Evaluation of the Alcohol Mandatory Treatment Program

PwC’s Indigenous Consulting
with Menzies School of Health Research
This Report has been prepared by PricewaterhouseCoopers Indigenous Consulting Pty Limited (PIC) in our capacity as advisors to Northern Territory Department of Health in accordance with our contract dated 9 October 2015.

The information, statements, statistics, material and commentary (together the “Information”) used in this Report have been prepared by PIC from publicly available material, from information provided by Northern Territory Department of Health and from discussions held with a range of Northern Territory Department of Health stakeholders. PIC has relied upon the accuracy, currency and completeness of the Information provided to it by Northern Territory Department of Health and the Northern Territory Department of Health stakeholders and takes no responsibility for the accuracy, currency, reliability or correctness of the Information and acknowledges that changes in circumstances after the time of publication may impact on the accuracy of the Information. The Information may change without notice and PIC is not in any way liable for the accuracy of any information used or relied upon by a third party.

Furthermore PIC has not independently validated or verified the Information provided to it for the purpose of the Report and the content of this Report does not in any way constitute an audit or assurance of any of the Information contained herein.

PIC has provided this advice solely for the benefit of Northern Territory Department of Health and disclaims all liability and responsibility (including arising from its negligence) to any other parties for any loss, damage, cost or expense incurred or arising out of any person using or relying upon the Information.
Executive Summary

Introduction

The Alcohol Mandatory Treatment Act (AMT Act) commenced in July 2013 as a harm reduction strategy to direct problem drinkers who might be unlikely or unable to voluntarily access treatment into appropriate treatment options. The Northern Territory (NT) Government committed to undertake a legislative review of the Act after six months of operation and to evaluate the Alcohol Mandatory Treatment (AMT) services and client outcomes soon thereafter. The legislative review was undertaken in early 2014, with key legislative amendments being passed in October 2014, and commenced in stages throughout 2015.

This independent evaluation of the AMT program commenced in November 2015 and has been undertaken by PricewaterhouseCoopers Indigenous Consulting (PIC) in partnership with Menzies School of Health Research (Menzies) over a period of 12 months. While it has been conducted at arm’s length from the Department of Health (DoH) who commissioned the evaluation, an Evaluation Steering Committee coordinated by the DoH Office of Evaluation has provided invaluable content advice and guidance to the researchers.

The intent of the evaluation was to:

- assess the extent to which the aims of the AMT Act have been met;
- consider the cost effectiveness of AMT and describe the way that AMT has been implemented and engaged with; and
- explore any unintended consequences resulting from AMT.

The AMT program

In summary, the AMT program provides for a comprehensive health assessment and tailored alcohol treatment plan for people who are taken into police protective custody for being intoxicated in public three or more times over a two month period.

The AMT program is not available for those who commit a crime under the influence of alcohol. These people may face charges and go before the Local Court.

The assessment and recommended treatment plans are considered by the AMT Tribunal who has the responsibility to decide on the ‘least restrictive treatment option’ to give effect to the objectives of the AMT program, and may make any of the following orders:

- a community treatment order, either in a residential or community setting;
- a mandatory residential treatment order for the person to be in treatment for up to three months; or
- a release or exemption order.

If the Tribunal makes a mandatory treatment order in relation to the affected person, it must also make an income management order if the person is an eligible welfare recipient.

The AMT program is delivered by a range of providers including NT Health, non-government service providers, NT Police, advocates, interpreters, the independent AMT Tribunal and the Community Visitor Program. All of these service components were operational within six months of the implementation of the AMT Act in July 2013.

Assessment and mandatory treatment services were initially established in Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs; however, the services in Nhulunbuy were discontinued in 2014, and the treatment service in Tennant Creek was discontinued in January 2016. Assessment services remain in Tennant Creek and are delivered from the hospital as in the case in Katherine. Standalone assessment centres in Darwin and Alice Springs are operated by Top End Health Services (TEHS) and Central Australian Health Services (CAHS) respectively. Separate mandatory residential treatment services are operated by non-government providers in both Darwin and Alice Springs. Although the Darwin assessment and treatment services are co-
located on the same site. Aftercare services were established in stages during 2015 and are delivered by non-government providers in Darwin and Alice Springs.

**Evaluation questions and methodology**

The Department of Health requested that the evaluation seek to answer five questions set across three components.

<table>
<thead>
<tr>
<th>Question</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent are the aims of the AMT being achieved for the client group?</td>
<td>Client outcomes</td>
</tr>
<tr>
<td>2. What is the relationship between a client's engagement in the program and identified outcomes?</td>
<td>Service model and implementation</td>
</tr>
<tr>
<td>3. How does each service model operate?</td>
<td>Cost effectiveness</td>
</tr>
<tr>
<td>4. Has the service model been implemented as intended and is the uptake as predicted?</td>
<td></td>
</tr>
<tr>
<td>5. Is the service model and its delivery in each location cost effective?</td>
<td></td>
</tr>
</tbody>
</table>

Different evaluation methodologies were used for each component:

- an impact evaluation method was used for the client outcomes component to assess the intended as well as unintended changes to clients that could be attributed to AMT;
- a process evaluation was used for the service model and implementation components; and
- traditional input costing methodologies were used for the cost effectiveness component of the evaluation.

The three evaluation components were undertaken concurrently and the findings were shared between teams and integrated on an ongoing basis. More information on the methodology for each component is detailed in Chapter 2. Importantly the evaluation was conducted with ethics approval from the two relevant NT Health Human Research Ethics Committees.

The client group for the impact evaluation was all people who had been eligible for AMT between 1 July 2014 and 30 June 2015, while the process and cost effectiveness components of the evaluation considered the whole timeframe of the AMT program from July 2013 to the present.

The information collected for each component of the evaluation is detailed in Chapters 3-5.

**High level findings**

The Evaluation Team’s findings and recommendations are detailed in Chapter 6. Throughout the evaluation, however, the team started to see several interlinked, high-level themes relating to the development and implementation of the Alcohol Mandatory Treatment (AMT) program.

Although these themes do not necessarily relate to any specific recommendation, the Evaluation Team believes they provide important context for the remainder of this report:

**Timeframe**

The AMT was implemented quickly, against the backdrop of a highly charged political and ethical debate. It was an attempt to address a complex challenge in limited time, without the benefit of a comparison model and with insufficient time to develop a sound program logic.

**Evolution of the system**

Partly as a result of the lack of development time and no initial program logic or theory of change model, the AMT system has evolved over time. Changes, and sometimes tensions, have occurred as services providers and stakeholders have each interpreted and adapted their roles in the absence of clear objectives and definitions.
Geographical differences
The Evaluation Team found variations in the way AMT works in different regions of the Territory. This is partly due to the evolution of the system described above, and partly due to existing differences in services and harm reduction strategies, for example Temporary Beat Locations.

Vulnerable clients
The Evaluation Team found that AMT has been implemented for very vulnerable people who typically do not voluntarily access existing AOD treatment. This includes people who are frequently taken into police protective custody and admitted to hospitals, in poor health, homeless and with histories of past trauma and disconnection from their families and communities.

Some health benefits
The comprehensive assessment for people who enter AMT was valuable, and for some people, AMT did have health and social well-being benefits – at least in the short-term. This included receiving treatment for immediate health concerns such as dental care, and the management of existing conditions such as diabetes and asthma, as well as an opportunity to be supported to reconnect with their family and community. However, there was no statistically significant difference between people who had had a Mandatory Residential Treatment Order and no treatment in terms of Emergency Department presentations and hospital admissions. Most were re-apprehended by NT Police multiple times, entering custody from homelessness and ending up homeless again.

People missing out
A significant number of people 'leaked out' of the AMT system and received no assessment or treatment. Sometimes this was expected – for example, people with outstanding warrants are not eligible for AMT and people with serious physical or mental health issues are immediately taken to hospital for treatment. This means a number of people who could potentially benefit from treatment were excluded from the process.

Cycling in and out of AMT
The Evaluation Team found that a high percentage of participants cycle in and out of the AMT system. A client may not attend treatment and there may be little follow up, and it is common for people to be picked up by police again. Research shows that people experiencing chronic alcohol misuse often make multiple attempts at treatment before sustaining behaviour change. Accordingly, an integrated system built with this in mind, would be worth developing.

Gaps in data integration
The comprehensive assessment undertaken as part of this evaluation was valuable in identifying the improvements for some people, but it was not possible to view the AMT program end-to-end. A more robust data system would allow tracking of individuals and their health and social outcomes. For example, for the people who received the least restrictive option of community treatment, there is no structure and no follow up. Although there is evidence that few people on community treatment options pursued treatment, the Evaluation Team was not able to assess this.

Recommendations
The recommendations in Chapter 6 of this report are not presented in priority order but rather as they relate to findings about the overall program, against the five evaluation questions, and about the evaluation and data limitations.

Overall AMT Program and Service System Findings

Recommendation 1: Develop a program logic model at the outset of any future initiatives to ensure that systems and resources are in place so people who enter the system have the highest likelihood of proceeding to the treatment phase and the program can achieve optimal outcomes for vulnerable and hard to reach people.

Recommendation 2: Engage with social service providers in the community, current AOD clients, their families, and other key stakeholders to assess the current demand for services, identify service gaps and develop cross-sector capacity to deliver a range of appropriate programs and services for people based on the needs of NT communities, families and individuals.
Recommendation 3: Invest in culturally appropriate alcohol related harm prevention and early intervention programs that are developed in consultation with local stakeholders and delivered in NT communities for young people, and other high-risk groups with high alcohol consumption.

Recommendation 4: Strengthen cross-agency and cross-sector communication and networking processes in each region to enhance understanding of the local service system and encourage collaboration and partnership across services and sectors.

Recommendation 5: Invest in cross-sector outreach services to homeless people in the major centres, supported by medical practitioners, assessment clinicians, case managers, police, housing and justice workers, supported by accommodation options that are more flexible and have access to wraparound services.

Question 1: To what extent are the aims of the AMT being achieved for the client group?

Recommendation 6: Ensure comprehensive clinical assessment services are available to people engaging in chronic, long-term harmful alcohol use to inform treatment planning, assess cognitive capacity and identify health and safety risks.

Recommendation 7: Ensure safe withdrawal facilities are available in all major centres, operating with clear primary health care policies and procedures and skilled clinicians identifying and managing the health risks of clients with harmful alcohol use.

Recommendation 8: Implement a comprehensive, client-centred and health-focused risk management approach to working with people engaging in chronic, long-term harmful alcohol use so that immediate and longer-term health risks can be identified, addressed and/or managed.

Recommendation 9: Develop an integrated Client Management System to record all demographic and health related data, along with risk factors for all individuals in any future alcohol assessment and treatment system. Such a system should include documentation of ongoing case management and tracking of the client’s progress as they engage with wraparound service providers and treatment will build an evidence base for program effectiveness, support a cross-agency approach and help to ensure that funding is directed into programs and services that deliver optimum outcomes.

Recommendation 10: Review reporting requirements for all non-government community treatment providers, and wraparound aftercare services so that compliance with treatment orders can be monitored, and client outcomes recorded.

Recommendation 11: Develop future initiatives and programs based on a longitudinal model of care that includes processes that allow people to enter and exit the program multiple times, and to learn from each attempt at changing behaviour, supported by a case management or care coordination approach throughout the various episodes of treatment and aftercare.

Question 2: What is the relationship between a clients’ engagement in the program and identified outcomes?

Recommendation 12: Engage and consult with Aboriginal and Torres Strait Islander people and their communities regarding the development of any future programs, as well as ensuring involvement in the leadership and operation of services, and engagement in the monitoring and evaluation of any programs and services.

Recommendation 13: Develop best practice protocols that draw on effective mainstream treatment programs that have an established evidence base of what works, and tailor for Aboriginal and Torres Strait Islander people with the support of community and representative organisations, as part of a planned, integrated set of treatment options recommended by the NT Government for use by service providers including non-government funded programs.

Recommendation 14: Engage the Aboriginal Interpreter Service to translate educational material for use by treatment programs and discuss how they can further assist with the effectiveness of group treatment sessions.

Recommendation 15: Continue to invest in building a culturally competent AOD workforce and increasing the number of AOD trained Aboriginal people across the NT available to work in AOD prevention, early intervention and treatment services.
Recommendation 16: Ensure that any future service system is be equipped to deal with people with severe cognitive impairment and have options available for people who may not be able to effectively engage with and benefit from treatment programs.

Recommendation 17: Develop the capacity for future assessment and treatment services to facilitate reconnection with non-drinking family members to allow family members to be engaged in aftercare planning, and for clients to be assisted to return home to communities and be connected to local support services.

Recommendation 18: Provide clients in treatment with pathways to appropriate support networks within their communities where they can continue to be supported to access ongoing treatments to reduce alcohol related harm.

Recommendation 19: During treatment, involve clients in developing their own alcohol related harm reduction and aftercare plan with their case manager so that it is most relevant to their needs so they are willing to engage fully in a treatment option likely to provide them the most benefit in reducing alcohol related harm.

Question 3: How does each service model operate?

Recommendation 20: Review the community residential treatment service sector to inform decisions about models of care, location and bed capacity required in future so the range of treatment services is matched to demand and the needs of the largely long term chronically homeless Aboriginal client group who engage in chronic, long-term harmful alcohol use.

Recommendation 21: Employ skilled AOD staff in assessment and care coordination roles in any future system for Aboriginal client group who engage in chronic, long-term harmful alcohol use.

Question 4: Has the service model been implemented as intended and is the uptake as predicted?

Recommendation 22: Ensure voluntary pathways into residential treatment exist for people who engage in chronic, long-term harmful alcohol use who wish to access this form of treatment, supported by access to a comprehensive assessment to inform treatment planning and support options.

Recommendation 23: Consider the most appropriate referral pathways for young people who engage in chronic, long-term harmful alcohol use and are taken into protective custody by police to enable this client group and their families to be assessed and offered access to treatment and wraparound support services.

Recommendation 24: Develop referral pathways to assessment that recognise that some people who engage in chronic, long-term harmful alcohol use may have challenging behaviours that have not resulted in them being charged with an offence, or being admitted to an inpatient mental health facility, but which make assessment in a congregate care setting very difficult.

Recommendation 25: Develop future programs with aftercare as an integral and intensive component of the service system, enabling regular contact with clients who engage in chronic, long-term harmful alcohol use to provide ongoing treatment and support.

Question 5: Is the service model and its delivery in each location cost effective?

Recommendation 26: Develop a strategic approach to fund government and contracted community services providers for all future programs and initiatives to reducing alcohol related harm. Adopting a planning, monitoring and reporting framework such as Results Based Accountability that can be embedded into program design, service specifications and funding contracts will help to ensure that investment is directed where it can be most cost effective.

Evaluation/Data Limitations

Recommendation 27: Facilitate a cross-agency approach to electronic record keeping and data collection so information can be shared between relevant agencies.

Recommendation 28: NT Health engage with acute services and other healthcare providers in the NT so that alcohol related and partially alcohol-attributable diseases and events are recorded and coded consistently and shared between relevant stakeholders involved in reducing alcohol related harm.
Acknowledgments

PwC’s Indigenous Consulting (PIC) would like to acknowledge and thank Menzies School of Heath Research, for the dedication, ethical and professional approach of the research and evaluation staff who worked closely with the PIC staff as a single, combined evaluation team. Both PIC and Menzies are passionate about improving the health and wellbeing of Indigenous people and felt privileged to be able to undertake this evaluation as we recognise the importance of capturing the lessons from the AMT program to inform future policy and service system responses to addressing alcohol related harm.

The Evaluation Team would also like to thank and acknowledge the contributions from the AMT Evaluation Steering Committee members, and in particular the Chair and staff of the Department of Health’s Office of Evaluation who provided regular guidance and support throughout the project. The team also want to thank the staff from government and other agencies who provided quantitative data for the evaluation.

Finally, the Evaluation Team would like to thank all of the participants in this evaluation for their commitment, energy and spirited questions, discussions and debate during the consultation sessions. This contributed greatly to the overall success of the evaluation, and to ensuring the findings and learnings were contextualised to the NT and to the needs of the client group for whom the program was developed to assist.
# Contents

Executive Summary ................................. i  
Acknowledgments ................................. vi  

## 1 Context and Background  
1.1 The Alcohol Mandatory Treatment program  
1.2 Alcohol related harm in the NT  
1.3 Social determinants of health  
1.4 Political and social context of the AMT program  
1.5 Pre AMT responses to problem drinking  
1.6 Post AMT responses to alcohol related harm  
1.7 Alcohol Mandatory Treatment legislative review  
1.8 The future of AMT  

## 2 Methodology  
2.1 Evaluation questions  
2.2 Client outcomes impact evaluation  
2.3 Service model and implementation process evaluation  
2.4 Cost effectiveness evaluation  
2.5 Literature review  

## 3 Service Models and Implementation  
3.1 Apprehension and triage  
3.2 AMT assessment and referral  
3.3 Mandatory residential treatment  
3.4 Community residential and other community treatment  
3.5 Aftercare  

## 4 Client Outcomes  
4.1 2014-15 AMT client cohort  
4.2 Assessing increased stability and improvements in health
4.3 Improvements in social functioning 53
4.4 'Restored'/increased capacity to make decisions about their alcohol use and personal welfare 55
4.5 Improvements in access to ongoing treatment to reduce the risk of alcohol consumption 59

5 Cost Effectiveness 62
5.1 Costs of apprehension and referral 62
5.2 Cost of AMT assessment 62
5.3 AMT Tribunal costs 63
5.4 AMT Community Visitor Program costs 64
5.5 Cost of mandatory residential treatment 64
5.6 Costs of AMT community treatment 66
5.7 Costs of aftercare 67
5.8 Regional comparisons 67
5.9 Comparison of community and mandatory residential treatment 68
5.10 Summary of effectiveness 68

6 Summary of findings and recommendations 70
6.1 AMT program and service system findings 70
6.2 To what extent are the aims of the AMT being achieved for the client group? 71
6.3 What is the relationship between a client's engagement in the program and identified outcomes? 73
6.4 How does each service model operate? 75
6.5 Has the service model been implemented as intended and is the uptake as predicted? 75
6.6 Is the service model and its delivery in each location cost effective? 77
6.7 Evaluation limitations 78

Appendix A Literature review 82
Appendix B Stakeholder engagement 92
Appendix C Program Logic 94
## List of tables and figures

### Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Evaluation questions</td>
<td>9</td>
</tr>
<tr>
<td>Table 2</td>
<td>NT Police AMT Data 1 July 2013 - 10 July 2016</td>
<td>14</td>
</tr>
<tr>
<td>Table 3</td>
<td>Types of tribunal orders</td>
<td>20</td>
</tr>
<tr>
<td>Table 4</td>
<td>Total tribunal hearings and orders 2013-14 - 2015-16</td>
<td>22</td>
</tr>
<tr>
<td>Table 5</td>
<td>Number of times clients appeared in a tribunal hearing in a year since 2014-15 and 2015-16</td>
<td>22</td>
</tr>
<tr>
<td>Table 6</td>
<td>Mandatory Residential Treatment Orders 2013-14 and 2015-16</td>
<td>28</td>
</tr>
<tr>
<td>Table 7</td>
<td>Selected summary episode counts for non-government mandatory treatment service providers where the 'AMT status' is residential from third quarter 2014 to third quarter 2016</td>
<td>29</td>
</tr>
<tr>
<td>Table 8</td>
<td>Community treatment provider</td>
<td>34</td>
</tr>
<tr>
<td>Table 9</td>
<td>Mandatory Community Treatment Orders 2013-14 - 2015-16</td>
<td>34</td>
</tr>
<tr>
<td>Table 10</td>
<td>Selected summary episode counts where the AMT status is 'community' 2014-15 and 2015-16</td>
<td>35</td>
</tr>
<tr>
<td>Table 11</td>
<td>Episodes for selected non-government community treatment providers where main treatment is rehabilitation and treatment delivery setting is residential 2014-15 - 2015-16</td>
<td>36</td>
</tr>
<tr>
<td>Table 12</td>
<td>Client demographics for the AMT participants (those who were ordered to receive treatment 1 July 2014 to 30 June 2015)</td>
<td>44</td>
</tr>
<tr>
<td>Table 13</td>
<td>Example of case study participant relapses</td>
<td>59</td>
</tr>
<tr>
<td>Table 14</td>
<td>AMT assessment budget allocations 2013-14 - 2015-16 and average cost of assessment (NTG managed services)</td>
<td>62</td>
</tr>
<tr>
<td>Table 15</td>
<td>AMT Tribunal Budget Allocations 1 July 2013 to 30 June 2016 and estimated cost per hearing and individual</td>
<td>64</td>
</tr>
<tr>
<td>Table 16</td>
<td>CVP budget allocations 1 July 2013 to 30 June 2017 and estimated cost per visit</td>
<td>64</td>
</tr>
<tr>
<td>Table 17</td>
<td>Mandatory residential treatment establishment and capital funding 2013-14 and 2016-17</td>
<td>65</td>
</tr>
<tr>
<td>Table 18</td>
<td>Mandatory residential treatment non-government grant funding 2013-14 to 2016-17 (NGO managed services)</td>
<td>65</td>
</tr>
<tr>
<td>Table 19</td>
<td>Average cost per episode of mandatory residential treatment in 2015-16</td>
<td>66</td>
</tr>
<tr>
<td>Table 20</td>
<td>AMT community treatment grant funding 2013-14 to 2016-17</td>
<td>66</td>
</tr>
</tbody>
</table>
Table 21: AMT NGO aftercare grant funding 67
Table 22: Regional comparison of the average cost of withdrawal and assessment for half years 2015-16 (NTG managed services) 67
Table 23: Comparison of the cost per episode of treatment in mandatory residential treatment and community residential treatment 2015-16 68
Table 24: Budget allocation for all AMT services in 2015-16 69

Figures

Figure 1: Client journey through the AMT service system 2
Figure 2: Desired approach to aftercare 38
Figure 3: People eligible for mandatory treatment in the cohort period 1 July 2014 to 30 June 2015 43
Figure 4: AMT participants and comparison group by gender 44
Figure 5: Age distribution of AMT participants and comparison group 44
Figure 6: Treatment order made for AMT participants between 1 July 2014 and 30 June 2015 45
Figure 7: Period during which AMT participants received treatment order, by order type 45
Figure 8: Age distribution and gender of case study participants 46
Figure 9: Days from first trigger to subsequent ED attendance 48
Figure 10: Days from first trigger to subsequent hospital admission 49
Figure 11: Annual number of Emergency Department presentations, per person between 1 July 2009 and 30 June 2014 50
Figure 12: Average number of ED presentation rates pre (before June 2014) and post AMT (after June 2015) 51
Figure 13: Number of hospital admission per person, per year, by case and control group 52
Figure 14: Protective custody apprehensions for cases and controls, pre and post treatment period 56
Figure 15: Days from trigger to subsequent protective custody 57
Figure 16: Range of protective custody apprehensions per person 1 July 2015 to 30 June 2016 58
Figure 17: AMT participant protective custody apprehensions during their RTO (1 July 2014 – 30 June 2016) 58
Figure 18: Average number of alcohol and other drug referrals 61
Acronyms

ACSQHC  Australian Commission on Safety and Quality in Health Care
ACWs  Aboriginal Community Workers
ADSCA  Alcohol and other drug Services Central Australia
AHWs  Aboriginal Health Workers
AIHW  Australian Institute of Health and Welfare
AMP  Alcohol Management Plans
AMT  Alcohol Mandatory Treatment
ANCOR  Australian National Child Offender Register
APOs  Alcohol Protection Orders
AOD  Alcohol and Other Drugs
ASAAS  Alice Springs Alcohol Assessment Service
BDR  Banned Drinker Register
BrAC  Breath Alcohol Content
CAAAPU  Central Australian Aboriginal Alcohol Programs Unit
CAAC  Central Australian Aboriginal Congress
CAAPS  Council for Aboriginal Alcohol Program Services
CAHS  Central Australian Health Service
CCIS  Community Care Information System
CDP  Community Development Program
CLP  Country Liberal Party
CTO  Community Treatment Order
CVP  Community Visitor Program
CVs  Community Visitors
DAATS  Darwin Alcohol Assessment and Treatment Service
DASA  Drug and Alcohol Services Australia
DoH  Department of Health
ED  Emergency Department
FORWAARD  Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties
IJIS  Integrated Justice Information System
IMO  Income Management Order
MARS  Mandatory Alcohol Reform Service
MCTO  Mandatory Community Treatment Order
MERIT  Magistrates Early Referral into Treatment
MRTO  Mandatory Residential Treatment Order
MTO  Mandatory Treatment Order
NAAJA  North Australian Aboriginal Justice Agency
NHMRC  National Health and Medical Research Council
NIDAC  National Indigenous Drug and Alcohol Committee
Context and Background

NT  Northern Territory
PAA  Police Administration Act
PC  Protective Custody
PCIS  Primary Care Information System
PIC  PricewaterhouseCoopers Indigenous Consulting
PICS  Primary Care Information System
POSIs  Point of Sale Interventions
RTO  Residential Treatment Order
SAC  Senior Assessment Clinician
STC  Senior Treatment Clinician
TADS  Top End Alcohol and Drug Services
TAN  Transport Advice/Advisory Notice
TEHS  Top End Health Service
TO  Treatment Order
WFQ  Wanted for Questioning
1 Context and Background

1.1 The Alcohol Mandatory Treatment Program

The Northern Territory Government passed the Alcohol Mandatory Treatment Act (AMT Act) with the stated objectives to “stabilise and improve health, improve social functioning, restore capacity to make decisions and improve access to treatment for problem drinkers”\(^1\). The AMT program was intended to be a harm reduction strategy that permitted mandatory treatment of problematic users of alcohol who are unlikely or unable to access treatment options voluntarily\(^2\). By adopting a harm reduction approach, the aim was to help some of the most chronic abusers of alcohol in the Northern Territory (NT) who were known to be at risk to themselves or others\(^3\). Therefore, the AMT program was established based on treatment, not punishment, principles.

Clients admitted to the AMT program have been placed in protective custody by the Police on more than one occasion, and AMT is intended to offer a “least restrictive alternative” to incarceration in the justice system. If they are charged with an offence the client will progress through the criminal justice system rather than AMT; however, progression through the criminal justice system does not guarantee a person will receive assessment and/or treatment for alcohol issues.

In summary, the AMT program requires that the person, who has been taken into police protective custody for the third time in two months, undergo an assessment by health staff and then appear before the Alcohol Mandatory Treatment Tribunal. The tribunal will then either make a mandatory treatment order in relation to the person if the tribunal is satisfied the person meets the criteria for a mandatory treatment order and is not a person to whom a mandatory treatment order must not be made; or the tribunal may otherwise make an order for the affected person to be released\(^4\). A voluntary pathway to assessment and treatment was introduced in early 2016.

During their treatment clients are offered a range of development programs, including life skills and work readiness programs. On completion of their treatment, clients are provided with an aftercare program of support for when they return home.

