and regional areas. When one of these factors is not present, the prospects are likely to be dire for the FASD sufferer. However, if an offender's FASD is not identified, the same

[46] Mr G Borchers SM, 2009, *Police v RF*, Northern Territory Court of Summary Jurisdiction Alice Springs.
[47] *R v Doolan* [2009] NTSC 60 at [17].
[48] Ibid at [22].
[49] Ibid at [24].
[50] Ibid at [26].
[51] Roach, K and Bailey, A 'The Relevance of Fetal Alcohol Spectrum Disorder in Canadian Criminal Law From Investigation to Sentencing' (2009) 42 University of British Columbia Law Review 1, 21.
[52] Burd, L; Selfridge, R; Klug, M and Juelson, T. 'Fetal Alcohol Syndrome in the Canadian Corrections System' (2003) 1 *Journal of FAS International* 2.

issues that arise in the court process also arise in the prison setting. The failure to identify FASD hinders access to appropriate sentencing or diversionary options.

There is an urgent need for more work on prevention, education and raising awareness of the FASD condition. APONT supports declaring FASD a disability. It is hoped that this may lead to earlier diagnoses and increased access to support services and programs.

6.3.1 FASD Offenders: Strategies from Canada

Canada is the leading international jurisdiction in terms of implementing supportive programs for FASD-affected offenders. Canadian stakeholders have combined a high level national framework for action with continuing legal professional education, availability of diagnostic tools, and a range of treatment options. Canadian criminal lawyer David Boulding has been instrumental in building national and international awareness of the need for a shift in thinking about how the criminal justice system deals with FASD.

Several Canadian jurisdictions have developed intensive support programs for FASD-affected individuals involved with the criminal justice system.[53] As of June 2008, eight programs (six for youth, two for adults) were operating and four had sustainable funding.[54] At least three have been evaluated.

Case Study 3: FASD Youth Justice Program

The program falls within the ambit of the Healthy Child Manitoba initiative,[55] which includes a range of FASD-related preventative, diagnostic and support services.[56] It aims to ensure that FASD-affected youth who are in conflict with the law receive a multidisciplinary assessment, diagnosis, appropriate judicial disposition and improved access to appropriate services. Referrals are accepted from the justice system, parents/guardians and youth. A 2006 evaluation[57] revealed strong support amongst stakeholder groups. The evaluation identified a need for the program to obtain sustainable funding that would allow expansion to include youth outside the City of Winnipeg.

[55] Healthy Child Manitoba, http://www.gov.mb.ca/healthychild/fasd/stopfasd.html
[55] Healthy Child Manitoba, http://www.gov.mb.ca/healthychild/fasd/stopfasd.html
[55] Healthy Child Manitoba, http://www.gov.mb.ca/healthychild/fasd/stopfasd.html
[56] Foetal Alcohol Spectrum Disorder Services in Manitoba Resource List, http://www.gov.mb.ca/healthychild/fasd/resources.html
[57] Foetal Alcohol Spectrum Disorder Youth Justice Pilot Project, http://www.justice.gc.ca/eng/pi/yj-jj/fund-fond/rep-rap/r4.html

Case Study 4: Yukon Community Wellness Court

The Court[58] is a long-term (18 month) program offering counseling and skills training to adult offenders. It targets offenders charged with minor offences and dealing with mental health problems, addictions or FASD. The structure and supervision provided by the program would theoretically benefit FASD sufferers during its 18-month duration. However, a recent evaluation found that only one of twelve people with FASD who applied for the program between 2007 and 2011 actually completed it.[59] Even if FASD sufferers do complete the program, the counseling and skills-training provided will not be effective in changing the behaviour of FASD sufferers post-release. To have a lasting impact, the Court would need to develop community connections capable of functioning as an *external brain* for the client post-release.

Recommendation 4: **APO NT recommends that FASD should be recognised as a disability in Australia (see Attachment D).**

Recommendation 5: **Australia has no specialised programs or facilities for FASD-affected offenders. As this is the primary obstacle to humane, appropriate care for FASD sufferers, it should be the focus of government investment. The Australian Government must commit to ongoing funding of specialised FASD programs and provide resources to ensure awareness is raised in the community, through initiatives such as, Anyinginyi FASD program.**

Recommendation 6: **It may also be possible to improve conditions for FASD-affected offenders by making better use of existing community supports. Professional education of police, probation officers, lawyers and judges and making diagnostic tools readily available is likely to produce higher rates of diagnosis of FASD. The benefits of diagnosis include improved access to appropriate therapeutic and supervisory services and potential identification of at-risk family members.[60]**

[58] Yukon Courts, http://www.yukoncourts.ca/courts/territorial/cwc.html
[59] http://www.yukon-news.com/life/28257/; Joseph Hornick, Karolina Kluz and Lorne Bertrand, 'An Evaluation of Yukon's Community Wellness Court' (2011) *Canadian Research Institute for Law and the Family*, p. 64.
[60] Ibid, above n 4.

