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4 September 2017

The Executive Director

Australian Law Reform Commission

GPO Box 3708

Sydney, NSW, 2001

Email: indigenous-incarceration@alrc.gov.au

Dear ALRC,

RE: Submission to the Inquiry into Incarceration Rates of Aboriginal and Torres Strait Islander Peoples

Thank you for the opportunity to make a submission to this very important Inquiry.

Please find attached (*) a brief submission modified from our recent submission to the NT Alcohol Policies and Legislation Review which addresses Question 8-2 and an electronic copy of last year's Annual Report and the link to earlier Annual reports. Our report on the final year of the Alcohol Mandatory Treatment facilities we monitored will be provide to the Minister for Health on 30 September 2017.

Yours sincerely,

[redacted]

Sally Sievers

Principal Community Visitor

Northern Territory Community Visitor Program

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Submission to the Inquiry into Incarceration Rates of Aboriginal and Torres Strait Islander Peoples

Executive Summary

This submission provides relevant information and notes public commentary by the Community Visitor Program (CVP) on the Alcohol Mandatory Treatment program. It endorses and advocates that the body of knowledge contained in the PricewaterhouseCoopers (PWC) Indigenous Consulting with Menzies School of Health Research report titled "Evaluation of the Alcohol Mandatory Treatment Program" (PWC Evaluation Report) and CVP Annual Reports inform the Inquiry in their considerations of future policies and legislative review.

The CVP role in Alcohol Mandatory Treatment (AMT) started in 2013 and concludes on 31 August, 2017. The work of the CVP is relevant as it relates to the issues involved with introducing legislation that mandated Alcohol treatment, including assessment and residential treatment.

The speed in which the legislation was introduced had significant impact on the implementation of the program. It was also affected by the limited skilled Alcohol and Drug work force which made ongoing recruitment and retention to implement the AMT difficult and indicates an ongoing need for broader workforce development. It is also relevant to the observations of the CVP that the client cohort in the mandatory treatment services, and the majority of people receiving such orders (97%) were Indigenous and the critical importance of providing culturally safe services.

The CVP recommendations are drawn from analysis of the CVP public reporting and are as follows:

- Any legislation requiring mandatory assessment and treatment for vulnerable clients must incorporate independent legislative oversight.
- That the body of knowledge contained in PWC Evaluation Report and CVP Annual Reports inform future policies and legislative review.
- That Alcohol and Other Drug (AOD) policy is developed applying best practice, evidence-based alcohol harm reduction framework and includes evaluation.

- That any AOD health legislation has underpinning principles and objects that respect client's inherent right to liberty and least restrictive care and is based on sound clinical therapeutic benefit that does not include criminal sanctions.

Background Information

The NT Community Visitor Program (CVP) is a legislative mechanism to protect the legal and human rights of people receiving mental health, disability and alcohol mandatory treatment services in the Northern Territory.[1] The CVP was established in 2001. The CVP visits health facilities regularly, assisting any clients (primarily adults) with complaints or enquiries, reviewing documentation as required and liaising with staff. The AMT Act sets out the scope of the statutory oversight functions when a person's civil liberties are curtailed and the restriction of mandatory detention occurs.

Legislation establishing the CVP provides broad powers to visit facilities, talk with residents, respond to enquiries and complaints, inspect facilities, review documents and report to the Minister. The CVP is an important part of the relevant health service's continuous improvement processes but strongly maintains its independence.

The CVP is a professional service, operating according to established values and procedures. The CVP ensures that its service is provided by skilled professionals, who are culturally safe and focused on the needs of clients. The service is responsive to the needs of clients in facilities and ensures, as much as possible, interpreters are used in its work.

The CVP is independent of the services it oversights, and values this independence highly. The majority of the work, however, is done directly with services at the lowest level. This benefits clients by working towards resolution as quickly as possible with the intention to improve the client's therapeutic experience and outcomes. This approach also ensures that the work of the CVP is part of continuous improvement process within services.

[1] The program is formally established under the *Mental Health and Related Services Act* (Part 14), the *Disability Services Act* (Part 6) and the *Alcohol Mandatory Treatment Act* (the AMT Act) (Part 5, Division 2).

The CVP is one of the systemic 'checks and balances' for health services, including in facilities providing involuntary treatment. The CVP works individually and systemically to ensure that the standard of the services provided under the relevant Acts is of a high quality and that people's rights are protected. The monitoring and inspection role of the CVP is one way in which the services are accountable to a third party.

Relevant CVP Commentary on AMT

The following table identifies the significant issues commented on by the CVP since the *Alcohol Mandatory Treatment Act* was introduced.

Annual Report	AMT Significant Commentary
2013-2014	Noted concerns related to the: - Model of care for assessment and treatment. - Culturally safe practice. - Lack of quality assurance and safety. - Evaluation of the program. - Least restrictive alternative.
2014-2015	- Need for an independent evaluation of the effectiveness of the AMT program. - Adequacy of quality assurance and safety, in particularly the lack of a unified risk management framework. - Need for a more systematic approach to individual review of Affected Persons to ensure that the 'least restrictive alternatives' are used. - Improved focus on cultural safety for all Affected Persons in AMT facilities (in light of 97% of Affected Persons being Indigenous Australians).
2015-2016	- The model used for AMT treatment, which is a joint government and non-government one, creates problems and risks because each party's roles and responsibilities are not clear.

	- In every decision made in AMT facilities, the least restrictive' option for the individual person must be considered, however in practice this is not always done. - Looking after people's rights, like making sure that people's rights in AMT are clearly explained and whether the basis for their detention can be challenged.
2016-2017	- To be tabled in the NT Legislative Assembly after being provided to the Minister on 30 September 2017.

The CVP observed that the speed[2] of the implementation of the AMT program without the adequate policy framework significantly impacted on the program.

The lack of experienced AOD clinical and support staff was evident throughout the duration of the AMT program. The CVP highlights that qualified staff are critical in developing and implementing successful AOD policy and services. Investment in improving the AOD workforce capacity together with recruitment and retention strategies must be incorporated within any NT AOD policy.

Further, the majority of people receiving mandatory treatment orders (97%) were Indigenous and it was found that there was limited planning and strategies in place to ensure culturally safe service.

Recommendations

The CVP recommends;

- Legislation requiring mandatory assessment and treatment must incorporate independent legislative oversight such as a community visitor program function.
- That the alcohol policies and any legislation incorporates the body of knowledge contained in the PWC Evaluation Report and CVP Annual Reports that contain transferrable learnings and open recommendations.

[2] Community Visitor Program, NT, *Annual Report 2014-2015, Model of Care and Treatment Program*, p 70. Accessible at https://cvp.nt.gov.au/__data/assets/pdf_file/0003/228180/CVP_Annual-Report_FINAL.pdf

- That AOD policy is developed applying best practice, evidence-based alcohol harm reduction framework and policies and programs are evaluated.
- That any new AOD health legislation has underpinning principles and objects that respects client's inherent right to liberty, least restrictive care and is based on clinical therapeutic benefit that does not include criminal sanctions.

Sally Sievers

Principal Community Visitor

4 September 2017