The service processes were divided into subsections to facilitate a systematic examination of the system. The subsections were:

- apprehension and triage
- assessment and referral
- mandatory residential treatment
- community treatment
- aftercare

For the purposes of the evaluation, the Evaluation Team worked with the NT Government and AMT service providers to comprehensively map the service processes in the program, and the client journey, from the point of contact with police to receiving aftercare at the end of mandatory treatment (Figure 1).

\(^1\) (NT Government, 2013)  
\(^2\) NT Alcohol and Other Drug Services, 2014:4  
\(^3\) NT Department of Health, 2016  
\(^4\) AMT Act section 33
Figure 1: Client journey through the AMT service system

Notes:
* AFOs no longer preclude a person from being eligible for Alcohol Mandatory Treatment, but did during 2014/15
** Charges punishable by 7 years or less no longer preclude a person from being eligible for Alcohol Mandatory Treatment, but did during 2014/15
*** ANCON = Australian National Child Offender Register
**** Mandatory Residential Treatment Service providers in Darwin transferred from the DFI to SAIS to SAIS at the end of March 2015. CAAAPU has always been the provider in Alice Springs.
The AMT service system has evolved since its initial implementation as the NT Government and service providers have worked to improve processes and outcomes for clients. However, the core service components of the AMT program are:

- police watch houses
- assessment centres
- mandatory residential treatment facilities
- AMT Tribunal
- advocates
- interpreters
- Community Visitors
- community treatment services both residential and non-residential
- aftercare services

Assessment and mandatory treatment services were initially established in Darwin, Nhulunbuy, Katherine, Tennant Creek, and Alice Springs. The services in Nhulunbuy were discontinued in 2014, and the treatment service in Tennant Creek was discontinued in January 2016. Assessment services remain in Tennant Creek and are delivered from the hospital, which is also the case in Katherine. Darwin and Alice Springs have standalone assessment centres, operated by Top End Health Services (TEHS) and Central Australian Health Services (CAHS) respectively. Non-government providers in Darwin and Alice Springs operate separate mandatory treatment services. Aftercare services, established in stages in 2015, are also delivered by non-government providers in Darwin and Alice Springs.
1.2 Alcohol related harm in the NT

The Northern Territory (NT) has for many years had the highest rates of alcohol related problems in Australia with alcohol consumption rates per capita in excess of the national level since the 1980s, and Territorians reported to be consuming alcohol at 1.5 times the national average. This is the case for both Indigenous and non-Indigenous groups (1.7 times and 1.5 times the national average respectively). The per capita alcohol consumption of the NT is reported to be the second highest in the world, estimated at 15.1 litres of pure alcohol per year per capita, with Aboriginal and Torres Strait Islanders consuming approximately 16.9 litres.

More recent research indicates these rates may be an underestimate as national per capita consumption of alcohol has been increasing over time due to the increased alcohol content of alcohol products. This rate of consumption has translated into high rates of hospitalisation in the NT at more than twice the national rate, with alcohol related injury rates remaining high at 63 per 100,000 for non-Indigenous and 414 per 100,000 for Indigenous people, consistent with evidence of increasing alcohol related harm at the national level.

Furthermore, alcohol related deaths in the NT are three times the national average with studies showing alcohol costs the NT $642 million a year, or $4197 for every adult Territorian, almost 4.5 times the national cost of $943 per adult (i.e. alcohol related health and hospitalisation costs, policing costs, courts and correctional services costs and loss of productivity). From 2008 to 2013 approximately 60% of police work involved alcohol related issues such as assault with 67% of all domestic violence involving alcohol.

1.3 Social determinants of health

The individuals most likely to come into contact with the AMT program are homeless or disconnected from family and community, and experiencing a range of complex issues in addition to their alcohol consumption such as ongoing and significant trauma. They are often economically marginalised and subject to systematic racism and discrimination. It is clear that policies and programs seeking to reduce risky levels of alcohol consumption via harm reduction are most likely to be successful if they are predicated on recognising and addressing causal factors, including the social determinants of health, not just reliant on individual treatment provided by a clinical workforce. Client centred, integrated services embedded in a system that addresses the social determinants, and the ability to be flexible in approach is fundamental to providing effective support for people dealing with alcohol addiction and misuse.

---

6 Chikritzhs et al., 2005
7 Northern Territory Government, 2014
8 Ramamoorthi et al., 2015
10 Jayaraj et al., 2012
11 NT Department of Health, 2012
13 NT Department of Health, 2016
14 NT Government, 2013
15 NT Police, 2014
16 NT Department of Health, 2016
Context and Background

The National Health and Medical Research Council (NHMRC) states that the reasons for drinking are likely to be closely related to age, culture and socioeconomic status.\(^8\) Research by the Australian Institute of Health and Welfare (AIHW) found the social and economic determinants of health in Australia included educational attainment; connection to family, community, country and culture; employment; housing; racism, and/or discrimination, and interaction with government systems including access and treatment within the health system and contact with the criminal justice system.\(^9\) An understanding of these factors and their interaction is critical to understanding, and providing treatment and support to Aboriginal and Torres Strait Islander people dealing with risky levels of alcohol consumption.

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

> The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised by the legacy of colonisation, racism and marginalisation from dominant 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.\(^2\)

Health and wellbeing is understood in a holistic context by Aboriginal and Torres Strait Islander people. Aboriginal peoples have a holistic view of health that focuses on the physical, spiritual, cultural, emotional and social wellbeing of the individual, family and community. A holistic approach emphasises the importance of strengthening cultural systems of care, control and responsibility.\(^3\)

Alcohol and other drug (AOD) use should be seen in the context of the individual, family and community/environment. AOD use impacts on each of these areas and each needs to be considered when choosing and developing appropriate interventions. Approaches need to respect the cultural rights, values, beliefs and expectations of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander leadership, community consultation, direction, negotiation and involvement form an essential part of this process.

1.4 Political and social context of the AMT program

The introduction of the AMT program was the subject of much political debate and process. The Country Liberal Party (CLP) announced the AMT program as part of its election campaign in 2012 as a replacement for the Banned Drinker Register (BDR). At that time there were approximately 2600 people on the BDR, and an evaluation into the effectiveness of that system had not been undertaken. Upon winning government, the CLP government disbanded the BDR and introduced legislation that would establish the AMT program.

Some parts of the community, legal and health sectors in the NT and nationally, have considered the AMT program a controversial approach to treating alcohol addiction. Some of the reasons include:

- the limited time for consultation on the legislation package

In an interview after talking to the "long-grassers", Senator Peris emphasised how homelessness makes alcohol abuse among Aboriginal people more obvious than alcohol use in the non-Indigenous community in Darwin.

"Those ladies, they weren't from Darwin, they were from communities that came in, so they're homeless and they drink when they come into town and it's easy to get alcohol [in town]."

“This is one of the most significant reforms in Northern Territory health and alcohol policy in recent years and the Government is determined to get it right” Hon John Elferink, former Minister for Health May 2013

\(^8\) National Health and Medical Research Council (NHMRC), Australian guidelines to reduce health risks from drinking alcohol, 2009, p. 14.
\(^3\) Commonwealth of Australian 2013. National Aboriginal and Torres Strait Islander Health Plan 2013-2023
• ethical concerns about detaining a person for mandated treatment
• the police pathway into a health program, and perceived lack of consideration about addressing the social determinants of health
• concern about institutional racism and whether the program discriminates against Aboriginal people.

The speed with which government agencies were required to prepare legislation and establish new alcohol treatment services and processes has had ongoing implications. To provide some context, the Department of Health was restructured and two health service networks were created, and other health and hospital service system reforms were also occurring over the same period, providing additional challenges for staff to navigate and manage new program implementation.\(^{22}\)

The ethical concerns have been subject to lengthy debate. The Literature review (Appendix A) provides a snapshot of the concerns.

While AMT is certainly a rare model of treatment, other states in Australia have also introduced policy that allows for mandated alcohol and other drug treatment for offenders. In Victoria the *Severe Substance Dependence Treatment Act* allows detention and treatment for up to 14 days for people with severe substance dependence as a last resort to provide lifesaving treatment. The New South Wales *Drug and Alcohol Treatment Act*, as in Victoria, is a last resort treatment option that allows initial detention for 28 days, with the option of extending to three months. Both NSW and Victorian statutes remove extended periods of incarceration, providing improved protection of patient rights based on international best practice. The difference with the NT's AMT program is that it mandates assessment and treatment for people who had not committed an offence.

Until early 2016, the only referral pathway into AMT was via police protective custody. Entry into AMT did not allow for referral from other health practitioners or community services. This led to concerns being raised that decision making should be based on health criteria, rather than police referral.\(^{23}\) A regulation was finalised in March 2016 allowing a medical practitioner to refer a client to AMT; however, no clients have been referred this way.

The other critical concern was that AMT would indirectly target Aboriginal people. Concerns were raised that the program would capture those Aboriginal people who live remotely and travel into the major centres, or experience homelessness, and are more likely to drink in public places.\(^{24}\) Previous studies had shown high rates of alcohol usage among homeless and itinerant Aboriginal people, adding weight to this concern.\(^{25}\)

### 1.5 Pre AMT responses to problem drinking

A number of programs have been implemented in the NT over the past few decades to address these problems including the Living with Alcohol Program, which operated between 1991 and 2000 and is still nationally considered best practice today.\(^{26}\) A series of alcohol management plans have focused on reducing harm and damage in communities by restricting consumption of alcohol either by geographical location, times when outlets could sell alcohol or by prohibiting public consumption of alcohol.\(^{27}\) Evaluations of the impact of the reduction of the alcohol supply in remote Indigenous communities have found that this strategy has been effective in reducing serious injury in selected communities.\(^{28}\)

---

\(^{22}\) NT Community Visitor Program Annual report 2013–14

\(^{23}\) APONT, 2014

\(^{24}\) APONT, 2013, *Not under the influence of evidence: As sober critique of the Alcohol Mandatory Treatment Bill: APONT Submission on the NT Alcohol Mandatory Treatment Bill*


\(^{26}\) NT Government, 2014:5

\(^{27}\) d'Abbs et al., 2010, 2011

\(^{28}\) Margolis et al., 2008
In 2011 the Banned Drinker Register (BDR) was introduced as part of the ‘Enough is Enough Alcohol Reform Package’. The package was designed to reduce excessive alcohol consumption and the associated financial, health and social costs. The BDR maintained central information about the identity of Banned Drinkers, or people who had been issued a Banned and Treatment notice for problem drinking. A person could be placed on the BDR if they had been taken into protective custody three times in three months or they had committed a violent offence and alcohol was involved. Most, if not all, alcohol takeaway outlets in the Territory had ID scanners installed to enable banned drinkers to be identified and the bans to be enforced. It was an offence to sell alcohol to a person on the BDR.\(^{29}\)

In 2013 the BDR was replaced by the Alcohol Mandatory Treatment program.\(^{30}\) As previously stated, this program was intended to reduce a person’s substance abuse and thereby improve their health and overall quality of life, as well as reducing their potential for future antisocial behaviour and criminal justice involvement.\(^{31}\) The AMT Bill was released for public consultation on 13 May 2013, and the AMT program began on 1 July 2013.

### 1.6 Post AMT responses to alcohol related harm

Other alcohol diversion programs have been implemented during the time AMT has been in place and have directly and indirectly affected the operation of AMT. They include:

- Alcohol Protection Orders (APOs)
- Point of Sale Interventions (POSIs)

APOs came into effect in December 2013 upon the assent of the Alcohol Protection Orders Act (APO Act) with the purpose of providing an additional law enforcement tool for the NT Police to deter alcohol related crime. Alcohol Protection Orders (APOs) can be used by police as an alternative to protective custody to detain people exhibiting alcohol induced antisocial behaviour. APOs are not a trigger for referral to AMT; that is, once a person is subject to an APO they are no longer eligible for referral into AMT. The person issued with an APO is not considered subject to protective custody and nor are they subject to any other custodial sentence or custodial penalty.

POSIs, previously known as Temporary Beat Locations, are “...a point of sale control measure to restrict alcohol supply to those persons who are likely, through their purchase and consumption of alcohol, to commit offences under the Liquor Act or to breach a condition of a current order regarding their prohibition from alcohol supply and consumption”.\(^{32}\)

The POSI was a primary strategy in Operation Veto in Katherine, which began in December 2014. Operation Veto resulted in significant reductions in offences against the person and property, and a reduction in reported incidents of antisocial behaviour.\(^{33}\)

Operation Leyland commenced in Alice Springs on 25 February 2014, ensuring a police presence at all takeaway liquor outlets to deter the purchase and subsequent consumption of liquor in alcohol protected areas. This operation concluded on 2 April 2014 and yielded a 54% reduction in assaults reported during the period, compared with the equivalent period in 2013. Alice Springs Police have since embedded POSIs in the daily crime reduction strategy to enhance community safety.\(^{34}\)

---

\(^{29}\) Enough is Enough Alcohol Reform Report July 2011 to December 2011  
\(^{30}\) John Elferink, MLA, Media Release, Government Releases Mandatory Alcohol Treatment Bill  
\(^{31}\) NT Department of Health, 2016  
\(^{32}\) Northern Territory Police, Fire and Emergency Services Annual Report 2014-15, p.29  
\(^{33}\) Northern Territory Police, Fire and Emergency Services Annual Report 2014-15, p.29  
\(^{34}\) Northern Territory Police, Fire and Emergency Services Annual Report 2013-14, p.35
1.7 Alcohol Mandatory Treatment legislative review

The NT Government committed to reviewing the AMT legislation after six months of the service operating in order to provide an opportunity to reflect on the workings of the AMT Act. The objective of the review was to “…assess the degree to which the Act is facilitating mandatory assessment and treatment for people who repeatedly misuse alcohol”35. A range of issues were identified that resulted in amendments being made to the AMT Act and Police Administration Act. These amendments were passed on 27 November 2014 and the changes to both Acts commenced on 15 January 2015. There were four separate amendments:

1. Decriminalising absconding from a secure mandatory residential treatment facility: prior to the amendments, it was a criminal offence to abscond from a treatment facility three times. The amendments removed the criminal element.

2. Introducing the 'stop the clock' provision: this meant that, if a client absconded from the treatment facility, the remainder of the order would be carried out upon their return.

3. Expanding pathways for referral: these amendments provided that a medical practitioner could refer a client to Senior Assessment Clinician for assessment. The regulation to effect this change came into force in March 2016.

4. Reducing criminal offence exclusions: the amendments meant that a person who was charged with committing an offence with a maximum penalty of imprisonment for a period of seven years or more is to be excluded from AMT. Prior to this, any person charged with a criminal offence was ineligible for AMT.

1.8 The future of AMT

As part of the 2016 election campaign Territory Labor promised to wind back the AMT program and reintroduce the BDR. Upon winning government in August 2016, the Minister for Health, the Hon. Natasha Fyles has confirmed this promise both in formal Parliamentary proceedings and the media.36

“Over the coming months, alcohol mandatory treatment will be wound back. The evidence of the success of alcohol mandatory treatment is shaky at best. It is a huge cost of $24m a year operation, plus capital costs on top of that. We will still have treatment options; it will not be mandatory.”37 Hon. Natasha Fyles, Minister for Health, November 2016

37 The Hon. Natasha Fyles, Minister for Health, Hansard Transcript 23 November 2016
2 Methodology

2.1 Evaluation questions

The Department of Health (DoH) asked that the evaluation address five questions. The questions were grouped into three components as shown in Table 1 below:

Table 1: Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. To what extent are the aims of the AMT being achieved for the client group?</td>
<td>Client outcomes</td>
</tr>
<tr>
<td>7. What is the relationship between a client’s engagement in the program and identified outcomes?</td>
<td>Service model and implementation</td>
</tr>
<tr>
<td>8. How does each service model operate?</td>
<td></td>
</tr>
<tr>
<td>9. Has the service model been implemented as intended and is the uptake as predicted?</td>
<td></td>
</tr>
<tr>
<td>10. Is the service model and its delivery in each location cost effective?</td>
<td>Cost effectiveness</td>
</tr>
</tbody>
</table>

Different evaluation methodologies were used to address each component and are described in more detail below.

2.2 Client outcomes impact evaluation

The purpose of the client outcomes component of the evaluation was to evaluate the impact of the AMT Act and program on clients. The impact was assessed in relation to the stated aims of the program, as outlined in the Act.

To answer the evaluation questions, the Evaluation Team assessed to what extent those who participated in mandatory alcohol mandatory treatment experienced:

- increased stability and improvements in health
- improvements in their social functioning (through appropriate therapeutic and other life and work skills interventions
- ‘restored’/increased capacity to make decisions about their alcohol use and personal welfare
- improvements in their access to ongoing treatment to reduce the risk of alcohol consumption.

In addition, the team compared any changes in outcomes between a group of people who had participated in the program (the intervention group) with a group of similar people who were eligible for mandatory treatment but were not assessed or treated (the control group).

Both the Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research in the Top End and the Central Australian Human Research Ethics Committee provided approval for the client outcomes component of the evaluation.

2.2.1 Cohort study

The impact of participation in alcohol mandatory treatment was assessed by quantitative analysis of linked AMT service, health, police and justice data for all people who had been eligible for AMT between 1 July 2014
and 30 June 2015. Retrospective data was collected for a five year period as well as prospective data for up to 12 months post treatment. De-identified data from pre-existing datasets was collected, with consent from data owners. A linkage key was applied by a third party and all data de-identified before datasets from NT Health, NT Police, sobering up shelters, the NT death register and Corrections was provided to the Evaluation Team for analysis.

Through linking data the Evaluation Team was able to compare outcomes across people who had and had not entered the program.

The population of people who had been eligible for AMT and who had received their first treatment order in the period 1 July 2014 to 30 June 2015 (later referred to as the AMT participant group) were compared to the group of people who had met the trigger for AMT during that same period, but who had not been transported to an assessment centre or who did not appear before the AMT Tribunal (later referred to as the comparison group). This enabled a comparison to be made between people who had had any contact with AMT.

### 2.2.2 Case studies

The purpose of the case studies was to provide qualitative information to inform the evaluation. Potential participants were contacted through the AMT residential treatment facilities, community based alcohol treatment providers and other health and legal services. Service providers made contact with the proposed participants, explained the purpose of the evaluation and asked people if they would be willing to hear more about how they could participate in the evaluation. For those clients who agreed to hear more, the Evaluation Team conducted the full informed consent process.

Data was collected via semi-structured interviews and reviewing records, subject to informed consent. Supplementary data was collected via interviews with Assessment Clinicians, nursing staff at the assessment and treatment centres, police officers and case coordinators. Interviews were held in neutral publically agreed locations chosen with the participant through the informed consent process.

During the initial interview demographic data collected from participants was compared against assessment records. This allowed evaluators to assess the reliability of participants’ memories and assess how well they understood or could recount their treatment experiences and history of treatment orders. Face to face interviews explored the following topics:

- personal experience with alcohol prior to and after treatment experiences
- personal experience of the AMT program, including perceptions of the physical environment within treatment centres, dignity and respect afforded to them throughout the apprehension, assessment and treatment process
- engagement and participation in the program and treatment
- subsequent self-reported improvements in health and alcohol use.

For participants who provided consent for the Evaluation Team to access additional records, the following information was collected:

- Transport Advice Notices from NT Police
- assessment reports from the Department of Health Senior Assessment Clinician
- applications and reports from the AMT Tribunal hearings
- residential treatment facility records

Not all participants consented to all records being made available; therefore not all data was accessible to the evaluators.

Case study data was coded or summarised and analysed manually. Each case study was also documented separately so that an individual’s story could be followed from apprehension, through assessment, treatment and aftercare. Once all case studies were completed the findings were aggregated and reported at the demographic as well as impact level.
2.3 Service model and implementation process evaluation

The process evaluation of the service models and operations was conducted in Darwin, Katherine and Alice Springs. Although AMT was set up in both Nhulunbuy and Tennant Creek, the department’s Terms of Reference for the evaluation excluded these locations from the scope. The period of interest for this aspect of the evaluation was determined to be from the commencement of the AMT program in July 2013 through to the late 2016: a period of three and a half years.

The Evaluation Team conducted an initial ‘walk through’ of the AMT service system operations from the client perspective in Darwin and Alice Springs in early 2016. This was followed by workshops, focus groups and individual meetings held with a wide range of service providers and other stakeholders in Darwin, Alice Springs and Katherine in three rounds between March and November 2016 (see Appendix B). The focus of these consultations was on understanding how AMT operates in each region, identifying the range of challenges or issues that have impacted on implementation, service usage and uptake issues, operational and system integration issues.

2.4 Cost effectiveness evaluation

The purpose of this component of the evaluation was to determine the overall costs of AMT, the costs of each service and in each region. Again the period of interest was from July 2013 to November 2016.

The Evaluation Team intended to obtain fixed and variable costs for each service within the AMT program, and identify any indirect costs that could not be directly accountable to AMT. Unfortunately not all of this costing information was available and the level of specificity of the data that was available did not enable this level of cost analysis. Consequently only the overall budgets allocated to each service and in each region will be provided. This will be explored further in Chapter 6 of this report.

2.5 Literature review

A focused literature review was undertaken to inform the overall approach and evaluation (see Appendix A). The review includes literature focused on Australian evidence and best practice relating to:

- entry to care
- components of treatment
- effectiveness of treatment, including factors contributing to effective treatment.

The review revealed that research and evidence on mandatory treatment, particularly in relation to Aboriginal and Torres Strait Islander people, is limited.
3 Service Models and Implementation

Evaluation questions

- How does each service model operate?
- Has the service model been implemented as intended and is the uptake as predicted?

The purpose of this chapter is to address the service model and implementation evaluation questions across each subsection of the AMT service, identifying the key challenges in implementing and operating the services and noting any regional variations.

To determine if the AMT program has been implemented as intended, the Evaluation Team first had to understand what the NT Government had originally intended. The program was implemented without a program logic or theory of change model and without an evaluation framework and hence the Evaluation Team elected to retrospectively develop a logic model with the group of NT Government staff and former staff who worked on the original system development and initial implementation. The intention was that the program logic would provide a sound and consistent baseline, against which the program and services could be evaluated. A copy of this program logic is in Appendix C.

3.1 Apprehension and triage

According to the AMT Act, there are currently two referral pathways into the AMT system. The primary referral pathway is through police protective custody and this has been in place since the initial implementation of the AMT service. The second referral option is through a medical practitioner. This is a voluntary option that came into effect in March 2016; however, data from the Department of Health indicates that this option has not been used as yet. This section will therefore focus on the process of clients being referred via police protective custody.

3.1.1 Police apprehension

When NT Police observe a person who appears to be intoxicated in public, they may take a range of possible actions:

- transport the person to the nearest sobering up shelter
- transport the person to a safe place where someone such as a family member or friend may look after them
- arrange hospitalisation if medical attention is warranted
- tip out the person’s alcohol
- move the person on
- place the person into police protective custody at the watch house.

Under section 128 of the Police Administration Act (PAA) police may take a person into police protective custody without a warrant if there is reasonable grounds for believing that the person:

- is intoxicated and as a result is unable to adequately care for himself or herself, and there is no other person available to provide care for that person
- may cause harm to himself or herself or someone else
• may intimidate, alarm or cause substantial annoyance to people
• is likely to commit an offence.

3.1.2 AMT trigger
An adult who is taken into protective custody three or more times in two months triggers a referral to an AMT assessment facility. Police must positively identify the person on each occasion for this to be possible. To do this police will take and record the person’s name, fingerprints and other biometric identifying information, such as facial recognition.

If a person becomes eligible for AMT, and is not subject to any excluding factors (described below), police must contact a Senior Assessment Clinician (SAC) at an AMT assessment facility to determine if the facility has capacity to admit the person. If the facility has capacity, police will then arrange to have the person transported to the facility as soon as practicable. The police will fill out the Transport Advice Notice (TAN) form, and provide a copy of to the SAC upon admission of the client. These actions must occur within six hours of the person being taken into protective custody or the person must be released. However, if it appears to the police member that the person is still intoxicated, the person may be kept for up to 10 hours upon the approval of a police superintendent or someone of a higher rank.

It is important police inform the person that he or she is:

• not under arrest for an offence
• being taken to an assessment facility for an assessment for Alcohol Mandatory Treatment
• able to contact a family member or friend on arrival at the assessment facility.

Upon admission to the assessment facility, the client is no longer in the custody of the police.

Excluding factors
Under the AMT Act, Police cannot refer an adult to AMT for assessment if the person:

• is an involuntary patient under the Mental Health and Related Services Act
• is a reportable offender under the Child Protection (Offender Reporting and Registration) Act
• is subject to a continuing detention order or supervision order under the Serious Sex Offenders Act
• has been charged with an offence for which the maximum penalty is imprisonment for a period of more than seven years.

3.1.3 Apprehension and triage numbers
NT Police provided aggregate data summarising the protective custody occasions in each calendar year since AMT commenced and the recorded outcomes at an aggregate not individual level according to categories determined by police. Table 3 shows how many times the trigger for referral to AMT was met in each location, the number of times police transported a person to an assessment facility, and the number of times a person was excluded, per calendar year.

Noting the data limitations, the information in Table 3 does show that the number of people meeting the trigger for referral to AMT each year is much higher than the number of people being transported to an assessment facility. As mentioned earlier, there are a number of people who are excluded from proceeding to an assessment under the AMT Act. The data shows that the numbers of apprehensions where these issues arose appear to vary year on year and region by region. There does not appear to be any pattern to the exclusions. On average,

---

38 Section 132(2), PAA
39 Section 132(2), PAA
40 Section 128A and Section 9(3) AMT Act
excluding the occasions when the person was not eligible for entry to assessment due to factors such as being a juvenile, offending, mental illness or other health reasons, the rate at which a person does not enter assessment ranges from around 31% to 54% per annum.

The data in Table 2 below is different to the linked client data used in Chapter 4 of this report. This is because the information provided by police was collated at the aggregate level not at the client or individual level. Consequently the police data shows the number of occasions of protective custody, not the number of individuals being placed in protective custody. It is also collated over a calendar year as opposed to a financial year. Consequently, a direct comparison of the two datasets is not possible. However, the findings are consistent: on many occasions a person who meets the trigger for AMT is not received at an assessment centre.