Recommendation 7: **Clinicians and Health professionals should have the resources and assistance from international and national FASD professional to develop treatment plans.**

Recommendation 8: **There is scope for Australian legal profession associations to develop policies to enhance recognition of and responses to FASD-affected offenders.**[61]

7. Best practices to minimise alcohol misuse and alcohol related harm

The best practices to minimise alcohol misuse and alcohol related harm is to implement a broad range of strategies, which include reductions in the supply and demand of alcohol and also reducing the harm. The previous NT Coordinator General indicated that the:

> "Success of particular measures to reduce alcohol related harm will depend on local circumstances and the development of place-based Alcohol Management Plans. However, the strategies adopted under these Plans are likely to require additional complementary government measures to reduce availability and access to alcohol through the buy-back of liquor licenses, additional restrictions on sales and trading times. Further consideration must be given to proposals and recommendations for the introduction of a 'floor price' on alcohol. Increasing the unit price of alcohol is known to be an effective strategy in reducing excessive alcohol consumption and related harm."[62]

The National Health and Medical Research Council (NHMRC) Guidelines for the Treatment of Alcohol Problems recommend a broad range of options including psychosocial interventions, motivational interviewing, relapse prevention strategies, CBT approaches, self-help, alcoholics' anonymous and related services and residential rehabilitation.[63] There is also some evidence and considerable anecdotal experience with therapies that may be particularly suited to Aboriginal populations, such as narrative therapy and art therapy.[64]

[61] Ibid.
[62] Ibid, above n 22, 119.
[63] National Health and Medical Research Council, 'Alcohol guidelines: reducing the health risks' 2011, Australian Government.
[64] AMSANT, A Model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory (2008), revised 2011.

7.1 What works

7.1.1 APO NT Grog Summits 2012-2013

APO NT made it a priority to hear the concerns coming from our members and their constituents about the devastating impact alcohol is having in their communities and to engage them in finding solutions. We hosted a number of community forums in the Northern Territory to enable Aboriginal peoples in the NT to get together to consider their own futures and goals in the context of the unprecedented imposed changes of recent years. The purpose was to provide Aboriginal organisations and community leaders in the NT the opportunity to discuss priority issues and potential solutions to current problems relating to alcohol and governance and leadership; and to put their concerns and solutions directly to Government.

It is important to point out that but for APO NT convening these forums, these opportunities for Aboriginal people to come together with experts would not have otherwise occurred. It reasserts the role of organisations like APO NT, with strong ties to local Aboriginal communities, play in to effectively engage Aboriginal people in high-level policy discussion. Forums like these are also crucial to avoid policy makers bypassing direct, community-led engagement and making decisions for Aboriginal people instead of with Aboriginal people.

APO NT sponsored a summit in Darwin in November 2012 on alcohol policy and its impact on Aboriginal people and communities that brought together 123 delegates from all regions of the NT. Delegates included Aboriginal leaders, board members of various Aboriginal organisations and representatives from many Aboriginal communities throughout the NT and also included service providers, medical professionals and relevant peak bodies.

The summit provided an opportunity to consider the evidence-base; to hear from Aboriginal communities in relation to what works well in alcohol management and what is not working; to consider the policy environment (federal and NT) and to propose alternative approaches.

- Develop a network of Aboriginal organisations and community members seeking to work together on these issues.

The forum members had an opportunity to present their ideas, issues, and agreed positions/statements to the relevant government agencies after the forum.

The key messages included:

- That NT has unacceptably high rates of alcohol related harm.

- Aboriginal people in the NT have a long history of fighting for alcohol restrictions right across the NT and we are now at a *critical point* in this journey.
- Aboriginal families are most affected by the destructive impacts of alcohol, including domestic violence, suicide, and removal of children from their families in high levels.
- Aboriginal people need to secure our future and our culture by keeping our children safe, healthy and strong.
- Evidence shows that Aboriginal people must be in control of developing and implementing strategies to tackle alcohol issues and associated problems, for them to be effective.
- Alcohol restrictions can provide necessary breathing space for Aboriginal communities, but are only one part of the solution.

At the summit, Aboriginal community members and organisations called on both levels of Government to:

- Involve our people in all levels of decision-making regarding alcohol policy, program development and resourcing in the NT;
- Acknowledge that our people live in two worlds – one of traditional culture and another modern world;
- Acknowledge that our people have answers to issues around alcohol related harm;
- Empower our people to resolve their own disputes and conflicts;
- Acknowledge the importance of our spirituality and culture in healing alcohol-related harm;
- 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;
- Ensure community-specific cross-cultural training for non-Aboriginal staff, including nurses, doctors, teachers, and police officers;
- Complete the current study into the impacts of licensed clubs before considering further policy reform;
- Bring back a system to restrict the supply of alcohol 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 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.

APO NT held a subsequent Central Australian Grog Summit in Alice Springs in 2013, with approximately a hundred delegates. Please find the report of the APO NT Central Australian Grog Summit in **Attachment A**.

Responses received from Aboriginal community members and organisations about the APO NT forums held in 2012/2013 have been resoundingly positive. APO NT believes that the control, empowerment and leadership demonstrated by Aboriginal people, organisations and communities during the forums should be fostered and enhanced. The opportunity for Aboriginal people to meet independent of Government has been crucial. At our forums Aboriginal delegates enthusiastically took control and we believe that these important conversations should be continued. The Minister for Indigenous Affairs, Minister Macklin met with delegates from the Grog Summit on 26 February 2013.