Table 2: NT Police AMT Data 1 July 2013 – 10 July 2016

<table>
<thead>
<tr>
<th>Watch house location</th>
<th>3+ Triggers</th>
<th>Transferred to assessment centre</th>
<th>Outstanding charges**</th>
<th>Excluded Mental Impairment Order**</th>
<th>Excluded due to APO**</th>
<th>No assessment available</th>
<th>Juvenile</th>
<th>No positive ID</th>
<th>No bed available**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>1538</td>
<td>301</td>
<td>8</td>
<td>822</td>
<td>2</td>
<td>7</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katherine</td>
<td>303</td>
<td>70</td>
<td>0</td>
<td>0</td>
<td>104</td>
<td>3</td>
<td>1</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Alice Springs</td>
<td>294</td>
<td>59</td>
<td>1</td>
<td>71</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>2135</td>
<td>430</td>
<td>19</td>
<td>997</td>
<td>6</td>
<td>8</td>
<td>120</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Darwin               | 1538        | 301                              | 8                     | 822                               | 2                    | 7                      | 82       |               |                    |
| Katherine            | 303         | 70                               | 0                     | 0                                 | 104                  | 3                      | 1        | 35            |                    |
| Alice Springs        | 294         | 59                               | 1                     | 71                                | 1                    | 0                      | 0        |               |                    |
| TOTAL                | 2135        | 430                              | 19                    | 997                               | 6                    | 8                      | 120      |               |                    |

| Darwin               | 1538        | 301                              | 8                     | 822                               | 2                    | 7                      | 82       |               |                    |
| Katherine            | 303         | 70                               | 0                     | 0                                 | 104                  | 3                      | 1        | 35            |                    |
| Alice Springs        | 294         | 59                               | 1                     | 71                                | 1                    | 0                      | 0        |               |                    |
| TOTAL                | 2135        | 430                              | 19                    | 997                               | 6                    | 8                      | 120      |               |                    |

| Darwin               | 454         | 19                               | 41                    | 0                                 | 36                   | 0                      | 6        | 161           |                    |
| Katherine            | 29          | 18                               | 5                     | 0                                 | 0                    | 1                      | 0        | 0             | 5                  |
| Alice Springs        | 249         | 120                              | 18                    | 31                                | 6                    | 38                     | 1        | 2             | 34                 |
| TOTAL                | 732         | 329                              | 41                    | 67                                | 75                   | 1                      | 8        | 200           |                    |

| Darwin               | 3894        | 948                              | 621                   | 142                               | 66                   | 1334                   | 9        | 35            | 846                |
| Katherine            | 575         | 206                              | 110                   | 4                                 | 2                    | 184                    | 9        | 2             | 60                 |
| Alice Springs        | 1173        | 591                              | 148                   | 54                                | 43                   | 216                    | 2        | 6             | 131                |
| TOTAL                | 5642        | 1745                             | 879                   | 200                               | 111                  | 1734                   | 20       | 43            | 1037               |

Note: The NT Police record this data by calendar year.
*Outstanding charges includes warrants, bail, Wanted for Questioning (WFQ), Australian National Child Offender Register (ANCOR) or on parole
**Data since 12 October 2014

Source: NT Police, Fire and Emergency Services

The NT Police data is limited by the record keeping system that police use, the Integrated Justice Information System (IJIS), to record protective custodies and AMT related information. Police have advised they can only select one of a small number of options when entering data about an AMT eligible individual, and so some options can become a ‘catch all’ for an array of circumstances discussed in more detail below.
Consultations with police, service providers and staff at assessment facilities provided additional information about the reasons police may not transfer an eligible person to an assessment facility:

- The watch house nurse has deemed the person to be in need of urgent medical attention and transport the person to the hospital’s emergency department.
- Police members have run out of time to hold someone in police protective custody (up to a maximum of 10 hours)\(^{41}\) and were not able to positively identify the person.
- There was no transportation available to transport the person to the assessment facility.
- A person subject to an Alcohol Protection Order (APO) is excluded from being assessed for AMT services because the person subject to the APO is not considered subject to protective custody.
- The assessment facility did not have capacity to assess and care for the person because there was no Senior Assessment Clinician available to admit the client (note: this was not required until December 2015), or the facility was at capacity and could not accommodate an additional person.
- The person is known to be violent and the assessment facility staff have excluded them from entering the assessment facility.

Although people under the age of 18 are excluded from the AMT program\(^{42}\), Table 3 data also shows that some juveniles are being admitted to protective custody in Darwin, Katherine and Alice Springs. There was little discussion about this with AMT service providers as they are not attending to this client group; however, the wider AOD sector providers did briefly discuss the growing needs of young people with substance abuse issues. The needs of and appropriate service responses for young people and their families is clearly a wider topic than was possible to discuss as part of this evaluation. However, the apprehension and custody experience could be seen as a critical referral opportunity for this group of young people.

### 3.1.4 Regional variations

The evaluation found that, despite the prescriptive boundaries and guidelines provided by the PAA, there are several regional variations at this point in the AMT system.

One variation is that both Darwin and Alice Springs watch houses have trialled the use of facial recognition to aid in the positive identification of people taken into custody. Consultations with police members throughout the evaluation indicate that the use of facial recognition supported more efficient identification processes.

However, the primary variation is in the types and frequency with which people who met the trigger for AMT, and were not excluded, proceeded to the next stage in the AMT process: assessment. The rates of transportation to assessment were significantly higher in Alice Springs than in the other locations, with Darwin recording the lowest rates across all years. The consultations suggested that there are a number of system blockages preventing all eligible clients from entering AMT.

Police reported that the AMT assessment facilities in all locations have been uncontactable or unavailable on multiple occasions since 2013. Further exploration of this issue identified that there have been occasions when the assessment facilities were closed, there was no SAC available to admit a new client, or there were no designated male or female beds available.

### 3.1.5 Challenges

The consultations identified a range of challenges to implementation of this part of the AMT program.

---

\(^{41}\) Police are provided with timeframes within which they can keep a person in police protective custody, as set out in the PAA. A person may be kept in police protective custody for up to six hours. However, if it appears to the police member that the person is still intoxicated, the person may be kept for up to 10 hours upon the approval of a police superintendent or someone of a higher rank (section 132 (2) of the PAA). If police are unable to positively identify the person in custody within the assigned timeframes, they must release the person.

\(^{42}\) S128A of the NT Police Administration Act states that persons apprehended and taken into custody and then referred to AMT must be an adult, and the NT Interpretations Act defines an adult as an individual who is at least 18 years of age.
**Legislation interpretation**

Police in each region raised the challenge of interpreting the AMT legislation accurately and consistently. For example, there were conflicting views on whether a client’s Breath Alcohol Content (BrAC) must read 0.0 before police transported a client to an assessment facility. This resulted in discussions between NT Police and AMT assessment facilities about when it was appropriate to transport a client to the facility. This had implications for keeping within legislated timeframes for both police and AMT assessment facilities, as well as the health of clients, because withdrawal from alcohol can intensify over time\(^{43}\). Police suggested that a comprehensive training package on the new legislation for police and assessment facility staff would have helped to prevent this.

**Compliance with the PAA and interpretation of ‘protective custody’**

Two separate coronial inquests\(^{44}\) revealed barriers to referrals into the AMT. One coronial inquest found that the person could have been referred to AMT a total of 14 times, but had only been assessed twice. The inquest reported that police had not transported the person to AMT assessment for reasons such as that there was no bed was available, that there had been no response from the assessment facility and that there had been no transport available.

These findings were consistent with the challenges reported during the evaluation.

In the second case, police took the person to the sobering up shelter four times and the watch house three times over three months. The person was taken to Royal Darwin Hospital on advice of the watch house nurse each time she was in the watch house. The Coroner argued the person would have been taken to AMT if police had positively identified her (and recorded the custodies) as an individual and recorded the custody at the watch house.

The Coroner’s report raised a lack of compliance with sections 128A and 128(2A) of the *Police Administration Act*, noting that a police member must:

- establish the identity of the person taken into custody as set out by section 128(2A)
- contact a Senior Assessment Clinician at an assessment facility if the person is eligible for AMT.

The report stated that “the Acting Deputy Commissioner conceded that Police do not comply fully with those sections. For the purposes of the Alcohol Mandatory Treatment scheme they do not record those taken into protective custody and taken to the Sobering up Shelter, or taken home or taken to the Hospital. Protective custodies are only recorded for that scheme if the person is taken to the Watch House.”\(^{45}\)

The report noted that police have no system for positively identifying and recording protective custody episodes that occur outside of the watch house.

### 3.2 AMT assessment and referral

This section will discuss the processes, regional variations, benefits and challenges associated with AMT assessment and the AMT Tribunal.

#### 3.2.1 Assessment services

AMT assessment services provide structured alcohol misuse and dependence assessment, diagnoses, and clinical management of alcohol withdrawal. The assessment is used to inform the AMT Tribunal’s decision about what treatment the client should receive.

There are currently three specific assessment facilities operated by NT Health. Prior to July 2014, they were all under the single entity of the Department of Health. Since July 2014, the Department of Health as the system manager has funded Central Australian Health Services (CAHS) and Top End Health Services (TEHS) under service delivery agreements to operate the following:


\(^{44}\) Inquest into the death of CWM [2016] NTLC 016 and Inquest into the death of MFTM [2016] NTLC 017

\(^{45}\) Inquest into the death of CWM [2016] NTLC 016
• Darwin Alcohol Assessment and Treatment Service (DAATS) operated by TEHS – capacity of 12 beds but only two in the intake process at any one time
• Katherine Mandatory Alcohol and Rehabilitation Service Unit (MARS Unit) operated by TEHS – capacity of six beds (three male and three female)
• Alice Springs Alcohol Assessment Service (ASAAS) operated by CAHS – capacity of eight beds
• Assessment of Tennant Creek clients is undertaken by Tennant Creek Hospital AOD clinicians.

DAATS has been located in several facilities. At first DAATS was co-located with the AMT treatment service in the Medi-Hotel at Royal Darwin Hospital. The service was moved to an interim facility at the old Berrimah Prison while the current facility was being upgraded for the purpose of AMT.

The MARS unit in Katherine is located within Katherine Hospital, in a pre-existing ward that was made into a secure ward for the purpose of AMT. ASAAS is located at a separate site on the outskirts of Alice Springs that was originally built to accommodate a secure residential care service for the Department of Health. Half of that facility was repurposed for the AMT assessment service.

Although each service differs in its capacity and layout, the DoH staffing model is consistent. It has the following roles to administer the functions under the Act and provide safe care for AMT clients:

• Senior Assessment Clinician (SAC): the SAC function is a legislated requirement and each assessment service must have an SAC. The SAC is responsible for a number of statutory functions including admitting and assessing the client, and preparing the client’s assessment report for the tribunal hearing. The AMT Act requires that the SAC must possess certain qualifications\(^{46}\).

• Medical Officer: a Medical Officer must review the client within 24 hours of their arrival at the assessment facility.

• Senior Treatment Clinician (STC): the STC works with the assessment facility and the treatment centre, delivering statutory functions for clients who have been mandated a residential treatment order. The STC prepares treatment plans, approves leave and ensure the client has an aftercare plan at the end of treatment.

• Nurses who provide ongoing clinical care to the clients – a nurse manager supervises the nursing staff and manages the general operations of the facilities.

• Support workers provide support to the SAC, Medical Officer, STC, nurses and nurse manager as required.

• Indigenous Liaison Officer provide cultural support to clients and staff

### 3.2.2 Assessment process

Police will transport a client to an AMT assessment facility upon confirmation that the assessment facility is able to accommodate a new client. The SAC admits the client, and signs and copies the Transport Advisory Notice (TAN). Copies of the TAN are also sent to the AMT Tribunal and the Community Visitor Program (by fax) to notify them of a new client’s admission. The TAN form and a completed client intake form are scanned into Primary Care Information System (PCIS), the Department of Health’s client information system.

The assessment facility cannot accept a client if:

• there is no SAC available (according to section 14 of AMT Act after December 2015)
• the facility is full and cannot accommodate any new clients
  or
• the client does not meet the AMT eligibility criteria (according to section 8(1) and (2) and division 3 of the AMT Act).

\(^{46}\) The Act requires that the SAC be either a medical practitioner or a person who in the CEO’s opinion, holds a qualification and has experience appropriate for the assessment of persons for misuse of alcohol. AMT Act section 131 (2)(b)
Additionally, the assessment facility will release the client if:

- the client is violent
- the police have made a mistake and there is an exemption for that person (section 32 of the AMT Act)
- the client needs an interpreter and there is no interpreter available
- the SAC has not had enough time to assess the client and prepare report for the tribunal or
- a medical officer will not be able to assess the client.

If the client is coherent enough, the SAC at the assessment facility will read the client the Statement of Rights. If it is apparent that the client is in need of an interpreter, the assessment facility will contact the Aboriginal Interpreter Service to arrange for an interpreter to visit to assist the client and staff. The process of reading the Statement of Rights with the client and ensuring the person is able to communicate adequately in English, or another language through the use of an interpreter, is a requirement of the AMT Act (section 15) and is to ensure clients understand their rights and the information to be collected. Assessment centres also have ‘talking posters’ in the major Aboriginal languages to assist in this process.

Assessment staff will transition clients into accommodation from the initial intake area, where the client is first assessed, when their BrAC reads 0.0. A clinician will conduct a full alcohol and other drug assessment and a risk assessment, and a medical practitioner will examine the client within the first day of admission. Clinicians provide the appropriate withdrawal management and support to the client. This process includes the following elements:

- client interview
- pathology screening
- medical assessment and withdrawal management including provision of medication
- mental health assessment
- initial treatment plan
- risk assessment.

Assessment facilities are secure and section 76 of the AMT Act stipulates that clients may not leave the facility unless that leave is authorised by the SAC. If the client leaves the facility without authorisation, or does not return from authorised leave, the SAC is required to send an Apprehension of Client form to police, to request assistance.

If police apprehend the client and the client is intoxicated, police may take the client back to the assessment facility where the person will then sober up and assessment will continue (section 79, AMT Act). If there are no longer any empty intake beds at the assessment facility, police are required to release the client if it is safe to do so.47

### 3.2.3 Report to the tribunal

The SAC uses the results of the assessments and screening to develop a report that is lodged with the AMT Tribunal. The AMT Act provides strict timeframes within which the SAC must admit the client, complete the assessment and lodge the report:

- assessment must be completed within 96 hours of the client’s admission
- the SAC then has 24 hours to lodge the report with the Tribunal.

---

47 Alcohol Mandatory Treatment Guidelines version 8.1

One client was admitted to assessment 4 times in 4 months, but always released as there was no interpreter available to assist with the assessment.
In assessing the client, the SAC is required to form an opinion as to whether the client is likely to fulfil the criteria for a mandatory treatment order. These criteria are:

a) the person is an adult
b) the person is misusing alcohol
c) as a result of the person’s alcohol misuse, the person has lost the capacity to make appropriate decisions about his or her alcohol use or personal welfare
d) the person’s alcohol misuse is a risk to the health, safety or welfare of the person or others (including children and other dependents)
e) the person would benefit from a mandatory treatment order
f) there are no less restrictive interventions reasonably available for dealing with health and safety risks.

The SAC’s report must include:

- a statement as to whether, in the SAC’s opinion, the client meets all the criteria for a mandatory treatment order, and the basis for that opinion
- demographic information about the client and all other information that would be relevant to the tribunal in deciding what order (if any) to make in relation to the person
- details of the treatment the SAC believes the client would be able to participate in and benefit from.

### 3.2.4 The Alcohol Mandatory Treatment Tribunal

The functions of the tribunal are set out in section 103 of the AMT Act. The tribunal is to:

- consider and make decisions about applications made to the tribunal about an order
- make mandatory treatment orders, income management orders and other orders in relation to its orders
- conduct inquiries in relation to proceedings, as appropriate.

In carrying out its functions the tribunal pays particular attention to the key principles set out in the AMT Act and must be satisfied that:

- the order given to a client is the least restrictive intervention that will be sufficient to remediate the health and safety risks presented by the client
- if the client is given a Mandatory Residential Treatment Order (MRTO), the involuntary detention of the client is used as the last resort and less restrictive interventions are not likely to be effective or sufficient support

Tribunal members are individuals appointed by the Minister for Justice, “...and must, as far as practicable, be constituted of members of both sexes and from diverse ethnic backgrounds, including members who are Aboriginal or Torres Strait Islanders or who demonstrate an understanding of Aboriginal or Torres Strait Islander culture.” At each hearing, the tribunal consists of three members with specific areas of expertise: a legal member who presides and decides questions of law; a member with health or medical expertise, particularly in relation to the care, rehabilitation and treatment of persons who misuse alcohol; and a community member who has a special interest or expertise in the issues facing affected persons who appear before the tribunal.

The types of orders the tribunal can make are described in Table 3. No order can exceed three months in duration, except for the income management order, which must not exceed 12 months.

---

48 Section 10 of the AMT Act
49 Section 104, Alcohol Mandatory Treatment Act 2013
50 AMT Tribunal Annual Report, 2013-14
51 Section 49, AMT Act
### Table 3: Types of tribunal orders

<table>
<thead>
<tr>
<th>Order</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Residential Treatment Order (MRTO)</td>
<td>Client is admitted to a secure mandatory residential treatment facility for up 12 weeks. Possession, purchase and consumption of alcohol is banned.</td>
</tr>
<tr>
<td>Community Residential Treatment Order (MCRT0)</td>
<td>Client is ordered to participate in residential treatment from a specified community treatment provider. Possession, purchase and consumption of alcohol is banned.</td>
</tr>
<tr>
<td>Community Treatment Order (CTO)</td>
<td>Client is ordered to participate in other forms of treatment from a specified community treatment provider, such as counselling, day programs etc. Possession, purchase and consumption of alcohol is banned.</td>
</tr>
<tr>
<td>Income Management Order (IMO)</td>
<td>If a client is an eligible welfare recipient the tribunal must make an income management order for up to 12 months. This can restrict up to 70% of the person’s income to the Basics Card.</td>
</tr>
<tr>
<td>Release Order</td>
<td>This order is made when the tribunal determines that the client does not, or no longer, meets the criteria for the making of a mandatory order. This can also be made when timeframes for assessment are exceeded, or where a client has left a treatment centre and is unlikely to return.</td>
</tr>
<tr>
<td>Revocation and Variation</td>
<td>The tribunal may in appropriate cases, and on application of a client, an SAC or STC, vary or revoke a mandatory treatment order (MTO) or replace a MTO with a different type of order.</td>
</tr>
</tbody>
</table>

#### 3.2.5 Tribunal hearings and advocates

Upon receiving an application for a hearing from the SAC, the tribunal has 96 hours to complete the hearing and make a decision regarding an appropriate order for the client. The tribunal must give sufficient notice to the client, SAC and the client’s primary contact about the date and time of the hearing.

The tribunal is required to appoint an advocate to represent the client at the hearing. Section 113 of the *AMT Act* stipulates that the advocate must be a legal practitioner, or a person, as approved by the CEO, who has “expertise in the general care, health care, rehabilitation or treatment of persons who are misusing alcohol.” The advocate is provided at no cost to the client. If an interpreter is required, the tribunal will also organise for an interpreter to assist the client at the hearing.

The tribunal must notify the advocate that a hearing is scheduled. The advocate may then meet with the client prior to the hearing to prepare and discuss any issues the client may have. If an interpreter is required, they are also able to meet with the client before the hearing to discuss the process and how they will interpret between the client, tribunal and other participants in the hearing.

The SAC attends and presents the assessment report to the tribunal in person. The hearing takes place via video conferencing. The SAC, client, advocate and interpreter (if required) gather in a dedicated room at the assessment facility, and the tribunal members conduct the hearing from the AMT tribunal office in Darwin. Client levels of understanding of the hearing process varies. A case study participant reported that the “people on TV” had made her get locked up. After some discussion it was apparent that the tribunal members had heard her case via a video link. She didn’t understand this, and interpreted the event as meaning that she had been on a television show.

Tribunal members may ask questions and engage directly with the client. If the client does not agree with the recommendations made by the SAC, the advocate can help the client to present why a different order should be made. This hearing process can take half an hour, or up to two hours in complex cases.

Before an order can be made (other than a release order), the tribunal must be satisfied on cogent evidence that the criteria for a mandatory treatment order, as set out in section 10 of the *AMT Act*, are met. That is, the client

---

32 Section 50, AMT Act
must be an adult who is misusing alcohol, with a resultant loss of the ability to make appropriate decisions about alcohol use or personal welfare, and a resultant risk to the health, safety or welfare of the affected person. The tribunal must also be sure there are no less restrictive interventions reasonably available to deal with the risks to the health, safety or welfare of the affected person (or their children or others).

At the completion of a hearing, the SAC will take the person back to the assessment facility until arrangements are made to transition the client to the next phase of their treatment, or to be released back into the community.

### 3.2.6 Community Visitors

The Northern Territory Community Visitor Program (CVP) is an independent service located in the Anti-Discrimination Commission. The commission’s roles are defined in legislation but the overarching aim is to ensure the rights of those being treated in certain mental health, disability, and AMT facilities in the NT are upheld and their views and concerns are heard. It is also one of the mechanisms in place to ensure that the standard of the services provided under these Acts is of a high quality.

The CVP provides individual Community Visitors to work with clients on a regular basis and also system and monitoring panels who visit assessment and treatment facilities every six months. The CVP team consists of:

- the principal Community Visitor
- the Community Visitor Program manager
- four Community Visitor coordinators (two for AMT)
- 10 Community Visitors.

Community Visitors conduct regular visits to the assessment and treatment facilities, and have a responsibility to resolve complaints, concerns and problems arising. Clients may raise concerns directly with a Community Visitor while on their visit, or a family member or friend may do so on their behalf. Community visitors may also raise concerns about the facilities or treatment from their own observations.

According to section 93 of the AMT Act, a Community Visitor who visits an assessment facility or treatment centre must give a report of his or her visit, including any findings and recommendations, to the principal Community Visitor. The SAC also receives a copy, who then works with the Community Visitor and client to resolve issues. If the issues are not resolved, the CVP incorporates this issue in the CVP annual report.

A CVP panel consisting of at least three members, which must include a health practitioner and a lawyer, visit centres six monthly. The CVP panel also has a system monitoring role. During visits the panel inquires into:

- the adequacy of opportunities and facilities for recreation, education, training and rehabilitation
- the extent to which the least restrictive alternative guides the treatment of clients, the quality of assessment, treatment and care provided
- the adequacy of information provided about complaints and legal rights
- any matter that may be referred by the Minister or the principal Community Visitor or any other matter the panel may consider appropriate.

### 3.2.7 Aggregate assessment data

Table 4 shows the number of tribunal hearings held and the number of times individuals may appear. Analysis shows that while the proportion of Community Treatment Orders being made has risen from 15% in the first year of operations (2013-14) to around 24% in 2015-16, the rate of MRTOs has dropped from 48% to 32% over the same period. The number of release orders has increased marginally over the same period from 22% to 24%.

---

53 The role of the CVP is defined in the Mental Health and Related Services Act, the Disability Services Act and the Alcohol Mandatory Treatment Act.

54 NT Community Visitor Report 2014 Annual Report

55 NT Community Visitor Program Annual Report 2013-14
Table 4: Total tribunal hearings and orders 2013-14 – 2015-16

<table>
<thead>
<tr>
<th>Hearing outcome</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRTO</td>
<td>208</td>
<td>169</td>
<td>151</td>
</tr>
<tr>
<td>CTO (includes CRTO and CTO)</td>
<td>65</td>
<td>119</td>
<td>112</td>
</tr>
<tr>
<td>Release</td>
<td>96</td>
<td>116</td>
<td>118</td>
</tr>
<tr>
<td>Vary/Revoke/Replace</td>
<td>40</td>
<td>59</td>
<td>72</td>
</tr>
<tr>
<td>Dismissed</td>
<td></td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>IMO vary*</td>
<td>16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total hearings</td>
<td><strong>435</strong></td>
<td><strong>479</strong></td>
<td><strong>465</strong></td>
</tr>
<tr>
<td>Total individuals</td>
<td><strong>323</strong></td>
<td><strong>338</strong></td>
<td><strong>339</strong></td>
</tr>
</tbody>
</table>

Notes: *The variations referred to in the first year of operations usually related to changing the quarantined percentage of a person’s income. Tribunal members informed the Evaluation Team that it later became standard practice to income manage 70% of a client’s income.

Source: AMT Tribunal Annual Reports 2013-14 and 2014-15 and data provided by AMT Tribunal Registrar 2015-16

The total number of individuals is significantly smaller than the number of hearings because some clients received more than one order. Table 5 below shows that in 2015-16 three clients had seven hearings with the tribunal. The reasons for hearings may include applications for variations and revocations of orders as well as MRTOs or CTOs. The changing nature of the orders being made by the tribunal may in part be related to this issue as well as to the depth of understanding and maturity of the tribunal process since inception.

Table 5: Number of times clients appeared in a tribunal hearing in a year 2014-15 and 2015-16

<table>
<thead>
<tr>
<th>Number of clients by number of appearances</th>
<th>Total hearings</th>
<th>Total clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>2014-15</strong></td>
<td>245</td>
<td>168</td>
</tr>
<tr>
<td><strong>2015-16</strong></td>
<td>217</td>
<td>105</td>
</tr>
</tbody>
</table>

Source: AMT Tribunal Registrar

3.2.8 Benefits from assessment

Primary health care comprehensive assessment and treatment

The Evaluation Team found that clients were consistently being supported to withdraw from alcohol safely and were being provided all the appropriate medical care during this time. Assessment staff also ensure any other pre-existing conditions are monitored during withdrawal to prevent complications arising. Once a client has safely withdrawn from the effects of alcohol they are provided with full time comprehensive health care and treatment for any existing conditions until transferred elsewhere as an outcome of the tribunal hearing.

Assessment staff also ensure that clients learn about and understand their conditions, what their medications are for and the importance of complying with a treatment program. As per usual clinical guidelines, assessment staff request interpreters to help discuss medical issues with clients when it is appropriate.
Openness to treatment

Evidence from the case studies suggests that, by the end of the assessment phase, after clients have had time to sober up and reflect, that they are more open to receiving treatment. For example, after completing the assessment process for the AMT program 75% of the case study group in this evaluation reported being highly or somewhat motivated to continue with the program, while 25% stated they were not very motivated or highly unmotivated/disinterested.

Service providers reported that they believed most people were in the pre-contemplative stage after assessment but did agree that most people were compliant and willing to engage in treatment. However, the workers felt that many people may not be ready to make long term changes in their drinking patterns and lifestyle, and that their experience was that most people would need more than one episode of treatment before changes would be seen.

All case study participants responded that they had been shown dignity and respect during the assessment process with one commenting “it’s a good place, they gave me clothes”.

3.2.9 Challenges with assessment

Client understanding of process

Stakeholders informed us through consultations that clients sometimes do not have a clear understanding of why they are in the assessment facility. This is often due to language barriers as English is not the first language of many clients. Assessment facilities reported working hard to ensure clients understood the process and their rights, including accessing interpreters when necessary. However, the Aboriginal Interpreter Service did not always have interpreters available due to high demand and stretched resources.

In addition to this, assessment centre staff and others have reported that some clients may have cognitive impairments that affect their ability to fully comprehend the information provided to them, even when aided by an interpreter. This has caused concern for staff, as assessment facilities are not resourced to conduct comprehensive cognitive assessments of clients, and services have told us there is an extensive waiting list to receive one by a specialist service in all locations in the NT. It has been suggested that waiting times can be up to 18 months in Alice Springs; however, we don’t have any accurate data about this. While accurate wait times could not be confirmed for the case study participants, the service providers did give anecdotal information to confirm the difficulty with accessing cognitive assessments for clients.

Client trauma

A common theme from the case studies and the stakeholder consultation sessions was that AMT clients are living with the effects of significant psychological and physical trauma. Psychologists are available to clients in varying degrees; however, staff have suggested that specialist post-trauma counselling is warranted in some circumstance – but these resources are hard to find and secure. Some staff in services discussed worrying about their clients when they leave the facilities, worrying not only about if the person will continue to drink but more about the person’s safety and ability to make protective decisions while under the influence of alcohol.

Several of the case study participants’ medical histories showed multiple fractures and other injuries associated with falls while intoxicated, as well as injuries from domestic and family violence and this is consistent with Emergency Department presentation data. Some participants discussed the loss of family members, loss of the custody of their children, ongoing domestic violence or other ‘trigger’ events such as unemployment, relationship difficulties and interpersonal conflict that led them to leave their communities and come into one of the regional centre where they commenced heavy and repeated drinking.

Workforce

The recruitment and retention of staff in assessment facilities has been an ongoing issue for the program. The reasons raised by stakeholders through consultations include:

- Some staff have a philosophical issue with detaining people for a health issue.
• The number of nursing and medical staff with specific alcohol and other drug qualifications in the NT who are willing to work in the AMT is limited.

Concerns were also raised for the wellbeing of staff who may be required to work long hours and on an ongoing basis as a result. For example, staff were often filling multiple roles and performing management and SAC functions for extended periods as long as six months. While this may be manageable in a small unit, there are very different responsibilities in each role and prioritising those may conflict at times.

A further issue raised was the importance of recruiting staff in assessment centres with sufficient experience and knowledge to work with the largely Indigenous client group, and to have the requisite cross cultural skills and competence, as well as understanding of social and emotional wellbeing issues more broadly.

Finally, there was some discussion about whether Aboriginal Health Practitioners (AHPs) or Aboriginal Community Workers (ACWs) should be employed in assessment centres to assist with client engagement and to contribute to the assessment process in the same ways that AHPs and ACWs have become integral to the functioning of remote primary health care services.

Clarity of roles and responsibilities

The consultations revealed that over time there has been a lack of clarity on the part of staff in both the assessment and treatment facilities about the roles and responsibilities between the assessment facilities and the treatment facilities. This relates particularly to the role of the Senior Treatment Clinician (STC), a mandated role in the treatment phase of the AMT program, who is an employee of NT Health but whose function sits within the treatment services that are now operated by non-government providers. Both assessment and treatment service staff have raised this issue, and the CVP reported role clarity as the number one issue in its 2015-16 Annual Report.

Tribunal hearings

The connection and sound of the tele link can make it hard to hear or understand. This can be particularly difficult for clients with hearing loss, or where there is a language barrier.

Advocates, assessment staff and interpreters have reported that client understanding of the process, and why the tribunal makes some decisions, varies considerably, even when aided by an interpreter. Client interviews identified that the use of medical and legal terminology can also be confusing and difficult to follow for the client.

Interpretation of legislation and clinical guidelines

Staff reported the development of clinical guidelines and a guide to interpreting the AMT lagged the implementation of the service, and this meant they have often missed important pieces of information. This was reported as concerning for staff who were keenly aware of the highly regulated environment in which they detain and treat clients. Staff in assessment centres reportedly developed their own guidelines and added information to it when an unprecedented event occurred before the Department of Health, as the system manager, released policy and procedural guidelines for the whole service.

Application of ‘least restrictive option’

Almost every stakeholder has raised the interpretation and application of the principle of the least restrictive option in the AMT system as an ongoing challenge. This has implications for the treatment of clients in assessment facilities, tribunal decision making, and treatment of clients in mandatory residential treatment.

The CVP has raised that the “AMT Act is written in a way that gives the Senior Assessment Clinician and Senior Treatment Clinician a wide power to decide what is the ‘least restrictive’ for any one person”\(^56\). In 2015-16 the CVP reported that around 14% of all AMT issues raised with them were about ‘least restrictive’ options, and while most cases were resolved (60%), what ‘least restrictive’ means differed between people.

Differences in interpretation of ‘least restrictive’ have occurred in the context of tribunal hearings between advocates, tribunal members and SACs, and practices within assessment and treatment facilities. The differences in interpretation appear to occur where different lenses, such as health or legal lenses, are applied to the principle, rather than a more complete view of the principle.

---

\(^{56}\) NT Community Visitor Program Annual Report 2015-16, page 51
The concept of ‘least restrictive’ is well understood in mental health and disability contexts, but is comparatively new and less understood in the AOD sector. While debate regarding the concept of ‘least restrictive’ is important, the AMT service, and more broadly the AOD sector, would have benefited from comprehensive information on the topic. The CVP’s most recent annual report states it has asked the Department of Health to develop a workshop about ‘least restrictive’ principles and how they apply to AOD treatment settings, to help services learn more about how these principles work in practice.57

**Homelessness**

Stakeholders across all regions raised homelessness as one of the most significant issues facing clients in the AMT program. This is a critical consideration for the SAC when completing the assessment and making recommendations for treatment – how to ensure clients have somewhere safe to go if they are released from assessment, or if the tribunal provides the client a Community Treatment Order. Anecdotal evidence suggests that clients are less likely to engage in treatment if they are homeless and so stakeholders were concerned about clients’ ability to engage in and follow through with community treatment if they did not have a stable place to live.

One case study participant reported wanting short term, transitional housing in Alice Springs and being unable to get it on release. This was due to housing wait lists, not due to inaction. Other case study participants talked about living in the ‘long grass’ prior to admission to assessment and that it was the first time they had had a good night’s sleep and felt safe. This was particularly so for women who reported being sexually and physically assaulted while homeless.

Service providers reported that suitable accommodation for the AMT client group was not readily available as the clients usually continued drinking if released from custody and assessment, and most social housing and supported accommodation facilities did not allow alcohol consumption on the premises.

### 3.3 Mandatory residential treatment

A Mandatory Residential Treatment Order (MRTO) requires the client’s admission and detention at a specified secure treatment centre for up to 12 weeks of treatment and rehabilitation. Treatment services develop individual treatment plans for each client, which may include participation in therapeutic community programs, cognitive based therapy, life and work skills programs, motivational enhancement, and development of alternative stress management and coping strategies.

The *AMT Act* requires that an aftercare plan is developed by the service with the client prior to the completion of treatment. The aftercare plan will consider the client’s needs for follow up support services and ongoing treatment, accommodation and employment.

There are currently two treatment facilities operated by non-government service providers under DoH Service Delivery Agreements to cover the entire NT:

- Saltbush Mob in Darwin
- Central Australia Aboriginal Alcohol Programs Unit (CAAAPU) in Alice Springs.

Saltbush Mob took carriage of the AMT residential treatment service in March 2015. The Department of Health operated the Darwin treatment centre from July 2013 to March 2015, first at the Medi-Hotel at Royal Darwin Hospital, then at an interim facility at Stringy Bark until the current facility upgrades were complete. Saltbush Mob is currently funded by NT Health to provide treatment and accommodation for up to 60 people, however the facility can house up to 78.

---

57 NT Community Visitor Program Annual Report 2015-16, page 51
CAAAPU has been funded by NT Health to deliver AMT services since July 2013. CAAAPU can provide mandatory residential treatment for up to 10 men and 10 women. In addition CAAAPU also provide voluntary rehabilitation services for men on the same site as mandatory treatment services.

Staffing numbers and structures have changed over time for both services, although the staffing model at both facilities has generally consisted of:

- case managers and therapeutic program workers
- full time shift support workers
- casual shift support workers
- management and administrative staff
- Indigenous Liaison Officers.

### 3.3.1 Transition from assessment

If a client receives an MRTO from the AMT Tribunal, the SAC from the assessment facility and the STC from the treatment centre arrange for the client to transition to the relevant treatment service. The SAC provides the STC with any documents relevant to the admission and treatment of the client.

On admission to the treatment service, the service provides the client:

- an orientation to the service facilities
- an allocated case worker
- access to an interpreter if needed
- information about the program, including expectations regarding behaviour and routines
- information about their rights in relation to AMT, including the process for reviewing and extensions of the Mandatory Residential Treatment Order and their right to appeal.

The Senior Treatment Clinician (STC), a role with legislated functions in the *AMT Act*, is responsible for the admission and approving the continuing detention of the client throughout their treatment. A client cannot leave mandatory treatment until the STC approves their departure. The STC is located within the non-government service provider’s treatment service; however, is directly employed by the government health service (TEHS or CAHS). At the client’s admission to the treatment centre, the STC is also responsible for:

- providing the client with the rights statement, and explaining its contents
- arranging an interpreter for the client if needed
- preparing a treatment plan for the client.

The consultations highlighted that there was confusion about the STC role in the transition from assessment to treatment, in part related to the distinction between the SAC and STC roles, and to the fact that they are employed by the government and not by the non-government service provider and hence confusion about their authority and relationship to treatment centre staff.

### 3.3.2 Treatment programs

An assigned case manager will work with the client to consolidate their individual treatment plan and provide a level of coordination that ensures integration of activity and purpose within the plan. Some elements that may be included in the treatment plans include:

- alcohol awareness
- art and music therapy
- work readiness and employment skills
- cooking
- health and wellness, including nutrition and fitness
• group therapy sessions
• relapse prevention
• counselling and cognitive behaviour therapy

When necessary, the treatment service may arrange for an interpreter to assist clients and staff throughout the treatment process. However, interpreters are most likely to be sought for medical consultations, understanding rights upon admission, and the development of treatment and aftercare plans. The AMT External Service Provider Guidelines, through which DoH sets some of the conditions under which services are provided, identifies that improving the use of interpreters is critical to effective health service delivery and will assist in ensuring that clients are not disadvantaged in the delivery of services. Interpreters have suggested that they could aid in education and group sessions to help make them more effective.

Although DoH issues guidelines about requirements for service delivery, it does not provide or define a treatment model for the service providers. Consequently the treatment programs delivered by the service providers differ and have been developed by them incrementally. The treatment programs appear to have been shaped by the knowledge and expertise of the staff employed within the services, as well as by the availability of other external services in each location such as other organisations that provide counselling or health promotion activities, day activity programs or work experience like activities. Both mandatory treatment service providers reported have modified their programs as they learnt more about the challenges facing their clients and taking into account the skills of Aboriginal staff they employ as support workers.

It is also worth noting that the literature review highlights that research and evaluation of mandatory or involuntary alcohol treatment programs, and the minimum standards for an effective programmatic response, is limited. The literature also shows that research and evaluation of treatment strategies for Aboriginal and Torres Strait Islander people in either voluntary or involuntary circumstances is also lacking. Consequently there is very little evidence about effective alcohol treatment for Aboriginal and Torres Strait Islander people generally and this provides an added challenge.

There are various reasons why a client may not complete their MRTO:

• the client may abscond
• the client may be transported to hospital for urgent medical treatment by the service
• the client may become an involuntary mental health patient
• the tribunal may revoke or alter the order

Section 46 of the Act allows the tribunal, in appropriate cases, and on application of a client, a SAC or an STC, to vary or revoke a mandatory treatment order or change it to a different type of order. The tribunal may revoke an order if the client no longer meets the criteria for AMT, or no longer appears to be benefit from the service. An MRTO may also be extended if the client would benefit from more time at the treatment centre. Both the Darwin and Alice Springs mandatory residential treatment services reported that this was usually something that the client had requested.

3.3.3 Medical treatment and mental health

Both the Darwin and Alice Springs mandatory residential treatment services work with health providers to ensure that clients receive the medical attention they need. The services will transport clients to dental and medical appointments, and arrange for specialists to visit treatment centres where possible. Independently from the STC, a medical officer and primary health care nurse monitor clients’ ongoing chronic illnesses and administer medications at the facility.

Both services work with local mental health services when clients need specialist care from providers such as psychologists, psychiatrists and counsellors. If a client is at immediate risk of self-harm or suicide, the service
will take the person to the hospital for immediate attention or arrange for the police to transport the client to the hospital if this is deemed necessary for safety reasons. Section 52 of the AMT Act provides that an MRTO is automatically suspended for the period that a client is an involuntary patient under the Mental Health Act or is an involuntary managed person.

Note that, if someone is serving out a residential treatment order and they are admitted to hospital, they return to the treatment facility after being treated at the hospital unless they cannot be located or their order is revoked by the tribunal.

### 3.3.4 Aggregate mandatory residential treatment data

The AMT Tribunal manually collects data about the hearings it conducts and what orders it makes. Table 6 below shows the number of MRTOs made across three financial years. Note, the numbers shown reflect number of orders and not the number of individuals receiving orders and is a subset of the orders recorded in Table 4.

The data shows a drop in the number of orders being made over those years, with the most marked drop in relation to orders made for people in the Katherine region. The consultations did not elicit any conclusive reasons for the drop; however, stakeholders did report that changes in personnel filling the SAC roles has resulted in changes to the types of recommendations being made to the tribunal.

<table>
<thead>
<tr>
<th>Location</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>109</td>
<td>107</td>
<td>97</td>
</tr>
<tr>
<td>Katherine</td>
<td>27</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Nhulunbuy</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>68</td>
<td>51</td>
<td>45</td>
</tr>
<tr>
<td>Tennant Creek</td>
<td>-</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>169</strong></td>
<td><strong>151</strong></td>
</tr>
</tbody>
</table>

Source: AMT Tribunal

The primary assessment and AMT treatment providers report quarterly into the Alcohol and Other Drugs National Minimum Data Set. In the early stages of the AMT program, including when DoH was operating the treatment service, data was not consistently collected. Data collection has improved since the third quarter of 2014. Consequently only data since that period has been analysed in the evaluation.

Table 7 shows a summary of the episodes of care for the two residential treatment services from the third calendar year quarter 2014. Since the Darwin treatment service was operated by DoH before March 2015, data for the Darwin provider begins in the second quarter of 2015.

The data shows that there are instances where treatment is closed and not completed, but the reasons for the uncompleted episode are not recorded. For example in the third quarter 2015, the Darwin provider recorded 26 closed and completed treatment episodes and 39 closed episodes of treatment. The reasons 13 episodes were not completed are not known and could be any of the reasons mentioned above.

The completion rates for episodes of mandatory residential treatment in 2014-15, the first year of operations for the non-government provider in Darwin, varied from 31.9% in Darwin to 64.8% in Alice Springs. The completion rates changed in 2015-16 to be 68.4 % in Darwin and 57.4% in Alice Springs.
Table 7: Selected summary episode counts for non-government mandatory treatment service providers where the 'AMT status' is residential from third quarter 2014 to third quarter 2016

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number opened</td>
<td>Alice Springs</td>
<td>13</td>
<td>12</td>
<td>15</td>
<td>14</td>
<td>16</td>
<td>16</td>
<td>3</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>30</td>
<td>37</td>
<td>24</td>
<td>37</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Number closed</td>
<td>Alice Springs</td>
<td>8</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>11</td>
<td>16</td>
<td>14</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>17</td>
<td>39</td>
<td>32</td>
<td>26</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Number closed where treatment completed</td>
<td>Alice Springs</td>
<td>0</td>
<td>11</td>
<td>11</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>8</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>26</td>
<td>19</td>
<td>22</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Number closed with follow-up date</td>
<td>Alice Springs</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>22</td>
<td>11</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Average length of stay of closed episodes (number of days)</td>
<td>Alice Springs</td>
<td>78.4</td>
<td>85.5</td>
<td>85.3</td>
<td>80.9</td>
<td>101.4</td>
<td>84.5</td>
<td>85.6</td>
<td>1.0</td>
<td>90.0</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>25.0</td>
<td>59.1</td>
<td>68.7</td>
<td>70.4</td>
<td>76.8</td>
<td>91.5</td>
<td>91.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number closed Indigenous</td>
<td>Alice Springs</td>
<td>8</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>11</td>
<td>16</td>
<td>14</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>38</td>
<td>30</td>
<td>26</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Number closed male</td>
<td>Alice Springs</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Darwin</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>31</td>
<td>26</td>
<td>15</td>
<td>22</td>
<td>20</td>
</tr>
</tbody>
</table>

Notes:
Number opened - Count of episodes based on 'treatment start date'
Number closed - Count of episodes where there is a valid 'date of cessation'
Number closed where treatment completed - Count where episode is closed and 'reason for cessation' is 'treatment completed'
Number closed with follow-up date - Count where episode is closed and a follow-up date is recorded
Number closed Indigenous - Count of closed episodes where the person is Indigenous
Number closed male - Count of closed episodes where the person is male

Source: Alcohol and Other Drugs National Minimum Data Set

3.3.5 Regional variations

The Darwin and Alice Springs services both provide a dedicated mandatory residential treatment service; however, there are some regional variations in the delivery of that service.

The Darwin service is located at an old prison site and has barbed wire and high fences around the facility, making it difficult for clients to leave without escorts. The service has set up a participant advisory board to provide clients with a mechanism to put forward their ideas to improve the facility and program. The facility has a small not for profit shop, and where clients can purchase items. The Darwin non-government provider is also funded to provide an aftercare program, and some clients participate in activities such as work readiness at the facility when their treatment is completed.

The Alice Springs service operates from a secure facility; however, the level of security is not as high as in Darwin and the consultations suggested that it is relatively easy for clients to abscond. The Alice Springs non-government organisation also provides rehabilitation services for voluntary clients from the same site as its AMT service.

The Minimum Data Set data for 2015-16 shows that the use of each service is variable. The Alice Springs service has a bed capacity of 20, and its number of opened cases (admissions) each quarter varies from three to 19 but has mostly been between 14 and 16 since being established. This represents use of around 70% or thereabouts. By comparison, the Darwin service has a bed capacity of 78, but operates with an expected capacity of 60. The number of opened cases each quarter varies from 24 to 38, which represents use of between 48% and 60%.

There are also variations in the average length of stay, completion rates for treatment and type of clients between the two services. In Alice Springs there has been a lower proportion of male clients with closed cases.
(47%) compared to Darwin (73%), and the Alice Springs service has a slightly longer average length of stay. Katherine clients who receive mandatory residential treatment orders need to travel to either Darwin or Alice Springs. The Darwin service doesn’t take clients on the weekend, and consequently Katherine clients may stay in the MARS Unit over the weekend for transporting on the Monday.

3.3.6 Benefit of mandatory residential treatment

Wanting to change

Consultations with staff at the Darwin and Alice Springs mandatory residential treatment services about the perceived benefit of MRT identified that the majority of their clients are pre-contemplative during their first time in AMT. Staff believe that, by the second and third episodes of AMT treatment, clients are becoming more engaged and wanting to change. These perceptions were supported by the client interviews undertaken for the case studies.

Services reported that the majority of their clients are pre-contemplative and this provides challenges in engaging clients in treatment. Pre-contemplation if the first stage of change. People in this stage are not considering change and do not consider their alcoholism a problem, whereas their family members and friends do. The AMT client group who have been mandated to attend treatment and arrived there via a police protective custody pathway are either not willing to engage or will be passive recipients of the treatment program until such time as they leave and resume their usual behaviours. It is also acknowledged that the client group who enter AMT are probably the least likely to seek help through a health service and hence may not be being offered brief interventions or other opportunities to consider treatment.

However, staff did report that most clients do make some change after one mandatory residential treatment episode. Treatment provides clients with time to sober up and think about things without humbug or pressure to drink from family and community members. Staff reported anecdotal improvements in cognition and self-esteem, and some clients showed a desire to change their behaviours associated with alcohol. The evaluation team also heard during the client interviews that some clients have begun reconnecting with family, and were making plans with the service to return to their community following treatment.

Improvements in physical health

Staff reported that the physical health of clients improves dramatically while in treatment at the Darwin and Alice Springs mandatory residential treatment services. Clients receive regular medical checks and medication is regularly distributed. In addition clients learn about their health conditions and the importance of taking medicines, often with interpreters assisting in this process. Clients also benefit from learning about good nutrition, cooking and learning about how alcohol affects their bodies and minds.

The case studies showed that most AMT clients have multiple health conditions that were either identified during assessment or highlighted as requiring treatment. These include asthma, sexually transmitted diseases, heart conditions, diabetes, kidney and liver disease. As one case study participant stated, “I got diabetes medication every day. Food - outside I didn’t think about food. I kept drinking and drinking me and my partner.”

Life skills, finances and education

Services assist clients to explore and understand their basic financial situations. For many this means assistance with:

- obtaining a bank account
- getting Centrelink benefits for the first time
- sorting out and understanding Centrelink payments
- lodging adult guardianship applications.
Some clients are also receiving assistance to obtain their driver’s licence. Programs also provide services to assist clients with work readiness, and some clients begin TAFE studies in an area they are interested in.

Life skills programs offered at the treatment facilities include helping people to understand and use banking services, income support and housing agencies. Clients are then provided with the contact details of a range of support agencies, documented in their aftercare plans.

At the Alice Springs mandatory residential treatment services, staff from other agencies run men’s and women’s programs weekly, facilitated by local Aboriginal people. Learning to live without the excitement and drama of life on the streets and in the long grass is challenging for participants. They are tired but speak of boredom, and the staff indicate there are often disputes over very minor things during the first few weeks in treatment, until people learn to sit with themselves. Cultural activities, such as painting and storytelling are encouraged while people are stabilising their moods and behaviours.

Reconnecting with family and culture

Staff reported that an important part of a client’s treatment was reconnecting with family and community if he or she wanted to. Staff have shown they are proactive in supporting clients to do this.

At the Darwin mandatory residential treatment service, for example, every morning starts with a group meeting where participants recall a very brief story or memory, such as the name of their favourite teacher. This storytelling opportunity often leads to people remembering and recounting related information and stories throughout the day, prompted by a single, simple question. This grounds people, and helps to stabilise them; they remember who they were before the alcohol took over.

All participants are asked explicitly about family conflicts and whether there is anyone they would like to reconnect with or make amends to. Case managers take people to visit family members in hospital, in prison and other places. In one case, at the completion of the client’s second mandatory residential treatment order, his case coordinator took him to the hospital where he had arranged to be met by his family. He was met by more than 20 family members and expressed great joy at seeing and being reunited with them. He had photos taken and later returned to his small dry community to live with family, from whom he had been estranged for many years.

3.3.7 Challenges of mandatory residential treatment

Smoking

Mandatory residential treatment services raised the difficulty for clients who are abstaining from two substance addictions – alcohol and tobacco. Service providers reported that clients find it very difficult to give up smoking while they are also receiving treatment for alcohol addiction, and this can create tensions in the treatment centres. As a result, nicotine replacement therapy was made available to clients.

The case studies highlighted that many AMT participants smoke tobacco and many have also smoked marijuana and engaged in other substances such as kava and petrol sniffing. One stated that he was “just drinking and smoking dope in Alice. Wasting my life. Bored.”

Returning to Country

Services expressed concern about clients returning to communities when released from assessment due to the lack of services available. The tribunal has begun to work with the remote AOD services across the NT to provide follow up with clients; however, for some smaller communities this service may be located in larger neighbouring communities, and not visit regularly enough for the needs of some clients.

Additionally the Return to Country program is no longer running, and the bush bus to get home can be very expensive, making it difficult for clients to return to their communities when released from residential treatment in Darwin and Alice Springs.
Shortage of housing and supported accommodation

The social and community housing waiting lists are long in the NT, and staff report that clients find it difficult to secure accommodation post release from assessment and treatment due to insufficient references or housing history. Clients transitioning from residential services may still need supported accommodation due to complex needs. Unfortunately, supported accommodation services are either limited or in high demand. Further, they may not be appropriate for people who have been used to living rough for long periods of time and have not yielded to an abstinence model of treatment and recovery, and hence wish to continue drinking post release. These accommodation concerns mean that a client may have no other option but to return to the long grass, or stay with friends or relatives where the environment may not be conducive to improving health and wellbeing and reducing alcohol intake.

The case studies highlighted that AMT participants found it hard to significantly change their drinking patterns if they remained in town, and having periods of abstinence while in their communities but returning to heavy binge drinking when they came back into town.

Services in conflict or not coordinating

Stakeholder interviews revealed that there is an apparent barrier or conflict between some community services and the AMT services, creating artificial barriers to effective referrals. In some cases this appears to be the result of philosophical differences to the idea of mandatory treatment. However, in other cases the lack of coordination among services appears to be the result of a lack of knowledge of the types of services provided and referral processes.

Staff at the Darwin mandatory residential treatment service acknowledged this as a concern and has been inviting services to the treatment facility to help overcome some of these barriers. Improved relationships with non-government providers would assist the Darwin and Alice Springs mandatory residential treatment services to provide programs for clients while in rehabilitation, and enhance the effectiveness of aftercare and other referrals for clients.

Trauma and trauma counselling and mental health

A common theme across all regions is that AMT clients are living with the effects of significant trauma. Psychologists are available to clients in varying degrees; however, staff have suggested that specialist trauma counselling is necessary in some circumstance. Such specialist resources are hard to find and secure.

Some of the case study participants had been assaulted while drinking, or by someone who was drinking. One young woman reported that a former relationship while very young was her introduction to both alcohol and abusive behaviour. She recalled that her boyfriend “started her drinking and was jealous and bashing her”. Other women showed their physical scars and recalled years of domestic abuse, sexual assault and trauma, but were unable to recall receiving any psychological support immediately after these events. Another recounted traumatic stories of violent assaults and other events that caused him shame and grief. He appeared to be deeply grateful for the opportunity to undergo treatment and determined to make a change in his life.

Programs not Indigenous focused – for local area

There is very little evidence about the efficacy of alcohol treatment programs for Aboriginal and Torres Strait Islander peoples, and this has provided challenges for the Darwin and Alice Springs mandatory residential treatment services. As a result, both services have worked to find ways to make their services culturally relevant and safe for clients; however, this can be challenging given the diversity of cultures in the NT. Both services partner with local Aboriginal organisations to provide culturally relevant and safe activities at the treatment centres. The Darwin and Alice Springs mandatory residential treatment services also encourage clients to cook roo tail and the STC often approves leave if a client has cultural responsibilities or sorry business to attend to.

Both services try to employ local Indigenous staff as case workers, and also employ Indigenous Liaison Officers. Stakeholders felt these positions were invaluable in assisting clients to engage and participate in programs.

There was also some discussion about the value of Aboriginal and Torres Strait Islander peoples’ involvement in the ongoing governance and management of alcohol treatment services as well as in the development of programs for specific regions.
Service Models and Implementation

During the consultations, stakeholders expressed interest in contributing to service level evaluation and research about alcohol treatment programs for the NT context, and reported that this type of investment would assist them with ongoing service design and refinement, and would pay dividends for future generations.

Service guidelines

Interviews with service providers revealed that some felt challenged by a lack of initial treatment and service guidelines, as well as some ongoing challenges with interpretation of the guidelines.

Although the service contracts between NT Health and non-government providers outline matters such as roles and responsibilities – for example, who was responsible for providing medical coverage at the treatment centres, safe and effective staff to client ratios, and the processes for client payment at treatment service – some service providers believed these matters required more clarity.