Recommendation 9: **APO NT recommends that the Committee refer to the complete outcomes of the APO NT Grog Summit Communiqué of 2012 (Attachment A) and APO NT Central Australian Grog Summit Final Report 2013 (Attachment B).**

7.1.2 Community Controlled Responses

To be effective, approaches to reduce alcohol related harm need to be holistic and community driven. The narrative of community control is not new. Recognition by Aboriginal people and communities that they have an important role to play in addressing alcohol related harm is not new. Much can be learnt from examining this role over the past decades, the successes and shortcomings, rather than seeking to stubbornly blaze a new path without reference to the past. The authors of The Little Children are Sacred Report resonated that:

> There is now sufficient evidence to show that well-resourced programs that are owned and run by the community are more successful than generic, short term, and sometimes inflexible programs imposed on communities.[65]

A report published in 2009 by the National Indigenous Drug and Alcohol Committee provided that:

> "In areas where there are Aboriginal community-controlled health services or Aboriginal alcohol and drug services, there are opportunities to involve these services in the health care

[65] Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, *Little are Children are Sacred* (2007), 53.

> of offenders and in their ongoing care post-release. It is equally important that treatment programs include a holistic range of treatment options that are well suited to, and responsive in, treating Indigenous offenders (and their families) with alcohol- and other drug-related problems. In many instances, Aboriginal community-controlled health services, Aboriginal alcohol and drug services and others that are best placed to address Indigenous health and wellbeing can provide continuity in the type of holistic care required for Indigenous offenders."[66]

Aboriginal community controlled health services (ACCHSs) recognise the need for holistic social and emotional well being services (SEWB) to be incorporated within primary health care service delivery. The process of Aboriginal community control in the area of health means that an Aboriginal health service is independent and autonomous and is controlled by the local Aboriginal community it serves in order to provide culturally appropriate health care to meet its health needs as defined by that community.'[67]

AMSANT strongly advocates for the need to integrate SEWB, mental health and Alcohol & Other Drug (AOD) services into Aboriginal community controlled comprehensive primary health care services.[68] There are strong co-morbidities between SEWB, mental health and AOD issues and a high burden of these issues throughout Aboriginal communities in the NT. ACCHSs are in the best position to provide services that are community controlled, culturally safe, preventative and treatment focussed, as part of integrated holistic care for individuals, families and communities.

June Oscar expressed the importance of community control in the Fitzroy Crossing at the APO NT Central Australian Summit in July 2013:

> "Our journey has told us that our people need to take control…I don't think of us as victims, support us to be the architects of our future, the future where every child has the right to be born healthy and fulfil their potential… Our community has taken control, but it will take us generations to reverse the impact of colonisation and the introduction of alcohol."[69]

[66] National Indigenous Drug and Alcohol Committee, (2009) 'Bridges and Barriers: Addressing Indigenous Incarceration and Health', 9.
[67] Best, O, 'Community Control Theory and Practice: A Case Study of the Brisbane Aboriginal and Islander Community
[68] AMSANT, 2011, A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory. Aboriginal Medical Services Alliance Northern Territory (AMSANT), Darwin, NT.
[69] Ibid, above n 36.

Case Study 5: Fitzroy Crossing

At the Central Australian Grog Summit 2013, June Oscar, Emily Carter and Patrick Davies presented on the way in which they have combated alcohol in their community of Fitzroy Crossing, Western Australia. That community was suffering from terrible alcohol-related harm including rising deaths and suicides. As a result of community action, and in the face of strong opposition, they were able to introduce alcohol restrictions. The alcohol restrictions were, as June Oscar, said 'a circuit breaker' to prevent the cloud of alcohol which prevents a community moving forward. But as Fitzroy Crossing demonstrates you also need programs to assist the community in recovery.

In Fitzroy Crossing there has been a *reduction* in hospital admissions, alcohol related violence and take-away sales and an *increase* in school attendance. As a result of this community action a spotlight was shone on Fitzroy Crossing and people became interested in helping them. They have partnered with the George Institute Sydney University to conduct a study on the prevalence of Foetal Alcohol Spectrum Disorders (FASD) with the aim to identify the scale of the issue and how to respond. This is an issue identified by that community and the project is driven by the community.

APO NT would like to see more stories like the one from Fitzroy Crossing in the NT – this will require community action, alcohol restrictions, support programs and partnerships to develop an evidence-base.

Recommendation 10: **APO NT recommends that alcohol policy approaches must be based on evidence must be holistic and must have a whole of community response.**

Recommendation 11: **APO NT recommends that all levels of Government provide on-going support and resources for Aboriginal Community Controlled Health Services (ACCHSs) to deliver Social and Emotional Well-being programs for Aboriginal people together with integrated SEWB, mental health and AOD services, as effective, evidence-based mechanisms to address harms caused by alcohol.**

7.1.3 Culturally appropriate alcohol rehabilitation services in the NT

Unfortunately, there are limited culturally appropriate alcohol rehabilitation services for Aboriginal people in the Northern Territory. Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD) and Council for Aboriginal Alcohol Program Services (CAAPS) provide residential rehabilitation to those affected by alcohol. Danila Dilba also provides short term accommodation for clients whilst they are awaiting

admission to treatment facilities whilst receiving intensive case management support. The accommodation at Galwu Hostel is also used upon completion from the various programs or treatment centre's whilst longer term accommodation is sourced or prior to returning to their home community.[70] The Respite and Rehabilitation Project has 4 beds (two rooms) for accommodation for individuals, couples and families. Goal setting, care planning, relapse prevention, community inclusion activities and addressing any health issues are a focus whilst clients are residing at Galawu.[71]