The Evaluation Team noted, however, that non-government provider staff were involved in writing the initial guidelines and had been invited to participate in updating the guidelines. High turnover of staff in services may be a contributing factor to confusion around some of these matters.

Staff recruitment and retention

As has been discussed earlier, there are also workforce challenges in the treatment sector. The Darwin and Alice Springs mandatory residential treatment services reported having had difficulty in recruiting and retaining staff with AOD qualifications. This issue was also raised by the CVP in its 2015-16 Annual report. The non-government providers reported that they believed some of the difficulty related to uncertainty around continuity of funding contracts and staff seeking better employment stability.

Absconding

The stakeholder consultations and case studies highlighted that AMT clients are more likely to abscond from the treatment centre in Alice Springs than in Darwin because clients can more easily climb the fence. However, the Darwin mandatory residential treatment service has reported that some clients will abscond while on leave arrangements. Anecdotal reasons reported by the case study participants include:

- worry about family and protecting the women, especially if they are living in a town camp
- jealousy issues
- want to go and drink
- homesick and feeling lonely
- cultural reasons, for example, there might be someone in the treatment centre they shouldn’t be around, or they might have cultural responsibilities they need to attend to
- don’t like being locked up and feel like they shouldn’t be as they didn’t commit an offence
- clients may not come back from sorry business when granted leave for funerals
- clients may not come back from a court hearing or shopping trip or other type of leave.

3.4 Community residential and other community treatment

Community Treatment Orders (CTOs) can be for residential (CRTO) as well as other forms of community treatment and are a less restrictive form of intervention than the MRTO. They still require the client’s participation in treatment from a specified community residential treatment provider or other community provider, and ban the client from possessing, purchasing and consuming alcohol. This order has the greatest amount of flexibility because it does not have a secure residential component, although some providers do offer community residential treatment. All clients receiving this order will also be placed on an Income Management Order if they are an eligible welfare recipient, resulting in 70% of their income being quarantined.

“Some of the women tell me they will drink again when they leave here as they know they will be hurt again when they leave here and drinking helps them to not feel the pain”

Treatment Centre worker
The organisations that currently provide CRTO and CTO services are shown in Table 8 below. These services were established before the implementation of AMT and have not been specifically funded to deliver AMT CTO services. The providers do not generally differentiate between clients who are being treated via a CTO or via some other form of referral process.

### Table 8: Community treatment providers

<table>
<thead>
<tr>
<th>Service type</th>
<th>Darwin</th>
<th>Katherine</th>
<th>Alice Springs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Community Treatment Order Providers</td>
<td>CAAPS</td>
<td>Kalano</td>
<td>DASA</td>
</tr>
<tr>
<td></td>
<td>Banyan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FORWAARD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amity, Salvation Army</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Treatment Order Providers</td>
<td>CatholicCare</td>
<td>Kalano</td>
<td>Holyoake</td>
</tr>
<tr>
<td></td>
<td>Mission Australia</td>
<td></td>
<td>DASA</td>
</tr>
<tr>
<td></td>
<td>Danila Dilba</td>
<td></td>
<td>CAAC</td>
</tr>
<tr>
<td></td>
<td>Top End Alcohol and Drug Services (TADS)</td>
<td></td>
<td>ADSCA</td>
</tr>
</tbody>
</table>

#### 3.4.1 Referring to a community treatment provider

If the SAC recommends that a client receive a CTO from the tribunal, the SAC will contact the service to discuss availability and possible treatment options. It is important that the SAC contact the service before the tribunal hearing to ensure an expeditious transfer of the client from the assessment facility to the service after the hearing. However, the tribunal may decide to give the client a CTO when the SAC has recommended an alternative treatment option, or a release order. In this instance the SAC is required to arrange a referral to a service after the tribunal hearing.

The assessment facility is not required to detain a client on a CTO until transfer to a service in the same way they are when a client receives an MRTO. When the tribunal makes a CTO the SAC can and often will assist the client with arranging transport; however, the client is able to be released from the assessment centre following a hearing. Upon the client’s release from the assessment facility, it is up to the community treatment provider to follow up with the client.

#### 3.4.2 Aggregate community treatment data

The AMT Tribunal manually collects data about the hearings it conducts and what orders it makes. Table 9 below shows the number of MCTOs made across three financial years. The numbers shown reflect the number of orders, including residential community treatment orders (CRTOs) and not the number of individuals.

### Table 9: Mandatory Community Treatment Orders 2013-14 – 2015-16

<table>
<thead>
<tr>
<th>Order type</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>3</td>
<td>59</td>
<td>56</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>37</td>
<td>38</td>
<td>45</td>
</tr>
<tr>
<td>Katherine</td>
<td>25</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>117</td>
<td>112</td>
</tr>
</tbody>
</table>

Source: AMT Tribunal

Community treatment providers are required to report AMT data into the Alcohol and Other Drugs National Minimum Data Set each quarter. The data has improved since the third quarter of 2014, however data was not regularly collected for the 2013-14 financial year and has not been included here.
The number of MCTOs the tribunal has made (shown above) is different to the number of opened cases recorded by non-government community treatment providers in the Alcohol and Other Drug National Minimum Data Set, shown in Table 10 and Table 11 below. For example, the AMT Tribunal made 112 CTOs in 2015-16. Of these, 25 appear as open cases in the non-government provider records as community episodes and 50 appear in the non-government provider records as residential episodes. This seems to leave a gap of 37 orders unrecorded.

The data sets are not linked and there is no way of knowing for sure if a person who receives a CTO follows through to engage with a community treatment provider. The National Minimum Data Set reports the case start date; however, it is not clear if there is consistency among providers about recording the referral as the case start date or the date when the client actually presents. Anecdotal evidence from consultations suggests that clients don’t turn up after the tribunal hearing, that services are unable to contact them and that there are little or no outreach attempts to locate the clients and encourage them to commence treatment.

**Table 10: Selected summary episode counts where the AMT status is ’community' 2014-15 and 2015-16**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number opened</td>
<td>43</td>
<td>25</td>
</tr>
<tr>
<td>Number closed</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td>Number closed where treatment completed</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Number closed with follow-up date</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Average length of stay of closed episodes</td>
<td>28.7</td>
<td>67.5</td>
</tr>
<tr>
<td>(number of days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number closed Indigenous</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td>Number closed male</td>
<td>40</td>
<td>24</td>
</tr>
</tbody>
</table>

Notes:
- Number opened: Count of episodes based on 'treatment start date'
- Number closed: Count of episodes where there is a valid 'date of cessation'
- Number closed where treatment completed: Count where episode is closed and 'reason for cessation' is 'treatment completed'
- Number closed with follow-up date: Count where episode is closed and a follow-up date is recorded
- Number closed Indigenous: Count of closed episodes where the person is Indigenous
- Number closed male: Count of closed episodes where the person is male

Source: Alcohol and Other Drugs National Minimum Data Set

Of the small number of opened AMT episodes of community treatment by non-government community treatment providers, only 53% were recorded as being completed during 2014-15 and 44% were recorded as completed during 2015-16. The completion rates are less for community residential treatment by AMT clients at 48% in 2014-15 and 4% in 2015-16. Again, the Evaluation Team is unsure of the reasons for these completion rates, and whether this is also due to clients not engaging past initial referral or clients choose to disengage part way through treatment.

Table 11 shows data for non-government community residential treatment providers for both AMT and non AMT clients. It appears to show that the completion rates for non AMT and AMT clients were fairly consistent at 49% and 48% respectively in 2014-15, whereas there was higher variability in 2015-16 with the non AMT rate being 48% and the AMT rate being 24%.

There appear to be no other marked differences between the non AMT and AMT episodes of residential treatment in terms of average length of stay, and the fact that most clients are male and Indigenous.
### Table 11: Episodes for selected non-government community treatment providers where main treatment is rehabilitation and treatment delivery setting is residential 2014-15 – 2015-16

<table>
<thead>
<tr>
<th>Metric</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number opened</td>
<td>Not AMT</td>
<td>404</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>69</td>
</tr>
<tr>
<td>Number closed</td>
<td>Not AMT</td>
<td>384</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>57</td>
</tr>
<tr>
<td>Number closed where treatment completed</td>
<td>Not AMT</td>
<td>199</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>33</td>
</tr>
<tr>
<td>Number closed with follow-up date</td>
<td>Not AMT</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>32</td>
</tr>
<tr>
<td>Number closed Indigenous</td>
<td>Not AMT</td>
<td>301</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>62</td>
</tr>
<tr>
<td>Number closed male</td>
<td>Not AMT</td>
<td>222</td>
</tr>
<tr>
<td></td>
<td>AMT</td>
<td>54</td>
</tr>
<tr>
<td>Average length of stay of closed episodes</td>
<td>Not AMT</td>
<td>59.1</td>
</tr>
<tr>
<td>(number of days)</td>
<td>AMT</td>
<td>53.5</td>
</tr>
</tbody>
</table>

**Notes:**
- Number opened: Count of episodes based on ‘treatment start date’
- Number closed: Count of episodes where there is a valid ‘date of cessation’
- Number closed where treatment completed: Count where episode is closed and ‘reason for cessation’ is ‘treatment completed’
- Number closed with follow-up date: Count where episode is closed and a follow-up date is recorded
- Number closed Indigenous: Count of closed episodes where the person is Indigenous
- Number closed male: Count of closed episodes where the person is male

Source: Alcohol and Other Drugs National Minimum Data Set

### 3.4.3 Benefits and challenges of community treatment

The quantitative information available to the Evaluation Team to enable an assessment of the benefits of community treatment has been limited and contradicts the qualitative information obtained from the stakeholder consultations. This suggested that most AMT clients did not access community treatment or, if they did, it was for a very short period of time (hours or days). Some community treatment providers talked about receiving referrals from the SAC, but in the main, most reported that the AMT clients did not present or were difficult to find and as they were voluntary clients the community treatment provider generally did not try to locate the clients.

The case studies found that some AMT clients had had previous experience with community treatment and in some instances had completed a period of residential treatment but returned to problematic drinking shortly thereafter.

In other instances the client self-reported accessing sobering up shelters, as well as other health and community services while sleeping rough or in the long grass; however, these presentations appear to have been incidental and not planned or managed by the client or the other provider.

Where the case study participant had received an initial CTO, in line with the principle of the least restrictive option, this order was subsequently revoked in favour of a MRTO by the tribunal when the client was taken into protective custody by police and another assessment occurred. In most instances the client had not presented to the community treatment provider.
The data for completion rates for residential treatment showed that in the main, completion occurred at a higher rate in mandatory residential treatment than in community residential treatment although there was variance by region, client type and year. For example, completion in mandatory residential treatment appeared to be highest in Darwin (68.4%) and vary in community residential treatment from around 24% for AMT clients and 49% for non AMT clients. The higher completion rates in mandatory residential treatment would be expected given the nature of the service and the order.

A key challenge reported by community treatment providers is working with clients to engage in the treatment after release from assessment. It is difficult for providers to contact clients after they have left assessment. Clients may be experiencing homelessness and living in the long grass, or they might not have access to a reliable mobile phone number.

In response to the apparent gap in follow up for clients ordered to community treatment, service providers have suggested that more investment in transitional services would benefit clients exiting from assessment.

Stakeholders also raised concern about the availability of community treatment options, specifically voluntary residential services for women in Alice Springs. For example, the Alice Springs mandatory residential treatment services has no funded voluntary beds for women; women referred to community residential treatment are therefore referred to mandatory residential treatment instead.

### 3.5 Aftercare

Section 65 of the AMT Act provides that aftercare plans are required for every client who participates in a mandatory treatment order – including MRTOs and CTOs. Clients are not mandated to participate in aftercare; however, they are strongly encouraged to do so. The purpose of aftercare is to continue support for a period of three to six months. Over this time support from the aftercare team is expected to decrease in intensity and frequency as the client builds links and relationships with alternative aftercare treatment and support providers. The plans are intended to focus on providing support and interventions “to encourage continued abstinence or harm minimisation; work towards the goals (in the plan) and to address and manage the risk of relapse after the client has been discharged from the mandatory phase of the program”\(^\text{61}\). The aftercare phase of treatment highlights the importance for long term, comprehensive and holistic support to achieve sustained behaviour change, psychosocial, health and wellbeing outcomes\(^\text{62}\).

Separate aftercare services were not established at the commencement of the AMT program. The Department of Health introduced dedicated aftercare services for AMT clients into the Darwin region in September 2014 and Alice Springs region in July 2014. Figure 2 shows the desired holistic approach to aftercare as outlined in the DoH AMT Clinical Practice Guideline\(^\text{63}\).

In practice, the aftercare case manager in the mandatory residential treatment services usually begins preparing the aftercare plan with the client about one month prior to the end of their treatment and must lodge the plan with the tribunal seven days before expiry of the order. The client is expected to be included in the preparation of the plan and final copies should be provided to:

- the client
- the client’s guardian or decision maker (if any)
- any person or service provider who will be involved in the client’s follow up treatment
- the tribunal.

---

\(^{61}\) Ibid

\(^{62}\) Alcohol Mandatory Treatment Clinical Practice Guideline Version 8.1, Department of Health, updated at 22 April 2015.

\(^{63}\) Ibid
The aftercare support provided by the aftercare providers to clients can include:

- information, advice and referrals relating to housing options and tenancy rights and responsibilities
- personal support in providing needs based assessments and the case management and coordination of individualized service packages
- personal support to the client in maintaining and developing links with family, friends, community and culture and reduce isolation
- client specialist services including assisting service deliverers and clients
- supporting daily living by linking clients with allied health services or paramedical care, including therapy for individuals, early childhood intervention, and drug and alcohol support or intervention.

The Evaluation Team found it difficult to obtain any definitive information about aftercare activity or processes used in the community treatment setting. This is due in part to the reports by community treatment providers that they have very few if any AMT clients, and because the aftercare plans for clients on CTOs are not being provided to the tribunal. Community treatment providers stated that they would manage aftercare in the same way they do for their other clients: develop an aftercare plan if the client is willing, provide referral information and assist clients to connect with other services if they wish.
3.5.1 Aggregate aftercare data

The Evaluation Team was unable to obtain any robust or consistent aggregated data about aftercare plans including service compliance and client engagement. At the time of writing this report there was insufficient data provided into the minimum data set by treatment providers. However, it is understood that providers are currently working with the Department of Health to input retrospective data into the minimum data set.

The AMT Tribunal was unable to report on aftercare compliance as the tribunal does not have all aftercare plans lodged with them and does not have a mechanism to obtain follow up or completion data unless the person re-presents before the tribunal. At that time the assessment report prepared by the SAC will have a comprehensive history that includes aftercare since the last presentation.

3.5.2 Benefits of aftercare

Follow up and continuity of care

Aftercare has the potential to provide clients with much needed follow up care after they leave mandatory treatment. When a client is able to fully engage with aftercare services, they can be linked in with a comprehensive support and health services to help overcome the client’s reason for alcohol addiction or abuse. Aftercare case workers see this phase as an extension of treatment and ensure therapeutic treatment is also part of the aftercare plan.

In the case of the Darwin mandatory residential treatment service, clients in treatment will be assigned a caseworker who will also work with them throughout the aftercare period. Clients benefit greatly from continuity of care, as relationships have been established and built over time.

Some case study participants returned home to their communities after release from residential treatment, with many accessing services from their local health centre on this return. However, not all remained in their communities and some said that they stopped drinking when their returned ‘out bush’, but would start again when they ended up back ‘in town’. The involvement and follow up from a case manager who got to know the client while in the treatment facility appears to have been beneficial.

However, as stated earlier, stakeholders reported feeling frustrated that many clients did not engage in aftercare services, despite plans being made with them.

Holistic and integrated approach

Aftercare provided by AMT services takes a holistic and integrated approach considering not only issues of alcohol use but also comorbidities, housing and financial needs, and the family and community context of the person. This is important in the ongoing care of clients, as we know that Aboriginal and Torres Strait Islander peoples have a holistic view of health that focuses on the physical, spiritual, cultural, emotional and social wellbeing of the individual, family and community. “A holistic approach emphasises the importance of strengthening cultural systems of care, control and responsibility”64.

Reunification with family and community

Aftercare services and treatment providers make efforts to help clients reconnect with family and transition back into their community. It is common that clients who live in the long grass, or have moved into regional centres away from their communities, have experienced some kind of conflict or trauma that has led to the disconnection. Overcoming past difficulties and reunifying with family and community is a very positive outcome of treatment and aftercare.

64 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy (2014-2019)
3.5.3 Challenges in aftercare

Funding and access to appropriate services

Developing aftercare options has been an ongoing challenge for AMT service providers. This partly stems from the short time frame in which the Department of Health had to design and implement AMT. Prioritising the deployment of assessment and treatment services, departmental staff had little time to incorporate detailed guidelines for provision of aftercare services. Funding for aftercare services was also delayed, and services report they have struggled to provide clients with comprehensive specialist aftercare support.

Service providers report they generally refer clients to existing health and community services; however, these services are not obliged to accept the AMT aftercare referral and contact by the client is voluntary.

Housing and homelessness

Homelessness and a lack of appropriate housing are fundamental issues in the ongoing support of AMT clients. Services report that many clients are homeless and live in the long grass before being admitted into AMT treatment facilities. Ensuring clients have a safe and supportive environment to return home to after treatment is essential to supporting clients to continue having a positive relationship with alcohol.

Services are keenly aware that if clients return to unhealthy home environments they will also return to problem drinking patterns. Humbug, pressure to drink, homelessness and domestic violence are some of the conditions clients report they may be returning to. Unfortunately there is insufficient public housing across the NT and the waiting list can be months, even years, long. After exiting AMT, many clients will also require supported accommodation or transitional housing – also in short supply. Access to supported accommodation is via referral or contact with an NGO, however coordination of available beds is not yet managed consistently in all regions. The Northern Territory Government has committed to establishing a joined up integrated approach and better coordination between government, non-government organisations and the private sector to provide wraparound services.

Several case study participants had been referred to social housing or supported accommodation facilities as part of their aftercare plan, but were awaiting housing or placements becoming available. In some instances service providers were found to have been creative in the use of their available accommodation, and found way to accommodate and support clients post release, such as enabling a client to voluntarily reside in one of the unoccupied units at the existing facility for a time to provide ongoing monitoring and for the client to live in an alcohol free location.

Remote service availability

Some clients opt to go home to their community for family support and because it is a dry community. Arranging follow up services for these clients is difficult due to the limited transport options to remote communities. AMT providers work with the Remote AOD Workforce; however, this is also limited in some areas of the NT.

Many clients will also still be dealing with trauma, and although they received counselling during treatment, ongoing care will be required. Stakeholders commented that providing culturally appropriate trauma counselling and other supports for clients in remote parts of the NT can be challenging.

Contacting clients

Services report that contacting clients after they leave AMT can be difficult. Reasons for this include:

- Some clients return to living in the long grass, or in town camps.
- Clients’ mobile phone numbers change, or there isn’t a reliable way to contact them.

---

65 Northern Territory Government 2016 “Housing Action NT - Urban and Regional”

---
As discussed above, the case studies have shown that follow up with clients is possible and valuable for clients; however, it can require innovative approaches and persistence. The workers at one service advised that they have taken to using an outreach approach, visiting shopping centres and public areas they know their clients have frequented in the past. When they do see their previous treatment clients, they engage in general conversation and use brief intervention style strategies to reinforce messages from treatment and encourage ongoing contact in more planned ways.
4 Client Outcomes

Evaluation questions:
- To what extent are the aims of the AMT being achieved for the client group?
- What is the relationship between a client’s engagement in the program and identified outcomes?

The purpose of this component of the evaluation is to evaluate the impact of the Alcohol Mandatory Treatment program on clients. The impact has been assessed in relation to the stated aims of the program, as outlined in the AMT Act. As stated in Chapter 2, the evaluation has assessed to what extent those who participated in AMT experience:
- increased stability and improvements in health
- improvements in their social functioning (through appropriate therapeutic and other life and work skills interventions)
- ‘restored’/increased capacity to make decisions about their alcohol use and personal welfare
- improvements in their access to ongoing treatment to reduce the risk of alcohol consumption.

4.1 2014-15 AMT client cohort

The evaluation used data generated by a cohort of all AMT clients who became eligible for AMT between 1 July 2014 and 30 June 2015.

The impact assessment has examined information gained for a people who had either:
1. received an episode of AMT in 2014-15 (the AMT participant group)
2. met the AMT trigger at least once during 2014-15, but did not receive any AMT ordered treatment in that period or prior to that period (the comparison group)
3. received one or more episodes of AMT and consented to participate in and offer their stories as case studies (the case study participants).

During the 12 months July 2014 to June 2015, at total of 810 people were considered for mandatory treatment because each had received three police protective custody orders (PCO) in a period of two months. This is the overall client cohort.

The cohort was divided into two groups for comparison purposes: the AMT participants, made up of those who underwent mandatory treatment (N=225) and those who were eligible, but did not receive a treatment order (the comparison group, N= 347).

In addition, a group of 238 people were excluded from the study. They were excluded because they had already been ordered to receive AMT in the previous year, and were therefore not a group of people who were eligible but never treated. Excluding them from the comparison group meant that there could be a true comparison between those people who had been subject to a treatment order, with people who had met the trigger for AMT assessment, but who had not experienced any form of treatment through the AMT program.
4.1.1 Characteristics of the cohort group

Figure 3 below shows the number of people eligible for mandatory treatment in the cohort period, and demonstrates how many people were retained in the system at each transition point. The graph illustrates how 225 people became the AMT participant group, by staying in the program until they received a treatment order.

The Evaluation Team was unable to determine how many of the cohort group completed an assessment because the Primary Care Information System (PICS) data collected at the assessment centres was incomplete and the data linkage process could not be undertaken with certainty for all of the 810 people. This meant it was difficult to assign comparison group status to all of those who were transported for assessment, as there would have been many data gaps.

It was therefore determined that the comparison group would be those people who had been eligible for assessment by having had at least three protective custodies in two months between 1 July 2014 and 30 June 2015, but who had not been transported to an assessment centre or who did not appear before the AMT Tribunal. This was a group of 347 people. People who had been before the tribunal in 2014-15 but who had had a treatment order in a previous year (238 people), were excluded as they had had exposure to the system. This resulted in an AMT participant group of 225 people who had their first treatment order in 2014-15.

This data demonstrates that many of those eligible for AMT never penetrate the system far enough to be assessed or receive treatment, and are therefore not able to benefit from treatment, as is intended in the AMT Act.

Figure 3: People eligible for mandatory treatment in the cohort period 1 July 2014 to 30 June 2015

Source: Protective Custody Apprehensions and Transport Advisory Notices, Department of Attorney-General and Justice; Tribunal register

4.1.2 Characteristics of the AMT participants and comparison group

Figures 4 and 6, and Table 12 show the demographics and other characteristics of the AMT participant group and compares them to the comparison group.
Client Outcomes

Figure 4: AMT participants and comparison group by gender

![Figure 4: AMT participants and comparison group by gender](image)

Source: Department of Attorney-General and Justice, Tribunal Register

Table 12: Client demographics for the AMT participants (those who were ordered to receive treatment 1 July 2014 to 30 June 2015)

<table>
<thead>
<tr>
<th></th>
<th>Number of persons</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>219</td>
<td>97</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>225</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Male</td>
<td>139</td>
<td>62</td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
<td>37</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>225</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Tribunal records

Figure 5: Age distribution of AMT participants and comparison group

![Figure 5: Age distribution of AMT participants and comparison group](image)

Source: Department of Attorney-General and Justice, Tribunal Register
Figure 5 shows that the AMT participants have an older age profile than the comparison group.

In terms of the geographic distribution of the AMT participant group, 64% went to tribunal hearings in the Top End (Darwin and Katherine) and 36% attended tribunal hearings in Central Australia (Alice Springs and Tennant Creek). It was not possible to accurately determine the home community or region for the AMT participant group due to the quality and consistency of the recording of this information across multiple data sources.

**Figure 6: Treatment orders made for AMT participants between 1 July 2014 and 30 June 2015**

![Figure 6: Treatment orders made for AMT participants between 1 July 2014 and 30 June 2015](source)

Figure 6 shows that 345 orders were made for the 225 AMT participants in 2014-15. Almost 30% of the AMT participants were not receiving their first treatment order.

For the periods for which records are available (1 July 2013 until 30 May 2016) the 225 AMT participants received a total of 589 TOs, including 275 MRTOs and 151 CTOs. Figure 7 below shows the periods during which the orders were issued for the AMT participant group.

**Figure 7: Period during which AMT participants received treatment orders, by order type**

![Figure 7: Period during which AMT participants received treatment orders, by order type](source)
4.1.3 Characteristics of the case study participants

The methodology for collecting the case studies is described in section 2.2.2. The Evaluation Team planned to include 20 to 30 participants; however, many potential participants approached were unable to provide informed consent due to cognitive impairment, or were intoxicated when located and had to be excluded. Other potential participants did not provide informed consent after being given detailed information of what would be required. At the conclusion of the case study period in November 2016, 55 people had been invited to participate, and a total of 17 clients were recruited and agreed to participate in the evaluation. These 17 clients were followed through their treatment journey over a period of up to a year.

The case study group (N=17) was almost equally male and female, and all identified as Aboriginal but one; that participant identified as Australian with a Pacific Islander background. Participants ages ranged from 25 to 54 years (see Figure 8).

Figure 8: Age distribution and gender of case study participants

A total of 42% of the case study participants identified as being single with the remainder being married or de facto (25%) or divorced (33%). A total of 64% reported having a junior high school education, having completed years 7 to 10, and one participant had a senior high school education, having completed years 11 and 12. One of the case study participants was working on a Community Development Program (CDP) job through Tangentyere Council at the time of commencing with the AMT program, a further 17% were on government funded pensions and 58% were unemployed. Identifying as unemployed did not necessarily translate to receiving government benefits, as some case study participants were not registered with Centrelink on entering the AMT program.

The case study participants had all been subject to at least one Mandatory Residential Treatment Order. A subset had also been subject to Income Management Orders in parallel with their mandatory treatment for alcohol dependence. Of the 17 case study participants, 67% undertook treatment in Alice Springs, and 33% were treated in Darwin.

Around one third of the case study participants reported past offending behaviour and some had had prior periods in a correctional facility. During interviews some spoke about being either victims or perpetrators of domestic and family violence.
4.2 Assessing increased stability and improvements in health

The evaluation has assessed to what extent those who participated in AMT experience increased stability and improvements in health by measuring:

- self-reported changes in health from case study participants
- any changes in the number of Emergency Department (ED) presentations for AMT participants compared with the comparison group
- any changes in the number of hospital admissions for AMT participants compared with the comparison group.

The data within the linked data set did not enable the Evaluation Team to explore AMT or comparison group participants’ access to other services; however, this was explored as far as was possible through the case study client interviews, service provider interviews and file note reviews.