The APO NT submission to the NT Government on the Alcohol Mandatory Treatment Bill noted that:

> 'There are insufficient alcohol treatment and rehabilitation services 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.' [72]

The previous Coordinator General for Remote Services expressed that:

> 'The interaction between individual and social factors suggests the need for a comprehensive policy measure to reduce alcohol-related harm not just for the drinkers themselves, but also to protect those individuals and groups who are at risk of being negatively affected by others' drinking.'[73]

Recommendation 12: **APO NT recommends more funding be diverted to culturally appropriate voluntary rehabilitation services, across all regions in the Northern Territory, as the least restrictive means of addressing alcohol dependence**

[70] Danila Dilba Annual Report, 2010, 13.
[71] Ibid.
[72] Ibid, above n 32, 2.
[73] Ibid, above n 22, 118 http://apont.org.au/index.php/resources.html

7.1.4 Alcohol Management Plans

A way that communities can be involved in dealing with alcohol related harm is through the establishment of Alcohol Management Plans. In the 2007 Social Justice Report, the Aboriginal and Torres Strait Islander Social Justice Commissioner provided a case study of the successful Umbakumba Alcohol Management Plan. In 2009, Nicole Watson, an Aboriginal lawyer from Queensland explained that this was the only community identified in the Little Children are Sacred Report as achieving success in the reduction of alcohol abuse.[74] Key features that contributed to the Plan's effectiveness included, community ownership, flexibility, the empowerment of women, and partnerships between the community and government agencies.

By 2008, Alcohol Management Plans were in place for Alice Springs, Katherine, Tennant Creek, Palmerston, East Arnhem Land, Jabiru, Borroloola and Darwin. These plans were developed in an effort to minimise harm from excessive alcohol consumption and were tailored to meet the particular needs of different locations.[75]

Alcohol management commenced in Groote Eylandt and Bickerton Island on 1 July 2005 requiring every person in the region, Aboriginal or non-Aboriginal to hold a permit to buy or consume take-away alcohol. The NT Government evaluated the Groote Eylandt and Bickerton Alcohol Management Plan in 2007. It is understood that many other alcohol management plans that have been developed by the community were not signed by Minister Macklin. Since the change of government, these have still not been signed.

The Community Legal Education team at NAAJA have provided some basic feedback from the areas they visit around the context of discussion alcohol protection orders, people drinking in the community and mandatory rehabilitation:

Case Study 6: Nhulunbuy/Yirrkala/Ski Beach

Staff from Miwatj Raypirri Rom, a program that includes Alcohol & Other Drugs workers, has negative views on alcohol protection orders, particularly in the context of local Alcohol Management Plans. One participant noted that APO's undermine the work that has been done at the local community level in developing effective Alcohol Management Plans. Implicit in this is an endorsement of those plans.

Case Study 7: Lajamanu

[74] Watson, N, 'Regulating Alcohol: One Step Forward, Two Steps Back?' 2009, 7, *Indigenous Law Bulletin*, 11, 27-30.
[75] Ibid, above n 22, 114. http://apont.org.au/index.php/resources.html

The elders in Lajamanu have been active on alcohol policy issues. The Kurdiji released a media release on 17 October 2012 to highlight their concerns about the liquor licenses of Top Springs and Kalkaringi Social Club.

Case Study 8: Tiwi Islands

People in Wurrumiyanga have been advocating for the creation of an alcohol and other drugs rehabilitation centre on the island. They want Tiwi Islanders to have a culturally appropriate and safe rehab centre, rather than the DAATS facility, which is envisaged to be run by Aboriginal people.

Case Study 9: Ngukurr

The women's safe house in Ngukurr has expressed concerns about the level of drinking in Ngukurr and the amount of alcohol able to be bought form licenced venues in Mataranka. They also spoke of an increase in domestic violence when drinking occurs and a spike in the Women's Safe House usage when men have been drinking.

Case Study 10: Maningrida

The Alcohol Management Plan involves a permit system for locals. It seems to work reasonably well. The police are of the view that violent incidents spike when the alcohol comes in.

It is understood that many other Alcohol Management Plans that have been developed by the community were not signed by Minister Macklin. Since the change of government, these have still not been signed. It has left many communities uncertain about the government approvals of the AMP's.

At the APO NT Central Australian Grog Summit in 2013, various summit participants criticised the processes for preparing Alcohol Management Plans, saying that they failed to adopt a community approach.[76] Complaints from Aboriginal community members at the Summit included:

- Government has too much control in the development of Alcohol Management Plan. Community members wanted more control over the processes for alcohol mandatory plans.[77] Samuel Bush-Blanasi from the Northern Land Council at the Summit said:

  > *"The AMP in my community isn't right. They are not talking to the right people. Kids and the non-drinkers need to have a say. They need to start talking to all Aboriginal organisations around Katherine. Alcohol is driving the Katherine town*.

[76] Ibid, above n 36.
[77] Ibid.

- Communities spend a lot of time working on plans, but then are not supported. Examples were given of communities working hard to develop plans that government's do not then endorse.
- Just one influential community member can derail a good process in the Alcohol Management Plan. One participant gave an example of how one drinker in the community had derailed an AMP.
- No funding is available to develop the strategies put forward in Alcohol Management Plans. Many summit participants said that community members have their own strategies, including safe houses, increasing the presence and work of night patrols, and setting up a safe drinking area outside the community, but that these ideas are not funded.

…. I am not afraid to have a go on this alcohol problem, if we all do it together."[78]

Please find APO NT's feedback on the draft minimum standards to the Australian Government included in this submission **(Attachment C).**

Recommendation 13: **The Australian Government needs to sign the Alcohol Management Plans that have been drafted by Northern Territory communities to ensure that the plan's can begin to take effect (see Attachment C).**

7.1.5 Therapeutic Jurisprudence: CREDIT and SMART courts

The Government should continue to support programs that align with re-investment strategies such as the Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) Program and Substance Misuse Assessment and Referral for Treatment (SMART) Court.

Winner of the Chief Minister's Award in 2006, the CREDIT program was a successful drug and alcohol diversionary program. It operated as a bail diversionary process for those charged with an offence linked to their drug or alcohol dependency. Since its inception in May, 2003, 286 clients have been referred by the Court to CREDIT NT. The overall completion rate for clients accepted into the program is 78.5% - being 56% of people referred to the program in Alice Springs and 83% of those referred in Darwin. The success of CREDIT NT in reducing illicit substance use harms surpassed expectation.[79]

On leaving her role as Chief Magistrate of the NT, Hilary Hannam delivered a presentation at the Indigenous Justice Conference where she highlighted:

[78] Ibid.
[79] NT Chief Minister's Awards 2006, NT Government http://www.nt.gov.au/chiefministerawards/award-past-winners/2006-awards.html#collab

> The fundamental issue is that imprisonment does not operate as a deterrent to potential offenders, and generally does not appear to result in rehabilitation, particularly for those with mental illness or drug or alcohol issues. This is of course demonstrated by the number of repeat offenders and the difficulty many offenders have in reintegrating into their community after imprisonment.

CREDIT Court ceased to exist when SMART Court commenced. SMART Court operated in a limited capacity in the NT on 1 July 2011 and from 1 July 2012, the court operated with full capacity which included a holistic integrated case management model for people being issues with SMART orders. The court issued 108 orders by the end of March 2012. This court was of 'therapeutic jurisprudence' and heard criminal matters where the offender had a history of serious substance misuse and had committed an offence.

The court aimed to:

- Reduce offending and antisocial behaviour associated with substance misuse;
- Increase rehabilitation
- Reduce the number of people re-offending and provide a pathway into treatment for problem drinkers; and
- Reduce the harms associated with substance misuse through improved health and social outcomes for people whose offending was related to substance abuse.

Ms Hannam believed that this model of SMART Court:

> 'was potentially one of the best models in Australia, as it was the only court that could address both misuse of alcohol and illicit drugs, was available for youths and adult offenders, and enabled the Court to make orders appropriate for less serious and more serious and more serious offenders.'

Yet, after only 18 months of operation it was abolished by the Country Liberal Government in its December 2012 budget. An extract of Hilary Hannam's speech highlights the inability of the government, in particular the Attorney General to understand the importance of therapeutic jurisprudence and the importance of drug and alcohol courts for offenders in the Northern Territory:

> In the Second Reading Speech for the Act, he said "this concept of therapeutic jurisprudence does not work in the Northern Territory", because "It is beyond the capacity of many of the people who come before the SMART Court to change and to take change seriously. Many of them are welfare dependent and are quite happy that way." He went on to say that "there is an expectation that Courts impose sentences which work as punishment, as well as

> deterring crimes. This concept of therapeutic jurisprudence steps away from the idea of punishment for a crime and of deterrent, and actually tries to embrace the individual and say: 'you have to go and correct yourself and once you have corrected yourself, we will be nice to you'". Finally he stated: "it is that failure of therapeutic jurisprudence which has seen the increases in crime that we have seen."[80]

Given the increasing over-representation of Indigenous offenders, the financial and social costs of incarceration should be recognised, along with urgent consideration of alternative and more effective ways of reducing alcohol and drug misuse-related offences. In 2009, The Productivity Commission reported that the total cost per prisoner in 2007-08 averaged $269 per day or $98,000 per year for each prisoner.[81] By comparison, the cost of residential rehabilitation was estimated to cost $98 per day.[82] The new Darwin prison will open in July at a cost of over half a billion dollars and it will soon be too small to fit the Northern Territory's expanding prison population. This is not sustainable.

This is money that could be spent on innovative policies and programs that prevent crime reduce re-offending and deal with the underlying causes of offending such as problem drinking. It is clear that in areas like housing, education and services to support the health and development of our children, there is a real need for more funding. These should be priorities, and can be better funded if we stop relying on failed 'tough on crime' approaches.[83]

Recommendation 14: **APO NT recommends strategies like the CREDIT Court and SMART Court should be re-instated to break the cycle of physical and social harm attributed from the misuse of alcohol and the rising rate of incarceration.**

[80] Hannam, H, 'Current Issues in Delivering Indigenous Justice: Challenges for the Courts', AIJA Indigenous Justice Conference and Elferink, J (Shadow AG at the time), Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Bill – second reading in continuation, 5 May 2011.
[81] National Indigenous Drug and Alcohol Committee (2009) Bridges and Barriers: Addressing Indigenous Incarceration and Health, 10.
[82] Moore, T.J., Ritter, A. & Caulkins, J.P. (2007). The costs and consequences of three policy options for reducing
heroin dependency. *Drug and Alcohol Review,* 26(4): 369-378.
[83] For further information on the need to retain the SMART Court see: Ibid, above n 26.