As will be shown in this chapter, participation in the program generally leads to improvement in the detection and management of chronic conditions and acute infections and wound care (Figure 10). The combination of regular food, sleep and health care all contribute to improved health for AMT participants in the short term. As discussed in the Apprehension and Assessment section, people who are very sick or frail when taken into protective custody are transferred to the hospital ED, either directly from police custody or from the assessment centre. This precludes the person from entering treatment as they do not progress to full assessment and hence their circumstances are not brought to the tribunal for hearing. This lack of re-entry into assessment (health status permitting) represents a gap in the service system.

Health assessment and treatment while in AMT

The assessment and residential treatment records indicate all participants in AMT are screened for alcohol dependence, alcohol related harm, mental health and then for more general health issues via adult health checks. Many also received dental checks (and follow up, when a dentist was available) and follow up for any adverse findings. The data for the AMT participants showed that all had at least one episode of medical or dental care, and most had between four and 10 episodes during the time they were in assessment and treatment.

There are some chronic health conditions that are more prevalent in the Aboriginal community, such as Hepatitis B, kidney disease and diabetes that are compounded by alcohol consumption. For example, NT hospital admissions data shows that 16 of the AMT participants and 14 people from the comparison group had:

- 176 inpatient admissions for alcohol related liver disease (80% cirrhosis, 8% fatty, 12% unspecified ) between 2010 and 2015
- spent a combined total of 855 days in hospital

Many participants with chronic conditions, or multiple risk factors for chronic conditions, are identified and placed on care plans.

While there may have been short term health gains for many participants, some who have chronic conditions may continue to have deteriorating health over time. The age and health of participants prior to entering treatment, and their subsequent access to appropriate medical treatment, affects how much improvement in health can be expected over the long term.

The client interviews for the case studies support the above findings for the AMT participant group. Several case study participants reported that they received care and medications during treatment for long term health conditions, such as asthma and diabetes and others reported that they were satisfied that their medical needs were attended to promptly.

The long term impact of AMT participation on health has not been established. Case study interview participants were asked if they thought their health had improved by attending the program, specifically in relation to medical care for health problems. Of those who responded to this question (only six participants) everyone responded...
positively (i.e. Yes) that their health had improved, noting their involvement in the men’s/women’s health check program as a benefit and indicating they were satisfied with their medical care. The assessment records indicate that all patients receive chronic disease screening and full adult health checks, and their medical records are accessed to ensure previously diagnosed conditions are followed up and medication administered where appropriate.

Figure 9 uses data from Police Protective Custody Apprehensions, the Tribunal Register and Department of Health’s Emergency Departments from 1st July 2013 onwards. There was no significant difference in how soon another ED presentation took place after meeting the AMT trigger, between those who never appeared before the Tribunal, and those who were sent to the Tribunal and received an order. The graph below shows that the representation rates for people who met the AMT trigger but who were not sent to the Tribunal, and those of the AMT cohort group (the AMT Participants and the Comparison Group) look different but this difference was not statistically significant (p=0.17).

The graph below shows that 3-4 months from the AMT trigger, over 50% of those people who were sent to the Tribunal and received a mandatory treatment order had presented to an ED, compared with 45-48% of people who never went to the Tribunal. By 9 months, over 70% of those who received a CTO or an RTO and approximately 60% of those who never went to the Tribunal, but also met the AMT trigger had presented at an ED. Almost all of the people in each of the three groups had presented at an ED within two years after meeting the AMT trigger.

**Figure 9: Days from first trigger to subsequent ED attendance**

![Graph showing days from first trigger to subsequent ED attendance](image)
Figure 10 also uses data from Police Protective Custody Apprehensions, the Tribunal register and Department of Health’s Hospital Inpatient Admissions from 1st July 2013 onwards. The graph shows that the hospital admission rates for people who met the AMT trigger but who were not sent to the Tribunal, and those of the AMT cohort group (the AMT Participants and the Comparison Group) appeared to differ, with higher rates of hospital admission for recipients of a treatment order. This difference was found to be statistically significant (p=0.0015).

Within three months of meeting the AMT trigger, 40% of people who appeared before the Tribunal & received a CTO had been admitted to hospital. Of those who either received an RTO, or who never went to a Tribunal hearing this percentage was slightly lower, with between 25-27% of people being subsequently admitted to hospital within three months after meeting the AMT trigger. However, by six months both CTO and RTO recipients were admitted to hospital at a higher rate than those who met the AMT trigger but never went to a Tribunal hearing, with 55% of people with CTOs and just over 50% of people with RTOs, compared with approximately 35% of people who never went to a Tribunal hearing.

While it cannot be confirmed that AMT participants had greater access to inpatient medical care as a result of treatment, one year after meeting the AMT trigger, around 80% of all AMT participants had been admitted to hospital compared with approximately 65% of people who never went to the Tribunal. After 18 months any difference in the rates of hospital admission between AMT and non-AMT participants was negligible.

**Figure 10: Days from first trigger to subsequent hospital admission**

Source: Department of Corrections, Protective Custody Apprehensions; Department of Attorney-General and Justice, Tribunal Register; Department of Health, Inpatient Admissions
Emergency department presentations

To assess the health impact of AMT on participants, presentations at the Emergency Department (ED) were compared over a five year period for the AMT participant group and the comparison group. This was done because it was hypothesised that ED presentations should decrease for people who have better health and therefore you would expect to see a positive change in the AMT participant group. In the five years prior to commencing an Alcohol Mandatory Treatment (AMT), the AMT participant group presented more frequently to the Emergency Department for alcohol-related causes than the comparison group.

Figure 11 below shows the average number of ED presentations per person per year for the two groups, broken down by category type as recorded by ED staff.

**Figure 11: Annual number of Emergency Department presentations, per person between 1 July 2009 and 30 June 2014**

![Graph showing emergency department presentations per person per year for AMT participants and the comparison group.](image)

Note: AbuP refers to the hospital diagnostic related group “abused person syndrome”. NoD refers to the category “No disease found”, and Alc-rel refers to the category “Alcohol related”.

Source: Department of Health, Emergency Department Presentations

As depicted in the graph, a large number of people presented at the ED but left without being seen by a doctor, with 2594 separate events. Records show this occurring with high frequency for AMT participants. They were also recorded at higher rates in the ED for alcohol related presentations, as they were for trauma, abused person syndrome, no disease found and all other events. In total, the AMT participants presented to the ED on average more than six times per year, per person; almost double the rate of the comparison group.

It is worth noting that trauma presentations to the ED are physical injuries, arising from incidents including domestic violence and assaults, accidents, and mental health issues. In some of these incidents, excessive alcohol use may have been a contributing factor of the situation causing harm. Homelessness has also been included in this category as this has been used by ED staff as a separate category to describe the presenting health problem. The ‘other’ category includes all other non-alcohol or trauma related classifications reported by the ED and may include issues such as chest pains, joint and limb pain and stomach pains. Due to a variety of categorisations used by ED department staff and the fact that some are recorded as symptoms (such as chest pains, stomach pains) rather than a clinical diagnosis, some of those ED presentations categorised as ‘other’ may in fact be partially alcohol-attributable disease.

Most of the case study participants reported that they engaged in violent behaviours, with at least four of the male participants having a legal history of

10,874 presentations to the ED over 5 yrs for 572 people in the AMT participant and comparison group
violence. Four women also reported having a history of being impacted by family or domestic violence.

One case study had a self-inflicted knife wound, and another conveyed their intention to cause self-harm upon entry into AMT. Both the case studies and the emergency department records of the cohort group demonstrate a strong correlation between alcohol misuse and violence, and this is consistent with current research from the Australian Institute of Criminology, which also states that women are more likely to be the victims of family violence if their partner drinks excessively.

**Figure 12: Average number of ED presentation rates pre (before June 2014) and post AMT (after June 2015)**

The average number of ED presentations per person per year for the AMT participants was significantly higher than the comparison group both pre-treatment and post AMT (Figure 12). Instead of participation in mandatory treatment reducing the number of ED presentations as expected, the opposite was found to be true. The participants continued to present at the ED more often than the comparison group. The average number of ED presentations increased post AMT for the AMT participant group, up to an average of four times per person, per year while there was a minor increase in the comparison group, which rose from 1.4 times to 1.6 times per year.

This shows that people are presenting to the ED with more frequency; however, without more detailed information about each event it is difficult to determine whether this demonstrates an overall deterioration in health for the AMT participants or an improvement in accessing ongoing treatment to reduce the risk of alcohol related harm. This group generates a significant workload for the ED, and the workload is not diminished by participation in AMT. The increase in the number of ED presentations may reflect a ‘restored’/increased capacity among AMT participants to make decisions about their alcohol use and personal welfare, but this is speculative.

The case studies highlighted that some people were accessing other health services prior to being admitted to AMT (such as community controlled health services) and reported an intention to continue to access community health services on release. Follow up for some of these showed that this was in fact occurring, but follow up was not possible for others due to the short time that had elapsed post release.

Over 5 yrs 229 of the total cohort of 810 people eligible for AMT presented to ED more than once in a day (1013 presentations)
Hospital admission information

Figure 13 shows that prior to treatment 69% of the comparison group and 84% of the AMT participant group had at least one hospital admission per year in the previous five years.

**Figure 13: Number of hospital admissions per person, per year, by case and control group**

The percentage of people in both the comparison and AMT participant groups who were admitted to hospital decreased in the post treatment period; however, the number of admission events per year increased significantly. This indicates that, for both groups, fewer people were being admitted to hospital, but those who were admitted were being admitted more frequently. Again, without specific data relating to the type of illness or injury that required a hospital admission, it is unclear whether this change represents an improvement, or how much the health of AMT participants has improved as a result of AMT treatment during the selected timeframe.

Deaths of people eligible for or who participated in treatment

A total of 25 people from the total eligible cohort of 810 died during the AMT client outcome evaluation window (1 July 2014 to 30 June 2015) or during the 12 month follow up period to 30 June 2016. The people who died were almost equally represented in the excluded, comparison and AMT participant groups (nine deaths amongst the excluded group and eight in each other group).

Four people died directly from alcohol related causes and at least nine people had alcohol related illness or disease listed as a secondary issue, but not primary cause of death. Of the eight AMT participants, four people had received a CTO, and five people had received a MRTO (one person received both). Some of the AMT participants died within a relatively short time after their treatment period (one to four months) and it is unclear whether for this group of people, the treatment had a positive or detrimental impact on their health.

There has not been information made available relating to the risk management approach applied to the AMT program during or post treatment, and therefore any potential health risks to individuals undergoing treatment orders are unknown. Nor does the data show how many of the AMT participants completed either CTO or MRTOs and whether they had underlying chronic health conditions due to long term alcohol abuse.

Of the 25 deaths for whom there are ages recorded (17), the average age was 40 years, which may suggest that the direct and indirect impacts of alcohol abuse have contributed to an overall life expectancy of the overall AMT eligible cohort group that is significantly lower than the national average.

There were two inquests held after the deaths of people during treatment and another 11 inquests for people who died within the 12 month period after treatment. The findings are varied and detailed, and well documented elsewhere.
Client Outcomes

Cognitive impairment

Cognitive impairment was evident among the case study group and was a factor in people being able to consent to participate in the case studies.

People with cognitive impairment are deemed not suitable for treatment on the basis that they would not benefit from the program, because they don’t have the cognitive skills to engage in the program. A Senior Assessment Clinician noted that, for some clients, they “may not recommend treatment due to cognitive issues but we might recommend guardianship. So even if they don’t go into treatment they may benefit.” A guardianship application will trigger a process of investigation and support for the participant. It is not clear how systematically this is occurring but residential treatment service providers were noted to be taking action to ensure people get guardianship applications. While this is positive and means that the person will have someone who can make decisions on their behalf and advocate with service providers, it may not follow that care to these people will improve as guardians cannot create or make changes to the services provided by others.

The assessment centres do not routinely screen for cognitive impairment but respond to it when it is apparent. Therefore data was not available for consideration in the AMT participant group. Lack of routine screening may be due to the lack of culturally appropriate, validated screening tools; however, the Evaluation Team noted that Royal Darwin Hospital is developing a screening protocol and resources. Unless cognitive impairment can be identified via screening, appropriate therapeutic and other supports to prevent further decline and promote recovery and/or improvement cannot be put in place.

Thiamine supplementation can be used as a preventive measure to address the risk of serious brain damage from thiamine deficiency (known as Wernicke-Korsakoff’s syndrome) that can result from heavy consumption of alcohol over many years, along with poor nutrition. Individual patient records were not reviewed during the evaluation to see if this preventive measure is in use during residential treatment; however, staff interviews confirmed that it was.

4.3 Improvements in social functioning

Improvements in social functioning have been measured by:

- self-reported experiences of treatment and social outcomes by the case study group
- engagement and participation in education and training as a result of treatment for the case study group
- reconnection with family, culture and community during or after treatment for the case study group
- increased engagement with support services as a result of treatment by the case study and AMT participant groups
- applications for housing as a result of AMT for the case study group
- changes in employment, income and living environment as a result of AMT for the case study group
- cultural safety and family connectedness for the case study group
- recovery from trauma for the case study group

The data available to measure these matters was largely drawn from the case studies and the Evaluation Team acknowledge that this was a small sample and that the conclusions may not be applicable to the wider AMT client population. The AMT program cannot currently easily track behaviour change or changes in social functioning over time.

For the case study participants, the evaluation found that improvements in social functioning were evident while people were undergoing treatment, and overall, participation in residential treatment does generally lead to improvements in social functioning. This is evidenced by increasing levels of engagement in treatment over multiple residential treatment orders, increased connectedness to family, greater willingness to engage in finding
Client Outcomes

suitable housing, securing income support or benefits, and most notably people self-reporting that they consider their drinking to be causing them problems, and they may be willing to reduce their drinking.

Case study participants identified the following benefits: sleep, clean clothes, food, medication and learning about the effects of alcohol on the body, feeling better when they left than when they entered, and having more ideas for how to manage or reduce their alcohol use.

Others, most notably Alice Springs participants, commented on boredom, lack of activities and within group tensions and arguments. One participant stated it was “Boring, don’t do anything in rec room. Some activities.... not enough outings, only on Friday” and another commented that “…the worker yells. Cheeky and mean to everyone. They get cheeky to me so I jumped the fence.”

In group tension was described by one participant as “I was being picked on by another patient that I met at [AMT]. She reckoned I was jealousing my partner in the men’s section. She made trouble for me.”

When specifically asked about engagement and participation in the AMT program 50% of the case study participants reported that they were involved, as much as they wanted to be, in decisions about their care and treatment. They reported individual decisions could be made about attending art therapy and music while other programs were compulsory. Others reported that if they wanted to do something, like craft, “someone just made a program and you go.”

During case study client interviews and file note review, it was noted that the treatment services have helped many participants to apply for income support in the form of benefits and pensions, helped them to organise their finances, repay outstanding Centrelink debts, register to provide child support and establish a means for saving money. They are also subject to an Income Management Order that quarantines a specific amount ranging from 50% to 100% of their income to be spent only on food, housing, clothing, education and healthcare. This may contribute to improving their health and social functioning however no conclusive links were found.

Several participants have been supported to continue or begin working. At residential treatment services former and current participants are involved in taking care of the garden and other facilities. People take these roles on as jobs voluntarily, and some participants have returned to work at the centre while they are in transitional housing. This gives them an opportunity to be treated like staff, and develop workplace skills.

Limited improvements in housing stability and some increased income stability were noted for some case study participants; however, the majority of participants either returned to their home communities or to overcrowded houses in town camps or the long grass/homelessness. Some case study participants did transition into public housing (the homes of relatives, not new tenancies). A few had public housing applications in progress after their AMT, and one couple who were able to find secure accommodation were asked to leave within a short space of time, due to the noise and conflict they generated.

The data collected by the AMT program service providers does not allow a definitive assessment in relation to housing stability to be made. The program does not routinely track housing outcomes and hence it was not possible to obtain further information about the wider AMT participant or comparison groups. For example, there is no mechanism for collecting information showing the number of people who were homeless prior to treatment, nor to collect information showing the number who complete treatment and go on to be re-housed in temporary, half way or long term public housing.
The Emergency Department (ED) hospital records indicate whether homelessness is an issue in the diagnosis, but not otherwise. (See ED referral information under Improved Health).

Several of the case study participants reported having some significant traumatic event such as a death in the family, divorce or loss of employment that precipitated or coincided with a significant increase in alcohol consumption or change in drinking patterns. This is consistent with the recognition of the social determinants of health and health inequity. People recounted stories that indicated their living situations were, or became, unstable as a result of these traumatic events.

The greatest contributor to increased social functioning seems to come from the intense effort made by service providers to help participants reconnect with family and non-drinking community members and begin the process of recovery from past traumatic events. This involves resolving outstanding grief, trauma and conflict.

There is a real emphasis on family reconnection, and this was evident through client interviews for the case study participants who were able to return home during or after treatment to participate in funerals, ceremony and the cultural and family life of their community. Assessment and treatment centre staff confirmed this, and one nurse noted that “we focus more on the cultural reconnection than the medical care.” Connecting with family and resolving old conflicts, while resource intensive and requiring facilitation from skilled staff, contributes to increased stability.

4.4 ‘Restored’/increased capacity to make decisions about their alcohol use and personal welfare

‘Restored’/increased capacity to make decisions about their alcohol use and personal welfare was measured by:

- a comparison of protective custody orders issued to people in the comparison group versus to people in the AMT participant group
- absconding rates
- any changes in protective custody apprehensions prior to and post participation in treatment for the same comparison and AMT participant groups
- reports of increased knowledge and awareness of the effects of alcohol and drinking by the case study participants
- self-directed changes as a result of AMT as demonstrated by the case study participants.

The evaluation found that participation in the AMT program has no impact on restoring or increasing capacity to make decisions about alcohol use, as indicated by ongoing apprehension into protective custody. Although the case study participants indicate increased knowledge and awareness of the effects of alcohol and drinking, change is difficult and slow, and the increased knowledge has not changed behaviour to the extent that it results in avoidance of protective custody.

Figure 14 shows the average number of times that the comparison group and AMT participants were apprehended and taken into protective custody per year, over the five years from 1 July 2011 to 30 June 2016.
Figure 14: Protective custody apprehensions for cases and controls, pre and post treatment period

The AMT participant group were apprehended into protective custody at almost double the rate of those in the comparison group on average. Given that multiple protective custody apprehensions within a short timeframe (three times in two months) is a determinant of who enters AMT, higher rates of protective custody apprehensions prior to treatment are to be expected. There was a reduction in the average number of times AMT participants were apprehended into police protective custody after 1 July 2015 (from five times per person per year to four times); however, this is consistent with an overall reduction in protective custody episodes at the time, as demonstrated by the reduction in the average protective custody rates for the comparison group.

It does appear from case studies, and anecdotal evidence from AMT staff members, that involvement in AMT may have some cumulative effect in reducing the frequency of protective custody apprehensions. Some cases studies have shown reduced breath alcohol levels recorded by police in subsequent protective custody apprehensions (from case studies) can be substantiated by this data.

Figure 15 below shows that those that have appeared before the Tribunal show no statistically significant difference in the time elapsed until they are apprehended into protective custody again regardless of whether they have received treatment or not. Appearing before the Tribunal, whether once or multiple times, does not delay the time to subsequent protective custody apprehensions. Almost everyone re-enters protective custody within a year. The red line (those who appeared before the Tribunal and received a Residential Treatment Order) shows that those people continued to be taken into custody within the first 60 to 90 days after their order date, when ostensibly they should have been in treatment. Just over 30% of those receiving a CTO had also been re-apprehended into police protective custody within 30 days, along with half of those who did not appear before the Tribunal.

The graph shows that 35% of those who received a residential treatment order re-entered protective custody within 50 days of receiving the treatment order. Within 6 months, almost 80% of people who met the AMT trigger but did not attend a Tribunal hearing were re-apprehended into police protective custody, compared with 85-90% of AMT participants. Within a year of meeting the AMT trigger, almost all of the people who attended a Tribunal hearing and received a treatment order and those who did not, were re-apprehended into police protective custody.
Most people were taken into police protective custody multiple times in the 12 month period from 1 July 2015 to 30 June 2016 after the evaluation window as demonstrated by Figure 16 below. Only 40 of the 225 AMT participants had no re-apprehensions following the AMT treatment period of evaluation. Just over half of the total participants had more than three protective custody re-apprehensions, 13% (N=29) of people had between 10 and 15 re-apprehensions, and eight people were re-apprehended more than 15 times in this 12 month period. One participant was re-apprehended into police protective custody 34 times.
An analysis of the absconding data from the AMT Tribunal Register indicates that many people abscond from the residential treatment facilities, indicating their ‘capacity to make decisions about their alcohol use and personal welfare’ has not been restored or increased sufficiently. It may also be related to the fact that the person is still in the pre-contemplative stage of change. Among the AMT participants 65 people absconded on 73 different residential treatment orders. This explains why there are so many occasions when people subject to a residential treatment order present at the ED or are apprehended again and taken into protective custody within 30 to 60 days.

Figure 17 below provides results from 233 MRTOs and shows that 91 MRTOs were completed without any absconding during the treatment term; however, the AMT participants absconded at least once during 73 residential treatment orders. As can be seen, people absconded up to four times while serving the one treatment order.
Of the 810 total AMT participants whose data was assessed during the evaluation, 17 people in the cohort study were in residential treatment beyond the 30 June 2016 cut-off. In further investigating this subset of participants it was found that these 17 individuals accounted for 921 separate protective custody apprehensions during this five year period, and they averaged approximately 10 protective custody apprehensions each per year.

Restored or increased capacity to make decisions about their alcohol use and personal welfare can also be evaluated by examining repeat episodes of protective custody. This can be measured by the time that elapses between the release from treatment and the first re-entry into police protective custody. Two of the case study participants received protective custody orders again within four or five days. The average number of days elapsed between completions of AMT and relapse (as indicated by a new protective custody episode), is 32 days, or 41 days if those with no relapse recorded are excluded. The actual number of days can be seen in Table 13 below.

Of the 10 case study participants who relapsed, seven had a second protective custody order and four of them had a third. This indicates they did not achieve an increased capacity to make decisions to reduce their drinking or protect their welfare.

Table 13: Example of case study participant relapses

<table>
<thead>
<tr>
<th>Completed treatment</th>
<th>1st next protective custody date</th>
<th># of days elapsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 September 2016</td>
<td>11 November 2016</td>
<td>52</td>
</tr>
<tr>
<td>5 August 2016</td>
<td>20 August 2016</td>
<td>15</td>
</tr>
<tr>
<td>20 September 2016</td>
<td>26 October 2016</td>
<td>36</td>
</tr>
<tr>
<td>4 October 2016</td>
<td>18 November 2016</td>
<td>45</td>
</tr>
<tr>
<td>27 October 2016</td>
<td>31 October 2016</td>
<td>4</td>
</tr>
<tr>
<td>18 August 2016</td>
<td>15 November 2016</td>
<td>89</td>
</tr>
<tr>
<td>15 March 2016</td>
<td>15 April 2016</td>
<td>31</td>
</tr>
<tr>
<td>7 September 2016</td>
<td>12 September 2016</td>
<td>5</td>
</tr>
<tr>
<td>7 September 2016</td>
<td>29 October 2016</td>
<td>52</td>
</tr>
<tr>
<td>21 July 2016</td>
<td>15 October 2016</td>
<td>86</td>
</tr>
</tbody>
</table>

Source: Case study data from IJIS, treatment and assessment records

Some of the signs of increased capacity to make decisions about their alcohol use and personal welfare that were observed among the case study participants include:

- willingness to proceed into treatment after completing the assessment period
- willingness to engage in activities at the treatment centre, especially after settling in, which can take two to three weeks
- increased openness about their personal circumstances and back stories, and an awareness of how the accumulated grief and trauma have impacted on their drinking decisions and behaviour.

4.5 Improvements in access to ongoing treatment to reduce the risk of alcohol consumption

Improvements in access to ongoing treatment to reduce the risk of alcohol consumption were measured by:

- examining participation and engagement in treatment, aftercare and voluntary treatment
- Identifying any changes in the number of alcohol and other drug service referrals as a result of AMT.
The evaluation found that the program reached those most vulnerable to alcohol related harm, including harm resulting in ED presentations and multiple protective custody apprehensions. However, a significant number of people become eligible for AMT and don’t proceed to treatment. This indicates that not all of the most vulnerable are receiving the opportunity to be assisted by the AMT program.

The Evaluation Team was able to access the tribunal and assessment records for all case study participants, which demonstrate that very few people had ever engaged in any voluntary alcohol treatment prior to receiving a mandatory treatment order. This is confirmed by the AOD service providers, who repeatedly indicated they have never seen a client who has been through mandatory treatment on a voluntary basis prior to their engagement with AMT: they just don’t reach these drinkers. The program increases their access to treatment.

The program cannot demonstrate whether those ordered to undergo mandatory treatment subsequently access voluntary treatment. This would require a linked data collection system across all AOD treatment providers that allow clients to be uniquely identified. However, both the comparison group and the AMT participant group experienced an increase in the average number of AOD referrals, and this may have increased uptake if the referrals were acted on. There is no tracked referral system in place across the sector, so uptake cannot be determined.

People receiving aftercare have asked and planned for ongoing support and therefore the program may improve ongoing access for the minority of all those eligible who go on to receive and complete a residential treatment order.

Seven case study participants had been referred to AOD services, one participant was required to complete a drink driver education course and three others had participated in some form of voluntary alcohol treatment programs prior to AMT. However, none of these three were able to recount any details of the treatment they received outside of mandatory residential treatment or describe any aspect of the treatment they found particularly useful.

Several case study participants had received community treatment orders before they were ordered to undergo residential treatment. They had not complied with the CTO, and subsequently when they were re-apprehended and re-assessed, they received residential treatment orders. However, this was not a random sample, as all had undergone residential treatment.

None of the case study participants indicated that they would voluntarily access ongoing treatment to reduce their alcohol consumption. However, several indicated they had developed some knowledge or skills that would help them reduce their alcohol use or reduce alcohol related harm. Many of the participants said that although they would not have entered treatment voluntarily, once they had completed their assessment period and were ready to see the tribunal, they were willing to consent to treatment. This is not consistent for all participants, as several were clearly struggling with the confinement and wanted to leave.

Although not witnessed in these case studies, interviews with treatment service providers indicate that there are a number of participants who have voluntarily applied to increase the treatment time beyond the 12 weeks over the past 12 months. Several have extended by a month, in both Darwin and Alice Springs, and at least one has asked for an additional three months, bringing their treatment time to six months. The treatment centre staff regularly noted that three months is not long enough for most people to really move from pre-contemplative stage to changing their behaviour significantly.

As noted in the literature 66, change is not viewed as a linear progression through the stages; rather, most clients move through the stages of change in a spiral pattern. While people progress from contemplation to preparation to action to maintenance, most will relapse. Fortunately, most move back to the contemplation stage and into preparation and action.