7.2 What does not work

7.2.1 Mandatory Treatment for Alcohol

The NT Country Liberal Party's *Alcohol and Mandatory Treatment Act* (AMT Act) came into effect on 1 July 2013. The original Alcohol Mandatory Treatment Bill was explained as a harm reduction strategy designed to get help for some of the most chronic abusers of alcohol in the NT.[84]

Under the *Alcohol Mandatory Treatment Act*, an adult who is taken into Police protective custody three or more times in two months for being intoxicated in public is eligible for referral to the alcohol mandatory treatment system. If there is capacity to assess them at an assessment centre, the person is taken to the assessment centre (in Alice Springs, this is in the secure care facility next to the prison), and an assessment clinician (usually a nurse) assesses their eligibility for an alcohol mandatory treatment order against a statutory criteria. The Alcohol Mandatory Treatment Tribunal must then consider and determine whether the person should be subject to a community-based or residential alcohol mandatory treatment order up to three months in duration, or whether the person should be released. Further, if an alcohol mandatory treatment order is made, an income management order must also be made. A person can be detained for up to nine days in the assessment facility pending the Tribunal's decision. If the Tribunal decides to make a residential alcohol mandatory treatment order, the person is then further detained in a residential treatment facility for the duration of the order and may be charged with a criminal offence punishable by 3 months imprisonment for absconding.

Despite the significant incursions on a person's freedoms and liberty under this scheme, and the vulnerability of those most likely to be referred into the scheme, there are few safeguards in place to protect the person's rights during this process and to protect the integrity of the assessment and decision-making process. The NT Government admitted in February 2014 that in Central Australia, no advocate or legal representation had been provided to a person appearing before the Tribunal. This is a significant issue. CAALAS successfully argued in the case of *RP v Alcohol Mandatory Treatment Tribunal of the Northern Territory* [2013] NTMC 32 that the failure to provide an advocate for RP, a woman from a remote community who didn't speak English as a first language, rendered the Tribunal's decision to order RP into mandatory residential alcohol treatment unlawful because she was denied natural justice.

The Country Liberals allocated $35 million a year to run the alcohol mandatory treatment program, before the AMT Act had even passed. Robyn Lambley, Minister for Health stated in her media

[84] Australian Broadcasting Corporation, 2013, 'Northern Territory Government passes contentious mandatory alcohol treatment legislation' *ABC News,* Friday 28 June.

release that this 'would see 800 of the Territory's worst problem drinkers undertake rehabilitation and work-based programs', yet in Jared Sharps' article in *Precedent*, the Government's 2013-14 budget papers show that it has now allocated $45 million to treat just 480 people this financial year.[85] This draws an enormous amount of resources away from other services that are under-funded or not funded at all: such as voluntary treatment services and facilities in remote communities and culturally strengthening approaches and models that could assist Aboriginal communities to take responsibility for the damage done by alcohol. The Chief Minister has said that government is expecting the success rate of mandatory rehabilitation won't be much higher than 5%. Approximately 800 people a year are expected to pass through the scheme. How can we justify spending 45 million dollars on success for 40 people a year?

APO NT opposes the Alcohol Mandatory Treatment Act because it is counter therapeutic, criminalises drunkenness and vulnerable individuals, and is an affront to the principles of individual liberty and freedom from arbitrary detention. It also creates yet another avenue to prison.

Australian Medical Association President Peter Beaumont stated:

> "The whole thing is meant to be a health pathway, and it's funny that the path leads to criminality if people don't abide by it. This is about illness and addiction; it's not about crimes, other than the fact that some people do commit crimes. But the ordinary courts of law can handle those; we already have laws for those."

NAAJA have provided the following case study of a client affected by the AMT Act:

Case Study 11

48 year old man, by order of the Alcohol Mandatory Treatment Tribunal on 22 April 2013 to be detained for 3months to 21 February 2014. On 11 February 2014 the client absconded from facility and located at shops intoxicated and charged with absconding from treatment facility (maximum 3 months penalty). He was later charged with breaching an Alcohol Protection Order by being intoxicated. The client has absconded on 5 occasions during the 3 month period.

APO NT is concerned with the limited data from the NT Government and the lack of evidence-based policy it is presenting on alcohol issues. It is extremely important that alcohol consumption data be made available to enable key stakeholders such as APO NT to engage on the serious issue of alcohol related harm in the Northern Territory.

[85] Ibid, above n 4..

APO NT made a submission on the Alcohol Mandatory Treatment Bill in 2013. This submission outlined policy alternatives to mandatory rehabilitation and discussed the need for holistic and multi-pronged approaches to addressing alcohol related harm including treatment and rehabilitation services, services for the homeless, trauma targeted programs, reducing alcohol availability and the need for voluntary treatment services. A copy of the submission "Not under the influence of evidence: a sober critique of the Alcohol Mandatory Treatment Bill" is attached **(Attachment E).** The Legal Services: Northern Territory Legal Aid Commission; Central Australian Aboriginal Legal Aid Services; North Australian Aboriginal Justice Agency; Central Australian Women's Legal Service and Darwin Community Legal Service also provided a submission to the Northern Territory Government on the six month review of the Alcohol Mandatory Treatment Legislation (**Attachment F**).[86]

Recommendation 15: **APO NT recommends that in regards to the effectiveness of the mandatory treatment of alcohol in the NT, the Committee refer to the recommendations in the APO NT Submission "Not under the influence of evidence: a sober critique of the Alcohol Mandatory Treatment Bill" (Attachment E) and the Legal Services Submission to the Northern Territory Government on the six month review of the Alcohol Mandatory Treatment Act (Attachment F).**

8.2.2 Alcohol Protection Orders

The *Alcohol Protection Act* was introduced into Parliament in October 2013. Under this Act, police were given the power to issue Alcohol Protection Orders (APOs) to anyone arrested for an alcohol-related offence attracting a jail sentence of six months or more. The legal sector in the Northern Territory strongly criticised the Bill and expressed their concerns about the adverse impact it would have on Aboriginal people in the Northern Territory. APO NT issued a media release on 7 November 2013 raising these concerns. The media release is included in this submission (**Attachment G**).[87]

The central message of the Royal Commission into Aboriginal Deaths in Custody was that to reduce the number of Aboriginal people who die in custody, the exposure of Aboriginal people to places of detention needs to be reduced. The Royal Commission made specific recommendations that drunkenness should be re-criminalised, yet an APO does the exact opposite, its effect is to

[86] A list of other organisations and links to their submissions on the Mandatory Alcohol Bill, including media releases can be found here: http://www.naaja.org.au/index.php/current-issues/mandatory-alcohol.html
[87] NAAJA also issued a media release 'Time to Stop and Re-think our Approach to Alcohol Policy in the Territory' on 6 June 2013 which listed a number of concerned Territorians, which can be found here: http://www.naaja.org.au/index.php/current-issues/mandatory-alcohol.html

criminalise people for drinking who have been placed on an order. In an interview with ABC News, Priscilla Collins, CEO of NAAJA stated that "Alcohol protection orders are really being issued out like lolly paper out on the streets. You can be issued one just for drinking on the street, for drink driving. We've already had 500 handed out this year."[88] In effect, the law makes their addiction to drink, a crime, which indefinitely leads to greater numbers of Aboriginal people in police and prison cells.

Kurdiji spokesperson Geoffrey Jungarrayi Barnes said:

> "The Government says these laws are for everybody, but where is the data to back that up? Everyday it's our people who are being affected by these Alcohol Protection Orders, especially in the urban centres, and not non-Indigenous people. Already the gaols are full with our people. This law will mean that even more Aboriginal people will be sent to gaol for APOs, when they should be with their families, attending ceremony, funerals and learning culture."[89]

This is particularly concerning, given the high imprisonment rate in the Northern Territory. Last year alone the NT's imprisonment rate grew 12 per cent. The Territory's imprisonment rate is about 5 times the national average. Our closest rival is Western Australia; we lock people up at more than 3 times the rate they do. At 30 June 2012, the NT had an imprisonment rate in Australia, at 826 prisoners per 100,000 adult population of those in NT prisons, 84% identified as Indigenous.[90] The Aboriginal and Torres Strait Islander Social Justice Commissioner stated in his report, *Indigenous Deaths in Custody 1989 – 1996*:

> Many Indigenous people are being placed in custody for trivial offences. Police initiated interventions result in the laying of charges - typically using offensive language, resisting arrest and assaulting police (or similar offences). The relatively high proportion of Indigenous prisoners incarcerated for assault occasioning no actual bodily harm is indicative of the 'trifecta' phenomenon - 12 per cent against 4 per cent for the general prison population.[91]

(i) Application of Alcohol Protection Orders

The regime is engaged for almost all criminal offending, it is not, in its application, limited to 'serious offences'. Qualifying offences are those punishable by imprisonment for six months or more. This

[88] Coggan, M, 'Police slow 'rivers of grog' but hospital admissions rise', Australian Broadcasting Corporation7.30 Report, 5 March 2014 http://www.abc.net.au/7.30/content/2014/s3957614.htm
[89] Kurdiji, 'Lajamanu Law & Justice Group calls for Alcohol Protection Orders to be scrapped', Media Release, 28 March 2014.
[90] Ibid, above n 8, 9.
[91] Ibid, above n 4 and Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, *Indigenous Deaths in Custody 1989 – 1996*. See ch.6: http://www.humanrights.gov.au/publications/indigenous-deaths-custody-chapter-6-police-practices

includes relatively minor offence such as loitering and disorderly behaviour in a public place. The regime also applies where a police officer believes the person was 'affected by alcohol' at the time of the alleged offence. The 'affected by alcohol' threshold is very low, particularly since it is not necessary for the offence to be related to the fact that the person is affected by alcohol.

The basis upon which an APO can be issued is also exceptionally broad. An officer need not, for example, form the reasonable belief that an APO is necessary or appropriate to prevent further offending. The discretion to impose a restriction that has such serious consequences should be clearly defined. It is also noted that an alcohol protection order is issued in writing. There is no requirement to ensure that a person can understand the notice or that it is explained to them in a language or in terms that they can understand. Given that breaching a notice is a criminal offence, this has the potential to operate unfairly, especially for Aboriginal people who may not be able to read the notice or do not speak English as a first language.