---

Figure 18: Average number of alcohol and other drug referrals

<table>
<thead>
<tr>
<th>Pre 1 July 2014</th>
<th>Post 30 June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>(192 events/year)</td>
<td>(182 events/year)</td>
</tr>
<tr>
<td>AMT Participants</td>
<td>Comparison Group</td>
</tr>
<tr>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>2.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Note: Referrals can be made by AOD service providers to other agencies or work units within the AD network and also by GPs, health care providers and social service agencies. They can also be made by concerned family members or by the individual themselves.

Source: Department of Health Community Care Information System (CCIS)

Figure 18 shows the average number of AOD referrals per person per year for the AMT participant group and comparison group before July 2014 and after June 2015 as derived from the CCIS data. Both the comparison group and the AMT participant group experienced an increase in the average number of AOD referrals in the 12 months post June 2015; however, the rate of increase is greater for the AMT participants than the comparison group, with double the average number of referrals post the AMT treatment period.

This may indicate a greater capacity to make decisions about their alcohol use in this group of 225 participants for those referrals that were self-referrals. It may show definite improvements in access to ongoing treatment to reduce the risk of alcohol consumption for both groups if the person attended after the referral. Unfortunately information on attendance post referral was not available for analysis.

Most referrals to counselling for both the comparison group and the AMT participants were for assessments of some kind. The data was incomplete; many records did not state the reason for referral. However, where the other reasons have been provided, we can see an increase in accessing some services that indicate there is increased awareness of and engagement with services provided to help reduce the risk of alcohol consumption by people at most risk of alcohol related harm.

There was an increase in the number of AMT participants being referred for counselling, education and training. In the five years prior to the treatment period this averaged three referrals per year, and there were eight referrals in the 12 months after the treatment period. There was also an increase in the number of self-referrals by AMT participants after the AMT treatment period. The CCIS data and the case study interviews confirmed that self-referrals rose from an average of 4.6 (23 people over five years) per year to 11 people per year post evaluation period. The figures for the comparison group also increased, from an average of 4.8 to 13 people per year post AMT evaluation period. While the increase in accessing treatment may indicate benefits for those people having undergone AMT, this shift may be due to external factors.

The stories re-told by many, but not all, participants interviewed for the case studies indicated that although initially they were not motivated to seek treatment, after the assessment period or after a few weeks in treatment they were willing to stay in treatment. Their comments indicate that, if there was some health care provided that benefited them in the short term, they were willing to participate in residential treatment. For example, one participant said he had been drinking heavily because he had a severe toothache. During the assessment period he was seen by a dentist and therefore experienced less pain. He was looking forward to further dental care while undergoing treatment. This was echoed in the interviews exploring aftercare, where participants recounted the relief they felt after having received primary health care and access to medical specialists during treatment. Where there was a tangible benefit to people, it seemed to motivate them to engage in treatment and work with their case manager and stay engaged with aftercare, especially if their case manager was assisting them into affordable housing or with finding work.
5 Cost Effectiveness

Evaluation question:

- Is the service model and its delivery in each location cost effective?

The purpose of this component of the evaluation was initially to determine the cost effectiveness of the AMT program. Following discussion with the Department of Health, the scope of this aspect was changed at the outset of the evaluation due to the lack of an agreed cost benefit analysis model. Significantly more time and resources would have been required to develop the cost benefit analysis model that was allocated for the evaluation. As a result, this section of the report details the general costing of the service, where accurate figures were available, and makes some comparisons to illustrate the cost effectiveness of the program.

Where possible, the establishment costs, and general operating costs of the AMT services are shown for each region. However mostly only budget information was available and assumptions have had to be made about the operating costs based on those figures only. We have made some rudimentary calculations about the cost of an episode of treatment in Mandatory Residential Treatment in Alice Springs and Darwin, in a year when both the number of episodes of treatment, and the financial year data match (2015-16).

Another limitation for this aspect of the evaluation is that the Department of Health was undergoing structural reform over the period of the AMT service implementation. AMT program costs were therefore variously apportioned to different cost codes within the department’s general ledger. This made it difficult to compare costs across years when the services changed from being managed centrally by the single entity of DoH to being funded by DoH being managed by the Top End Health Services and Central Australia Health Services under service delivery agreements.

5.1 Costs of apprehension and referral

The costs of apprehension of people on the street and the costs of keeping people in custody could be argued to be core business for police, and hence be part of the standard operating budgets for NT Police. This evaluation found no indication that AMT resulted in significantly more or fewer apprehensions than might otherwise have occurred had the program not been in place. For example, people who had been through assessment and treatment were still being taken into protective custody again after these services.

At the commencement of the AMT program the NT Police were provided with a one-off establishment amount of $400 000 for equipment. During consultations the police advised there had been additional costs associated with transporting eligible persons to an AMT assessment facility and processing the ID of people brought into protective custody, however the Evaluation Team was not able to determine the indirect costs associated with these processes.

5.2 Cost of AMT assessment

The Department of Health provided the budget allocation amounts for each of the assessment facilities in Darwin, Katherine and Alice Springs. The initial capital and establishment allocations were not identified as separate amounts. In addition, since the Department of Health operated both of the assessment and mandatory residential treatment services in Darwin until March 2015, it was not possible to disaggregate the specific budget allocations for assessment and treatment as they were combined until that time.

Furthermore the Evaluation Team was unable to obtain validated expenditure data for assessment services. Consequently, only budget allocations are provided for financial years 2013-14 and 2014-15; these include both assessment and mandatory residential treatment for Darwin (Table 14).
Table 14: AMT assessment budget allocations 2013-14 to– 2015-16 and average cost of assessment (NTG managed services)

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin – DAATS*</td>
<td>$9,522,050</td>
<td>$3,989,622</td>
<td>$4,319,216</td>
<td>$18,261,043</td>
</tr>
<tr>
<td>Alice Springs - ASAAS</td>
<td>$2,789,023</td>
<td>$2,369,607</td>
<td>$2,977,478</td>
<td>$8,136,109</td>
</tr>
<tr>
<td>Katherine - MARS Unit</td>
<td>$1,336,867</td>
<td>$1,113,818</td>
<td>$948,284</td>
<td>$3,398,970</td>
</tr>
<tr>
<td>Assessment total</td>
<td>$14,078,095</td>
<td>$7,473,047</td>
<td>$8,244,978</td>
<td>$29,796,123</td>
</tr>
<tr>
<td>Number of clients transported for assessment**</td>
<td>546</td>
<td>605</td>
<td>329</td>
<td>1,480</td>
</tr>
<tr>
<td>Average cost per assessment***</td>
<td>$25,784</td>
<td>$12,352</td>
<td>$25,061</td>
<td>$20,132</td>
</tr>
</tbody>
</table>

Notes: The NT Health service budget allocations include capital, personnel and operational allocations.

*The DAAS allocation includes funding for the AMT treatment service until this service was commenced by the Darwin AMT service in March 2015.

**The NT Police data has been used for cost because the number of assessments is not consistently recorded or captured elsewhere. Police data is recorded for a calendar year but will enable an average cost for analysis purposes.

***These average costs are distorted by the amalgamation of the assessment and the treatment service allocations.

The Evaluation Team has attempted to determine an average cost per episode of assessment within AMT. As outlined earlier, an episode of assessment includes the supervision and management of an AMT client’s withdrawal as well as the preparation of the assessment report for the AMT Tribunal. The allocations for the salaries of the SACs and STCs are also included in the budgets for the NT Health assessment centres as these positions are NT Health employees. Consequently all the activities of the SAC and STC would also be included in the episode of assessment cost.

The analysis shows that the average cost varied considerably from $12,352 to $25,784 between 2013-14 and 2015-16. However, due to the budget limitations mentioned above and the lack of reliable numbers of clients admitted to assessment, the Evaluation Team is concerned that these figures may not be accurate reflection of assessment costs. The inclusion of some capital and establishment costs in the first year as well as the changes in the treatment service delivery model from government to non-government in year three, and other potential variable cost items could not be factored into the analysis.

5.3 AMT Tribunal costs

The budget allocations for the AMT Tribunal including funding for advocates, is shown in Table 15. These allocations do not include funding for interpreters. Average costs of tribunal hearings have been calculated using the tribunal budget allocations and tribunal hearing data for the three financial years from 2013-14 to 2015-16. For the purposes of analysis, we assumed that all clients are provided with an advocate for a hearing.

It is estimated that the cost of each hearing has ranged from $1,616 in 2013-14 to $2,461 in 2015-16, and the cost of the hearing process per individual ranged from $2,176 in 2013-14 to $3,375 in 2015-16.
Table 15: AMT Tribunal Budget Allocations 1 July 2013 to 30 June 2016 and estimated cost per hearing and Individual

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tribunal funding</td>
<td>$702 000</td>
<td>$727 000</td>
<td>$727 000</td>
<td>$727 000</td>
</tr>
<tr>
<td>Advocates funding</td>
<td>$1 080</td>
<td>$248 183</td>
<td>$417 286</td>
<td>N/A</td>
</tr>
<tr>
<td>No. of hearings</td>
<td>435</td>
<td>479</td>
<td>465</td>
<td>N/A</td>
</tr>
<tr>
<td>Cost per hearing</td>
<td>$1 616</td>
<td>$2 036</td>
<td>$2 461</td>
<td>N/A</td>
</tr>
<tr>
<td>No. of individuals</td>
<td>323</td>
<td>338</td>
<td>339</td>
<td>N/A</td>
</tr>
<tr>
<td>Cost per person</td>
<td>$2 176</td>
<td>$2 885</td>
<td>$3 375</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: Hearing numbers are not complete for 2016-17.
Source: AMT Tribunal Annual Report and Register; Department of Health

5.4 AMT Community Visitor Program costs

The same process was followed to record the budget allocations for the CVP (Table 16) and to estimate a cost per visit for Community Visitors. There are significant limitations to this estimate also, as it does not allow for fixed, variable and administrative costs. Additionally the CVP did not begin visiting services until December 2013, which may explain the lower number of visits in 2013-14; however, it is likely the higher funding in year 1 was in recognition of first year establishment costs such as recruitment and training.

Table 16: CVP budget allocations 1 July 2013 to 30 June 2017 and estimated cost per visit

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVP</td>
<td>$580 000</td>
<td>$480 000</td>
<td>$480 000</td>
<td>$480 000</td>
</tr>
<tr>
<td>Visits</td>
<td>128</td>
<td>240</td>
<td>217</td>
<td>N/A</td>
</tr>
<tr>
<td>Cost per Visit</td>
<td>$4 531</td>
<td>$2 000</td>
<td>$2 212</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: Numbers of hearings are not complete for 2016-17.
Source: CVP Annual Reports; Department of Health

5.5 Cost of mandatory residential treatment

A complete picture of the establishment costs for mandatory residential treatment in Darwin could not be obtained because the Department of Health provided both assessment and treatment services in Darwin until March 2015. The budget allocation figures provided to the Evaluation Team included personnel, operational and capital costs and were recorded across multiple cost centres in the first two years of the program.

Establishment and capital funding was provided to the non-government mandatory residential treatment service providers and this is shown in Table 17.

Table 18 shows the grant funding provided to the non-government mandatory residential treatment providers. Note that these are funded amounts only and do not reflect the actual expenditure of the services.
Table 17: Mandatory residential treatment establishment and capital funding 2013-14 to 2016-17

<table>
<thead>
<tr>
<th>Program</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>Sub-total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$999 546</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$999 546</td>
</tr>
<tr>
<td>Alice Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital works</td>
<td>$1 871 000</td>
<td></td>
<td></td>
<td></td>
<td>$1 787,000</td>
</tr>
<tr>
<td>Final payment capital works</td>
<td>$182 273</td>
<td></td>
<td></td>
<td></td>
<td>$182,273</td>
</tr>
<tr>
<td>Scope of works cost</td>
<td>$53,932</td>
<td></td>
<td></td>
<td></td>
<td>$53,932</td>
</tr>
<tr>
<td>Fence</td>
<td>$16 090</td>
<td></td>
<td></td>
<td></td>
<td>$16,090</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2 039 295</td>
</tr>
</tbody>
</table>

Mandatory residential treatment establishment and capital costs total $3 038 841

Source: Department of Health

Table 18: Mandatory residential treatment non-government grant funding 2013-14 to 2016-17

<table>
<thead>
<tr>
<th>Program</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>Sub-total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMT Residential Rehab</td>
<td>$1 787 000</td>
<td>$1 992 750</td>
<td>$2 169 920</td>
<td>$2 169 929</td>
<td>$5 712 820</td>
</tr>
<tr>
<td>AMT In reach</td>
<td>$205 750</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$205 750</td>
</tr>
<tr>
<td>AMT Care &amp; Outreach</td>
<td>$69 225</td>
<td>0</td>
<td>0</td>
<td></td>
<td>$69 222</td>
</tr>
<tr>
<td>AMT case advance</td>
<td>0</td>
<td>$500 000</td>
<td>0</td>
<td>0</td>
<td>$500 000</td>
</tr>
<tr>
<td></td>
<td>$2 061 975</td>
<td>$2 429 750</td>
<td>$1 550 141</td>
<td>$2 169 929</td>
<td>$8 211 795</td>
</tr>
<tr>
<td>Alice Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMT Residential Rehab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12 312 837</td>
</tr>
<tr>
<td>AMT In reach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$205 750</td>
</tr>
<tr>
<td>AMT Care &amp; Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$69 222</td>
</tr>
<tr>
<td>AMT case advance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$500 000</td>
</tr>
<tr>
<td></td>
<td>$2 061 975</td>
<td>$2 429 750</td>
<td>$1 550 141</td>
<td>$2 169 929</td>
<td>$8 211 795</td>
</tr>
<tr>
<td>Alice Springs sub-total</td>
<td>$6 487 795</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mandatory residential treatment non-government grant funding total $18 800 632

Notes: The Darwin mandatory residential treatment service were contracted to deliver mandatory residential treatment in Darwin in March 2015, therefore there is no funding amount in 2013-14, and the funding for 2014-15 was for the period from 23 March 2015 to 30 June 2015.

The Alice Springs mandatory residential treatment services have been contracted to deliver mandatory residential treatment since the program began in July 2013.

Source: Department of Health

The Evaluation Team has calculated an estimated cost per episode of mandatory residential treatment based on the funding amounts for the two treatment services, and the number of opened episodes of treatment for 2015-16 provided in the Alcohol and Other Drugs National Minimum Data Set (Table 7). The analysis shows that there is a significant difference in the funding per open episode of treatment between Darwin and Alice Springs, with the costs being $41 239 and $28 706 respectively (Table 19). The average cost of a closed episode of completed treatment in Darwin was $60 306 compared to Alice Springs where the average cost was lower at $50 004.
Again, the Evaluation Team is cautious about the use of these estimates as they do not represent actual expenditure. Additionally, the full cost for an episode of treatment would also include the cost for the following services whose costs have not been available in this evaluation at a regional level:

- interpreter support from the Aboriginal Interpreter Service
- Community Visitor visits
- advocate support for tribunal hearings
- the tribunal hearing, including tribunal members, registrar and administrative costs.

### 5.6 Costs of AMT community treatment

Most community treatment providers receive general AOD grant funding from the Department of Health to provide a range of community residential and other treatment programs in regional centres across the NT. For the purposes of comparison a sample of four community treatment providers was selected and their grant funding amounts combined as a basis of determining the costs of community residential treatment. This sample received a total of $3,084,559 in grant funding in 2015-16.

In addition non-government providers in two locations received specific AMT funding as detailed in Table 20 below.

#### Table 20: AMT community treatment grant funding 2013-14 to 2016-17

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>$250,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Katherine</td>
<td>$320,000</td>
<td>0</td>
<td>$220,000</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health Grant Funding Agreements
5.7 Costs of aftercare

The first aftercare specific funding was provided to the Alice Springs aftercare service provider in July 2014. The Darwin aftercare service received funding in September 2014. The funded amounts are shown below in Table 21. Reliable data about the numbers of clients who received and followed through with an aftercare plan is unavailable, so it is not possible to calculate the cost of aftercare per person.

Table 21: AMT NGO aftercare grant funding

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>0</td>
<td>$497 153</td>
<td>$722 153</td>
<td>$462 960</td>
<td>$1 682 266.</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>0</td>
<td>0</td>
<td>$300 000</td>
<td>$308 640</td>
<td>$608 640</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2 290 906</td>
</tr>
</tbody>
</table>

Source: Department of Health Grant Funding Agreements

5.8 Regional comparisons

It has only been possible to compare the average cost of an episode of assessment in each region and of the average cost of an episode of mandatory residential treatment in Darwin and Alice Springs for the 2015-16 financial year. This is the only year in which the budget allocations for Darwin assessment and treatment services are separated, and hence when a more reliable cost breakdown is possible. However, the same caveats need to put on these average costs as a result of the validity of the financial data available to the Evaluation Team.

The average cost of an episode of assessment has been calculated using NT Police records for the number of people transported to assessment, as this was the only data set that showed the location where clients were transported. Noting the limitations on this data described elsewhere in this report the comparison has been done using half year budget allocations.

This analysis shows that the average costs of an episode of assessment vary by as much as 43% from $11 307 in Darwin to $26 341 in Katherine (Table 22).

Table 22: Regional comparison of the average costs of withdrawal and assessment for half year 2015-16 (NTG managed services)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of people transported for assessment (1 January to 10 July 2015)</th>
<th>Half year budget allocation 2015-16</th>
<th>Average cost per episode of withdrawal and assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>191</td>
<td>$2 159 608</td>
<td>$11 307</td>
</tr>
<tr>
<td>Katherine</td>
<td>18</td>
<td>$474 142</td>
<td>$26 341</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>120</td>
<td>$1 488 739</td>
<td>$12 406</td>
</tr>
</tbody>
</table>

Source: NT Police Protective Custody records and Department of Health Budget Allocations.

The Evaluation Team notes that, regardless of admission numbers, AMT assessment centres are required to be open to accept admissions and hence there are minimum non-variable staffing and overhead costs. A detailed breakdown of variable and non-variable costs was not possible for comparison.

The average cost for an episode of mandatory residential treatment (shown in Table 18 above) was $41 239 in Darwin compared to $28 706 in Alice Springs. Again the Evaluation Team noted that the two AMT treatment
services received budget allocations to provide a certain number of treatment beds, and not on the basis of actual admission data.

5.9 Comparison of community and mandatory residential treatment

In order to assess the cost effectiveness of the AMT program, the Evaluation Team has attempted to compare the costs of an episode of mandatory residential treatment with an episode of community residential treatment. In addition to the AMT financial data, the team used the grant funding allocations for the community residential treatment services and the AOD National Minimum Data Set for episodes of treatment to calculate the episode of treatment costs.

Table 23 shows that the indicative and approximate cost estimates of residential treatment episodes are significantly higher for the mandatory residential treatment services compared to the community residential services. The average length of stay of closed episodes of treatment completed in both types of services was comparable between the service types. The average cost of an open episode of treatment in the community residential treatment services was $8,36 which was 22% of the average cost in mandatory residential treatment at $37,677. The average cost of a closed episode of completed treatment in the community residential treatment services was $17,830 which was 31% of the average cost in mandatory residential treatment at $57,731.

Table 23: Comparison of the cost per episode of treatment in mandatory residential treatment and community residential treatment 2015-16

<table>
<thead>
<tr>
<th>Cost per episode of treatment in 2015-16</th>
<th>Community residential treatment</th>
<th>Mandatory residential treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO residential treatment grants*</td>
<td>$3,084,559</td>
<td>$7,158,657</td>
</tr>
<tr>
<td>Number of opened treatment episodes</td>
<td>370</td>
<td>190</td>
</tr>
<tr>
<td>Average cost per opened treatment episode</td>
<td>$8,336</td>
<td>$37,677</td>
</tr>
<tr>
<td>Number of closed episodes where treatment completed**</td>
<td>173</td>
<td>124</td>
</tr>
<tr>
<td>Average cost per closed episode where treatment completed</td>
<td>$17,830</td>
<td>$57,731</td>
</tr>
</tbody>
</table>

Note:
*The community residential treatment grant amount was the sum of grants provided to four non-government organisations that provide residential treatment services. This was existing funding not provided specifically as part of the AMT program. Some providers’ funding also includes non-residential treatment activities such as case management, day activities and aftercare. The services do not differentiate between treatment for alcohol or drug misuse.

**The community residential treatment services provide treatment to AMT and non AMT clients. Mandatory residential treatment services only provide residential treatment to AMT clients.

Source: Alcohol and Other Drugs National Minimum Data Set; Department of Health AOD Grant Agreements and Service Plans

5.10 Summary of effectiveness

The Evaluation Team’s assessment of cost effectiveness was limited by the availability of budget and expenditure data. For example, only allocated funding amounts for government and non-government service providers was available, whereas actual expenditure amounts would have provided a more accurate costing picture and assisted in estimating the cost per episode of treatment.

In addition, the team was not able to assess the indirect costs for other services. Earlier access to data might have enabled us to consult with other service providers and potentially obtain indirect costs. However, we received that
data relatively late in the course of the evaluation and time did not permit this. For example, data about the number of Emergency Department (ED) presentations would have enabled us to consult with the ED about the indirect costs of ED presentations.

Taking these limitations into account, the team has attempted to determine the cost of the AMT program for the most recent 2015-16 year taking into account all the budget and client data that has been available during this evaluation.

As Table 24 shows, the total allocation of funding for AMT program specific services in 2015-16 was $18,277,362 to deliver services to around 339 individual clients across the NT. This resulted in an average cost per client of around $53,915.

### Table 24: Budget allocation for all AMT services in 2015-16

<table>
<thead>
<tr>
<th>Budget allocation or cost component by service type and management</th>
<th>2015-16 allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin – DAATS (NTG)</td>
<td>$4,319,216</td>
</tr>
<tr>
<td>Alice Springs – ASAAS (NTG)</td>
<td>$2,977,478</td>
</tr>
<tr>
<td>Katherine – MARS (NTG)</td>
<td>$948,284</td>
</tr>
<tr>
<td>Darwin Mandatory Residential Treatment Service (NGO)</td>
<td>$5,216,016</td>
</tr>
<tr>
<td>Alice Springs Mandatory Residential Treatment Service (NGO)</td>
<td>$2,169,929</td>
</tr>
<tr>
<td>AMT Tribunal</td>
<td>$727,000</td>
</tr>
<tr>
<td>Advocates</td>
<td>$417,286</td>
</tr>
<tr>
<td>Community Visitor Program</td>
<td>$480,000</td>
</tr>
<tr>
<td>Darwin AMT aftercare service (NGO)</td>
<td>$722,153</td>
</tr>
<tr>
<td>Alice Springs AMT aftercare service (NGO)</td>
<td>$300,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$18,277,362</strong></td>
</tr>
<tr>
<td>Number of clients who received an AMT assessment*</td>
<td>329 (half year)</td>
</tr>
<tr>
<td>Number of clients who received an AMT Tribunal hearing</td>
<td>339</td>
</tr>
<tr>
<td>Number of open mandatory residential treatment episodes</td>
<td>190</td>
</tr>
<tr>
<td><strong>Average cost per client</strong></td>
<td><strong>$53,915</strong></td>
</tr>
</tbody>
</table>

Notes:
*The actual number of assessments completed cannot be accurately counted and so the NT Police records for the number of people transporting to assessment centre was used. However, this is a calendar year figure from 1 January to 10 July.

**The total number of clients has been assumed to be 339 for the purposes of analysis.

When considering the findings from the client outcomes section which showed that there had been no discernible decrease in ED presentations or hospital admissions for people who had been through mandatory treatment, and that many of the people had received more than one episode of mandatory treatment in that period, this cost per client seems high. Also since the evaluation found that some clients only receive an assessment and are then released, while others may have multiple assessments and periods of the mandatory residential treatment in the year, the average client’s costs will actually vary markedly.
6 Summary of findings and recommendations

This summary draws together findings from the various components of the evaluation as they pertain to the five evaluation questions in addition to the findings related to the whole AMT program and service system. These findings and issues have informed recommendations that the Evaluation Team believes could be implemented to enhance the provision of services and improve outcomes for the vulnerable people for whom the AMT program was developed.

6.1 AMT program and service system findings

The AMT program was implemented and rolled out over a short timeframe, without the benefit of having a similar program to inform the planning process, without comprehensive data about the specific needs of the potential client group and the risk factors that influence their alcohol consumption at levels that would cause them to meet the AMT trigger, and without a defined theory of change or program logic to underpin the system and guide the development of policies, procedures, and systems, along with determining effective data collection for performance evaluation.

The AMT Bill was drafted, released for public consultation and passed, and the services required to operate the program were established all within about a six month period. The Evaluation Team recognises that this was an immense challenge for NT Government staff and external service providers and that the AMT program and service system has evolved continuously as agency staff and service providers strive to improve AMT services for optimal client outcomes.

There was little time or opportunity for the various agencies involved in AMT to work through the process from end to end resulting in differing emphasis and understanding of how it would operate. The legislation largely determined the activities NT Police must undertake while the person is in protective custody, the timeframes to undertake withdrawal and health assessment activities at the assessment centres and the processes related to ensuring the person’s AMT Tribunal hearing was fair and just. Yet for a range of logistical, operational and client related reasons the number of people who were eligible for AMT and who ultimately received treatment was fewer than the number of those who did not receive treatment.

While the AMT client group is highly visible due to their frequent contact with police and acute health agencies, the specific needs of the client group are not well documented. The homeless status of all the individuals who entered into the AMT through the justice system is not known. Nor has the Evaluation Team been able to confirm with certainty how many of those eligible were victims of family violence, trauma, and other causal or risk factors that may determine their ability to succeed in making long-term lifestyle changes post AMT treatment, or that may be significant factors in the volume and frequency of alcohol consumption. However, both the qualitative and quantitative data gathered in this evaluation indicate that the AMT group are people who face or have faced many challenging circumstances in their lives.

It is also worth noting here that, while there have been changes to AMT so emergency doctors and other health professionals can make referrals, the entry into the program is still most likely to be through the justice system by the three times in two months protective custody trigger. In consultations with service providers, it became evident that, despite the wording of the AMT Act, there was still a lack of clarity among those delivering the services, about whether the AMT program was purely a health intervention or a punitive approach to problem drinking.

It is therefore unknown how many people in the NT would be eligible for AMT, or assessed for alcohol related harm treatment options if entry pathways were made available through the healthcare system as well as other community care pathways. With the alcohol consumption in the NT being the highest in Australia, it could be argued that the AMT program has failed to reach a significant proportion of the population who may benefit from accessing assessment and treatment services. By using a very selective criteria (the AMT trigger) that targets only the relatively small number of people, investment in addressing alcohol related harm may be too narrowly focused and potentially less cost effective than if program design was based on addressing identified risk factors and had a significant prevention and early intervention approach.
Taking a whole of government and cross-sector approach in any future system will be critical. The AMT system has predominantly involved the justice and health departments, yet the needs of the clients mean that agencies such as Centrelink, housing, and other social services have or should have been engaged. Achieving sustainable change for people requires collaboration and coordination of activities between government service providers and the community-based treatment and wraparound support agencies.