(ii) Powers of Search

The power given to police to search people who are the subject of an APO is much too broad. Section 19 allows for a police officer who reasonably believes that an adult is subject to an APO to search the person without a warrant. There is no requirement that the police officer has a reasonable belief that the person has breached their order. They can simply search them because they are on an order, for no other reason. This is an unacceptably broad power. It can be contrasted with the power in section 18 to require a person to submit to a breath test. This power requires a police officer to reasonably believe that an adult 'has recently consumed alcohol'. The power to search has no such (appropriate) requirement.

(iii) Right of Review

The provisions allowing for a reconsideration and review of decisions in relation to an APO are inadequate. These provisions should ensure that the regime is fair and allows people to challenge a decision to place them on an APO.

(iv) Not applied Territory wide

In Nhulunbuy, some organisations have noted that some people on APO's are moving away from their home communities to consume alcohol, as the APO's system has not been rolled out territory wide.

The following examples are Aboriginal people who have been given an APO and/ or have breached an APO. These examples were provided by CAALAS and NAAJA:

Case Study 12

A 50 year old man from remote community living homeless in Darwin. The defendant has a criminal history of traffic offences and minor liquor offences and has never been to prison. He was initially charged with Assaulting Police by going into the sea of Eastpoint and waving knife, police in standoff for 30 minutes. Matter is set for hearing. The offence would be likely if convicted amount to a suspended sentence. Man given an APO on day of initial arrest. Was further charged on 3 occasions for Breaching APO by drinking alcohol in a park twice and once outside a bank, nil violence or other offending. Arrested and brought to court and bail opposed by prosecutor that defendant would re-offend by drinking. Client would have remained in custody for 7 weeks for hearing date.

Case Study 13

A 19 year old female. Charged for driving under the influence and assaulting a police, when arrested kicked a police officer. Nil history. Given an APO.

Case Study 14

36 year old man initially charged with obscene language and disorderly behaviour. Served with an APO the day after. Charged on 5 further separate occasions for breach of APO. First breach occurred within 7 hours of release. Breaches by being intoxicated in public spaces being asleep, carpark, street and under a bridge. Client is now in custody. Says “Can’t help myself, always drink. If I don’t drink – get sick – feel terrible”.

Case Study 15

44 year old man from remote community charged with breach of DVO. The circumstances of the issuing of the APO were that the man was drinking with his brother-in-law in an undercover area out of the rain. The protected person sat with our client and her brother for about an hour. This client spoke very little English and required an interpreter. The APO was served on him next day. It is highly unlikely that police used an interpreter to explain the terms of the APO to our client. Month later charged with breaching his DVO (non-contact while intoxicated conditions) and breaching his APO. No violence was alleged. For one of the charges, both our client and his partner went to the Casino together to drink there together. The other allegation was that our client was standing next to the protected person holding a

can of drink. Arrested and brought to court and bail opposed by prosecutor that defendant would re-offend by drinking.

Case Study 16

A man from a town in Central Australia was arrested for breaching a non-intoxication domestic violence order that had been issued a few years earlier by drinking in the company of the protected person. Neither the man nor the protected person realised that a non-intoxication domestic violence order was still in place. They were drinking together consensually on the street. There was no allegation of violence or any argument, and no complaint had been made. Police discovered the man was subject to the DVO and was in breach of it when they spoke to the pair and checked his name.

He was arrested and held in police custody over night and served with a first Alcohol Protection Order at about 5.30am. Later in the day, he was observed by police holding a cask of wine. The man was arrested and taken to the watch house, where he was breath tested. He returned a positive result. Police reminded him of the conditions of his APO, and the man stated, 'I left it at home but I didn't know how to read it'. The police said that they had explained the conditions of the APO to him when they gave it to him, but the man said, 'He didn't understand it then'.

The man was served with another APO. About a week later, police found the man in highly intoxicated and arrested him for breaching his APO and took him to the police station. He was arrested again a day later for breaching the APO again, and was also given further non-drinking bail conditions. A few days later he was found in the pub, and was again arrested for breaching his APO and taken to the police station.

The man has an alcohol problem and the APOs were setting him up to fail. The issue of the APOs resulted in the man being arrested and held in police custody on multiple occasions for continuing to drink, in contravention of the APOs.

Recommendation 16: **APO NT does not support Alcohol Protection Orders in the NT. APO NT recommends that comprehensive measures be used to address alcohol in the NT that is evidence-based, will reduce alcohol harm, is culturally relevant and which will not apply criminalisation for a health problem (see Attachment G).**

9. Conclusion

It is well understood that there is a strong correlation between alcohol consumption and health and that social outcomes are complex and multi-dimensional. To counter this, APO NT believes that policy makers must take into account the different characteristics, effects and consequences of its consumption on individuals, families, communities and the broader public. Policy makers should also take into consideration, the reasons why Aboriginal people drink. Efforts to reduce the harmful uses of alcohol in the Aboriginal community must include a comprehensive whole-of-government and whole-of-community approach not just for the drinkers themselves but to protect those individuals and groups who are at risk of being negatively affected by others' drinking.[92]

[92] Ibid, above n 22, 118 http://apont.org.au/index.php/resources.html

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