While there are philosophically different approaches to addressing alcohol related harm, and this can impede the development of an effective cross-sector approach, a robust program logic can inform a workable planning, implementation and reporting framework for the range of community-based services, government funded AOD and social service providers, and engage communities and families.

**Recommendation 1:** Develop a program logic model at the outset of any future initiatives to ensure that systems and resources are in place so people who enter the system have the highest likelihood of proceeding to the treatment phase and the program can achieve optimal outcomes for vulnerable and hard to reach people.

**Recommendation 2:** Engage with social service providers in the community, current AOD clients, their families, and other key stakeholders to assess the current demand for services, identify service gaps and develop cross-sector capacity to deliver a range of appropriate programs and services for people based on the needs of NT communities, families and individuals.

**Recommendation 3:** Invest in culturally appropriate alcohol related harm prevention and early intervention programs that are developed in consultation with local stakeholders and delivered in NT communities for young people, and other high-risk groups with high alcohol consumption.

**Recommendation 4:** Strengthen cross-agency and cross-sector communication and networking processes in each region to enhance understanding of the local service system and encourage collaboration and partnership across services and sectors.

**Recommendation 5:** Invest in cross-sector outreach services to homeless people in the major centres, supported by medical practitioners, assessment clinicians, case managers, police, housing and justice workers, supported by accommodation options that are more flexible and have access to wraparound services.

### 6.2 To what extent are the aims of the AMT being achieved for the client group?

The combined data from de-identified client data, client interviews and stakeholder consultations has revealed that the AMT service system has reached a large number of the most vulnerable, homeless drinkers with high levels of antisocial behaviour and alcohol related health concerns.

Over the period of the evaluation the AMT participant and comparison groups who had met the trigger for AMT in 2014-15, and were then followed for up to 12 months post their contact with AMT, generated a vast number of protective custody orders, which indicated that they did not have the capacity to make sound decisions about their alcohol use and personal welfare. They also presented regularly to Emergency Departments (EDs). This indicated that they have poor health and experience other traumas and issues that require urgent medical attention, yet they often left the ED before having been seen by a doctor, sometimes only to return within 72 hours.

The evaluation found that 810 people had met the trigger for AMT in 2014-15, but only 301 people received a treatment order of some form, and 190 of those had at least one episode of mandatory residential treatment. The individuals who received a treatment order were almost all Indigenous and equally male and female. In general, the clients reached by the AMT are not reached by the usual alcohol services and do not present for treatment voluntarily. Case studies with this client group showed that AMT participants often present with multiple issues that compound to affect their ability to access the usual alcohol services. The issues include chronic health conditions, mental health issues and cognitive impairments. For example, many of the case study participants recalled that their personal experiences of violence, conflict, grief and trauma were directly linked to why their consumption of alcohol increased dramatically or why they began to drink. Others discussed the influence of friends and family in whether they were abstaining from alcohol or drinking to excess, and other factors such as homelessness, or being ‘in town’ but without somewhere to stay were themes that arose during the case study participant interviews.

Analysis of the findings revealed that not all individuals follow through and commence their community treatment orders, have variable completion rates in both community residential and mandatory residential treatment, often abscond from mandatory residential treatment services, and are often apprehended and taken...
Summary of findings and recommendations

into police protective custody—sometimes only days and weeks after leaving treatment. They are then reassessed and are likely to have more than one treatment order made by the AMT Tribunal.

The case studies showed that, when someone does undergo withdrawal and assessment and complete residential treatment orders, they benefit at least in the short term from the improved living conditions, nourishment and care provided. The adult health checks, screening and follow up, and dental care provided had short term health benefits that could result in longer term improvements. The role of medical staff and a qualified SAC was found to be critical to the safe withdrawal process and the completion of comprehensive assessments to guide treatment planning.

It is not clear from the data examined in the evaluation whether or to what extent the short term health and wellbeing improvements will be sustained over time. It does seem, however, that very few people accrue long term benefits from just one episode of residential treatment.

The chronic nature of the drinking and associated health problems identified among those eligible for AMT indicate that people are likely to need multiple and ongoing treatment and care in order to receive sustained benefit. The data from the case study participants and the cohort study suggest that participation in residential treatment may achieve sustained behaviour change if the participant is exposed long enough and often enough. As the program currently operates, the data indicates that the client doesn't get enough exposure to treatment for it to achieve sustained positive results. It should be expected that long term chronic risky alcohol consumption will require a service system that retains people in the system. The service system should expect people to 'fail forward'—that is, they should be retained in the system, once reached, and expected to undergo relapse as part of the behaviour change process and to learn from each attempt at changing behaviour. This recognised process of behaviour change should be accounted for in a long term service model.

However, notwithstanding the improvements noted for some participants, the evaluation found that the AMT program could be better targeted and focused. Although the most vulnerable chronic drinkers are reached by NT Police, they don’t penetrate the system far enough to participate in or complete treatment or they fail to engage in treatment sufficiently to receive any beneficial effect. Therefore the aims of the program are not achieved for them.

The evaluation found there are multiple reasons for people ‘leaking out’ of the system before reaching the treatment phase. These include police not being able to positively identify people, the person having mental health or other acute health issues that need to be addressed, people having outstanding warrants, assessment beds not being available, the time for assessment taking longer than allowable under the legislation, or the person absconding from assessment. All result in people not reaching the point where an assessment has been completed and a treatment plan prepared. Given the effort and expense involved in reaching the client group, to have the majority (77%) not proceed into treatment is problematic. The workload for NT Police and the acute care sector alone is heavily impacted by this group, and even limited change that reduced the numbers of antisocial drinkers or numbers of events they generate would have a significant impact on workload and wellbeing.

Lastly the evaluation found that the AMT program does not address the underlying social and cultural determinants of risky alcohol consumption. The current treatment models and period of three months is not long enough to address contributing factors such as housing stress, deep trauma and cognitive impairment.

**Recommendation 6:** Ensure comprehensive clinical assessment services are available to people engaging in chronic, long-term harmful alcohol use to inform treatment planning, assess cognitive capacity and identify health and safety risks.

**Recommendation 7:** Ensure safe withdrawal facilities are available in all major centres, operating with clear primary health care policies and procedures and skilled clinicians identifying and managing the health risks of clients with harmful alcohol use.

**Recommendation 8:** Implement a comprehensive, client-centred and health-focused risk management approach to working with people engaging in chronic, long-term harmful alcohol use so that immediate and longer-term health risks can be identified, addressed and/or managed.

**Recommendation 9:** Develop an integrated Client Management System to record all demographic and health related data, along with risk factors for all individuals in any future alcohol assessment and treatment system. Such a system should include documentation of ongoing case management and tracking of the client’s progress as they engage with wraparound service providers and treatment will build an evidence base for program-effectiveness, support a cross-agency approach and help to ensure that funding is directed into programs and services that deliver optimum outcomes.

Evaluation of the Alcohol Mandatory Treatment Program
PwC’s Indigenous Consulting

72
Summary of findings and recommendations

**Recommendation 10**: Review reporting requirements for all non-government community treatment providers, and wraparound aftercare services so that compliance with treatment orders can be monitored, and client outcomes recorded.

**Recommendation 11**: Develop future initiatives and programs based on a longitudinal model of care that includes processes that allow people to enter and exit the program multiple times, and to learn from each attempt at changing behaviour, supported by a case management or care coordination approach throughout the various episodes of treatment and aftercare.

### 6.3 What is the relationship between a client’s engagement in the program and identified outcomes?

AMT participants are disproportionately Indigenous (97% of AMT participants compared to 30% of the NT population) and the case studies showed that most speak several Indigenous languages. The ability for clients to engage fully in treatment can also be impacted by the extent to which they feel culturally safe and able to participate in discussion and programs. The literature review for the evaluation showed that culturally appropriate solutions that reflect local cultural norms, practices and sensitivities are more likely to be effective when treating alcohol addictions. Accordingly the National Indigenous Drug and Alcohol Committee (NIDAC) treatment guidelines recommend culturally specific interventions that:

- provide teachings on how to attain and maintain connection with creation
- are grounded in an understanding of historical factors, including traditional life, colonisation and its ongoing effects
- utilise Aboriginal family systems approach to care, control and responsibility
- support traditional ways of learning
- use a strengths-based approach
- include traditional medicines, bush tucker, healers and elders
- use approaches such as ‘out bush’ and ‘returning to country’ which recognise the healing effects of the land.

The AMT evaluation found that many of these principles do underpin the way the AMT assessment and residential treatment services operate. Through the case studies, many clients stated that their families and homes were in remote communities, despite them living in the major towns at the time they were being taken into protective custodies. The case study participants reported positively about some of the activities implemented by the treatment services to make the programs and facilities culturally relevant, but most talked about not really understanding what was happening to them, not understanding the tribunal process and wanting to leave the treatment facilities to get home to their families.

Service providers and the Community Visitors reported that interpreters did assist with client understanding and that, although use of Aboriginal interpreters was increasingly prioritised particularly at the assessment and tribunal stages of the AMT process, there were difficulties with timely access to interpreters at times. While many AMT services already employ Indigenous staff and all recognise the value of doing this, they reported difficulty recruiting enough Indigenous staff with AOD skills.

The Evaluation Team believes that any assessment and treatment services in a future program would need to operate according to the NIDAC guidelines, building on and learning from the experiences of the AMT services and other community controlled health programs and services.

The evaluation found that there were a number of other factors that impacted clients’ ability to fully engage with the AMT program. Among them was cognitive impairment. Although the Evaluation Team was unable to compare the cognitive capacity of the AMT participants and comparison group as this data is not routinely or consistently collected and recorded, the case studies and stakeholder interviews highlighted the importance of this issue and the impact it may have on a client’s ability to participate fully in the assessment process and the tribunal hearing, and to maximise the opportunities afforded by treatment. The case study consent process found some people were not able to give consent due to cognitive impairment issues. Service providers and other stakeholders also expressed concern about the cognitive capacities of the client group and of the challenges with obtaining appropriate and timely assessments.

The case studies also confirmed service provider perceptions that AMT clients who were able to reconnect with family, especially non-drinking family members, experienced positive outcomes such as return to communities
and stopping drinking, as well as being motivated to change and complete treatment so they can return home. Case study participants and service providers talked positively about Return to Country programs that enable people to be assisted to return home, as well as connecting with community based services and supports to sustain non-drinking behaviour and address the factors that draw people back to town. However, the service providers were also aware that for many people, the changes in drinking patterns and associated improvements in health and social functioning, are not always sustained, and that some people return to town to binge drinking, often in cyclical patterns. The AMT participant data and case study stories supported this finding and hence the need to find ways to enable people to participate in multiple treatment episodes over time, as well as to reconnect with family and/or return home to communities as quickly as possible after engagement in a program.

For those who participate in multiple episodes of residential treatment, the benefits appear to start to accumulate. Participants can be seen to move slowly from a pre-contemplative phase to considering the need for behaviour change and active engagement in planning to reduce risky levels of alcohol consumptions in the future. The protective custody recidivism rates in the limited follow-up period (up to 12 months for some) indicate that the majority are unable to carry this out without relapse.

This change from a pre-contemplative stage is not well captured or reflected in the data system, but is evident when examining multiple assessment records for a repeat participant over time. There is evidence that some people reduce their risky alcohol consumption by drinking less, or less often, or by returning home to dry communities or family groups, at least for a period of time. However, the data collection methods are not yet robust enough to enable those involved in working with these individuals to monitor and see improvements over time, and across the various services within the system of care.

The service system should therefore allow for periods of restricted detainment for assessment as well as more voluntary, non-residential, possibly incentivised treatment to improve the impact on the client group.

**Recommendation 12:** Engage and consult with Aboriginal and Torres Strait Islander people and their communities regarding the development of any future programs, as well as ensuring involvement in the leadership and operation of services, and engagement in the monitoring and evaluation of any programs and services.

**Recommendation 13:** Develop best practice protocols that draw on effective mainstream treatment programs that have an established evidence base of what works, and tailor for Aboriginal and Torres Strait Islander people with the support of community and representative organisations, as part of a planned, integrated set of treatment options recommended by the NT Government for use by service providers including non-government funded programs.

**Recommendation 14:** Engage the Aboriginal Interpreter Service to translate educational material for use by treatment programs and discuss how they can further assist with the effectiveness of group treatment sessions.

**Recommendation 15:** Continue to invest in building a culturally competent AOD workforce and increasing the number of AOD trained Aboriginal people across the NT available to work in AOD prevention, early intervention and treatment services.

**Recommendation 16:** Ensure that any future service system is be equipped to deal with people with severe cognitive impairment and have options available for people who may not be able to effectively engage with and benefit from treatment programs.

**Recommendation 17:** Develop the capacity for future assessment and treatment services to facilitate reconnection with non-drinking family members to allow family members to be engaged in aftercare planning, and for clients to be assisted to return home to communities and be connected to local support services.

**Recommendation 18:** Provide clients in treatment with pathways to appropriate support networks within their communities where they can continue to be supported to access ongoing treatments to reduce alcohol related harm.

**Recommendation 19:** During treatment, involve clients in developing their own alcohol related harm reduction and aftercare plan with their case manager so that it is most relevant to their needs so they are willing to engage fully in a treatment option likely to provide them the most benefit in reducing alcohol related harm.
6.4 How does each service model operate?

Section 3 provided a detailed summary of how the AMT service system operates in Darwin, Katherine and Alice Springs. The analysis showed that the program involves a mix of services operated by non-government service providers as well and government agencies and statutory authorities, all working as one system of care and support.

In general the evaluation found that the overall roles and responsibilities of the different services were consistent across the NT regions, even though there were slight differences in the way services operate day to day and service capacity varied from region to region. The roles of the Northern Territory (NT) wide system functions such as the AMT Tribunal, advocates, interpreters and Community Visitors were also consistent across regions.

The evaluation found that the NT Police frontline responses to people who are intoxicated in public places, which are usually individual decisions based on the presenting issues at the time, largely determines who comes into protective custody, and hence who becomes eligible to meet the AMT trigger. Once in protective custody, the procedures police used to determine a person’s identity, engage the nurse for a health assessment, undertake risk assessments etc, were all fairly consistent across regions and locations.

Similarly, once people were transported to the assessment centres, the activities and operations of the centres were found to be very similar and following a common model. This is most likely because they have continued to operate under a single set of policies and procedures for an NT wide approach, despite the Department of Health undergoing structural change since the AMT program began and the assessment services now being managed by the CAHS and TEHS.

The service provider interviews and stakeholder consultations found there were differences in the way the mandatory residential treatment services deliver their treatment programs to AMT clients, with each provider having developed its own program model over time in response to the needs of its own client groups. Both services employ staff with qualifications in AOD service delivery, and both have a strong focus on the professional development of their teams. Although the evaluation found there was no AMT treatment model prescribed in NT policy, there was also no relevant and evaluated mandatory residential treatment model in the national and international literature. Consequently, the development of tailored approaches over time has been appropriate; however, there is an opportunity to review all treatment services to develop and articulate future treatment models for use in the NT.

The roles of the Senior Assessment Clinician (SAC) and Senior Treatment Clinician (STC) were found to be critical to the delivery of comprehensive assessments, as well as to the coordination of care across assessment and treatment centres, and to the treatment and aftercare planning for clients. The employment of qualified clinicians in these roles was reported to have been essential to a holistic and multidisciplinary approach. However, stakeholders were concerned about the ability to recruit and retain staff in these roles at times, and the effect on system operations when these roles are not filled. The evaluation found there remains some confusion about the responsibilities of these two roles in relation to the external treatment service providers.

Recommendation 20: Review the community residential treatment service sector to inform decisions about models of care, location and bed capacity required in future so the range of treatment services is matched to demand and the needs of the largely long term chronically homeless Aboriginal client group who engage in chronic, long-term harmful alcohol use.

Recommendation 21: Employ skilled AOD staff in assessment and care coordination roles in any future system for Aboriginal client group who engage in chronic, long-term harmful alcohol use.

6.5 Has the service model been implemented as intended and is the uptake as predicted?

The Evaluation Team understands that, at the outset of the design of the AMT program, the government implementation team obtained information from the NT Police about the number of people being taken into protective custody in the preceding years and used this to inform decisions about the capacity for the assessment and treatment services. However, this information was not available to the Evaluation Team and so it has not been possible to assess the extent to which the program uptake has occurred as predicted.

In order to answer the question about whether services were implemented as intended, the Evaluation Team elected to retrospectively develop a program logic in consultation with NT Government staff who were involved
Summary of findings and recommendations

in the design of the program. The intention was that this logic model would provide a baseline against which the AMT program could be measured. While the development process did assist the team to understand the AMT program, the measures in the model could either not be defined clearly enough or the data was not being collected for many of the outputs and outcomes.

The evaluation found that the AMT program has evolved continuously as staff began operating the new services while still building the program model and developing policies and procedures, but that there has always been a focus on delivering services that would improve outcomes for clients. The continually changing service system has meant that implementation has been ongoing and there has not been a single point in time against which to measure.

The main implementation challenges and issues identified during the evaluation are summarised below:

- There was significant opposition to mandatory treatment from the community and legal sectors who raised ethical concerns about depriving a person of their liberty for the purposes of providing treatment for a health issue. In a practical sense, the philosophical opposition meant that services did not tender to provide mandatory treatment residential services, which was a particular issue in Darwin. This also played out in community treatment and aftercare where services were reluctant to work with mandatory residential treatment services. This may have also partly been due to a lack of understanding of or different philosophical views about the treatment that was required to be provided. This sentiment appears to have shifted over the past 12 months and services appear to be working more collaboratively.

- The oversight and monitoring functions assigned to the Community Visitor Program (CVP) did not begin visiting assessment facilities and treatment centres until December 2013 due to the rapid expansion required for the CVP to start this role. When the Community Visitors (CVs) did begin visiting, roles and responsibilities were not well understood and the evaluation found that relationships between services and CVs were tense as a result. However, the relationships appear to have improved over time and there is now greater understanding and appreciation of roles.

- Similarly the advocates representing clients at AMT Tribunal hearings did not begin until November 2013 in Darwin and Katherine, and June 2014 in Alice Springs. Consequently, there was some initial confusion about roles and the differences between legal representation and the role of an advocate. The legislative review of the AMT Act found that legal representation was not necessary because the tribunal is a statutory rather than judicial body, and the appointment of an advocate was sufficient.

- The evaluation found that interpretation of some parts of the AMT Act and Police Administration Act differed at times. In some instances the services were initially unsure how they should act in certain circumstances. This does appear to have contributed to tension between service providers at times.

- A common and continuing challenge is the interpretation of the ‘least restrictive’ option in the context of tribunal hearings and treatment plans. The evaluation found that advocates, tribunal members and SACs, have had different views and would have benefited from comprehensive information and training on the topic.

- Perhaps unexpectedly, the evaluation found that a small number of young people under the age of 18 are being taken into protective custody and, since they are excluded from admission to the AMT program, the police make decisions about referral and care for these individuals.

- As highlighted earlier, the evaluation found that a large number of people who met the trigger for AMT did not proceed to treatment. The reasons vary, but clients with challenging behaviours, acute health or mental health issues and those with outstanding warrants received no assessment and hence no access to treatment. The stakeholders consulted as part of the evaluation felt that these people still need assistance with their alcohol misuse but the AMT program has not met their needs.

- Despite the inclusion of a voluntary pathway for access to AMT assessment and treatment in 2015, the evaluation found that so far no clients have entered the program this way. Stakeholders believed that the introduction of the voluntary pathway was a positive measure and should be maintained in any future system.

- Little focus was given to aftercare in the initial development and implementation of the AMT program. While it is acknowledged that this was due to very short time frames to deliver the services, it is unfortunate that this critical element was delayed. The evaluation found that many AMT clients relapse post treatment and stakeholders all felt that ongoing and holistic support was critical to provide an environment for sustainable change.
**Recommendation 22:** Ensure voluntary pathways into residential treatment exist for people who engage in chronic, long-term harmful alcohol use who wish to access this form of treatment, supported by access to a comprehensive assessment to inform treatment planning and support options.

**Recommendation 23:** Consider the most appropriate referral pathways for young people who engage in chronic, long-term harmful alcohol use and are taken into protective custody by police to enable this client group and their families to be assessed and offered access to treatment and wraparound support services.

**Recommendation 24:** Develop referral pathways to assessment that recognise that some people who engage in chronic, long-term harmful alcohol use may have challenging behaviours that have not resulted in them being charged with an offence, or being admitted to an inpatient mental health facility, but which make assessment in a congregate care setting very difficult.

**Recommendation 25:** Develop future programs with aftercare as an integral and intensive component of the service system, enabling regular contact with clients who engage in chronic, long-term harmful alcohol use to provide ongoing treatment and support.

### 6.6 Is the service model and its delivery in each location cost effective?

In the order of $59 million has been allocated for the core services in the AMT program since July 2013. The actual level of expenditure and the indirect costs of providing other services to the client group could not be determined by the Evaluation Team.

The data shows that there were 1745 occasions when a person entered the assessment point of the AMT system between July 2013 and July 2016 including many people who had more than one occasion in those three years. The data also shows that these people not only had high rates of presentations to police protective custody that resulted in them meeting the AMT trigger, they also had many ED and hospital admissions during that time.

A detailed cost effectiveness analysis of the AMT program was impeded by:

1. a lack of detailed expenditure information for each element of the AMT program, such as fixed and variable costs, and clear differentiation between capital and operational costs
2. combined budget allocations for assessment and treatment services operated by TEHS in Darwin until the treatment service began being operated by a non-government provider
3. lack of reliable and complete client data at each point of the system
4. lack of a cost benefit indicator model for the AMT program.

Comparing costs of mandatory residential treatment to community residential treatment in the NT was undertaken with available data and showed significantly higher costs for both open and completed episodes of treatment. Although the average length of stay of closed episodes of treatment completed in both types of services was comparable, the average cost of an open episode of treatment in the community residential treatment services was $8,336 which was 22% of the average cost in mandatory residential treatment at $37,677. The average cost of a closed episode of completed treatment in the community residential treatment services was $17,830 which was 31% of the average cost in mandatory residential treatment at $57,731.

Regional cost comparisons were also undertaken but only for assessment and treatment services in 2015-16, as this was the only year when the figures were comparable. It showed that the costs of assessment varied year on year and by region, and that there is a higher cost per episode of mandatory residential treatment in Darwin than in Alice Springs.

---

67 This is the total number of people transported to assessment centres by NT Police since the AMT program began. It includes people who had multiple episodes of assessment and treatment during that time and those who may not have proceeded to assessment and/or treatment.
Recommendation 26: Develop a strategic approach to fund government and contracted community services providers for all future programs and initiatives to reducing alcohol related harm. Adopting a planning, monitoring and reporting framework such as Results Based Accountability that can be embedded into program design, service specifications and funding contracts will help to ensure that investment is directed where it can be most cost effective.

6.7 Evaluation limitations

The short timeframe in which the AMT program was implemented, the fact that the program is possibly the only system like it in the world (as per the literature review), and the changes to the system once implemented presented challenges for evaluation. Without a clearly articulated program logic, baselines for quantitative data and defined anticipated outcomes, it is difficult to measure changes over time (i.e. before AMT and post AMT) for people who participated in the program.

The evaluation has highlighted that, despite the fact that problem drinking, and to a lesser extent homelessness makes this group of people highly visible to police, EDs and other agencies, very little is documented in regards to the pathways, causal and risk factors leading to an individual reaching the trigger point for the AMT program.

The information currently being collected within the health, justice and social service agencies has been made available to the Evaluation Team; however, the AMT program was not designed with any monitoring, evaluation and reporting framework in place.

The time period specified by the Department of Health for the client outcomes element of the evaluation was 1 July 2014 to 30 June 2015, and selected data sets for the previous five years and up to a further 12 months was made available. The post AMT period was therefore limited as many people had not completed their MTO or had only recently completed it, and so longer term outcomes could not be measured. This approach also meant that the actual length of time for evaluating participants post AMT varied for individuals based on when they had entered into treatment during the evaluation period.

The service system implementation and cost effectiveness elements of the evaluation were not time-limited and covered the whole period of the AMT program operations. However, the evaluation was hindered by the lack of clear program logic, anticipated outcomes and similar programs to compare against. It was also hindered by the fact that the legislation, services and processes continued to evolve throughout that period of time, and that expenditure data was not collected for all service elements in a comparable form.

The AMT system itself presented challenges to the Evaluation Team as well as those implementing the program. The fact that an individual may enter into the system multiple times, that many people could exit out of the system at various stages, and that many people had multiple treatment orders made it challenging to establish clearly who was in the comparison group and who was in the AMT participant group.

Finally, the AMT system has no client level end to end tracking capability and so the evaluation did not have sufficient information to accurately evaluate the effectiveness of treatment orders. There is little evidence to underpin comment on whether community treatment orders are more or less effective than mandatory resident treatment or to assess the impact of non-compliance. However, the anecdotal evidence provided by the non-government service provider sector appears to correlate with Attorney-General and Justice data showing that re-apprehension into police protective custody during a participant’s community treatment order period occurs relatively frequently, as do repeated presentations at Emergency Departments.

6.7.1 Data limitations

The Evaluation Team identified a number of specific challenges related to the data available to support the evaluation and the tracking of impacts for clients. The main data issues are summarised below:

- There was insufficient information in relation to community treatment orders, in particular to determine how often people left community residential treatment or failed to complete a CTO.
- It was not possible to determine how many people complied with their aftercare plan, as this information is not consistently collected across the system.
- The data provided in the Tribunal Register was manually recorded and incomplete in terms of specific demographic information relating to clients such as gender or dates of birth, and outcomes were recorded
in free format text fields where the same outcome was represented by multiple text values. However, this data was more complete than the PICS data.

- The hospital records for Emergency Department categories did not always clearly differentiate those presentations that may be partially attributable to alcohol from those that were unrelated.
- The hospital records for Emergency Department and admissions used a variety of descriptive codes for presentations which may or may not have the same underlying health condition or cause.

In summary, the electronic management and data collection systems and protocols for both the NT Health and non-government service providers have impeded the measurement of program outcomes. The benefit of a client level shared record that can be tracked with the client is essential in monitoring the long-term impacts of any interventions.

**Recommendation 27:** Facilitate a cross-agency approach to electronic record keeping and data collection so information can be shared between relevant agencies.

**Recommendation 28:** NT Health engage with acute services and other healthcare providers in the NT so that alcohol related and partially alcohol-attributable diseases and events are recorded and coded consistently and shared between relevant stakeholders involved in reducing alcohol related harm.
Appendices

Appendix A  Literature review  82
Appendix B  Stakeholder engagement  92
Appendix C  Program Logic  94
Appendix A  Literature review

Background

The Northern Territory (NT) has for many years had the highest rates of alcohol related problems in Australia with alcohol consumption rates per capita in excess of the national level since the 1980s (Skov et al. 2010), with Territorians reported to be consuming alcohol at 1.5 times the national average (Northern Territory Government 2014, Chikritzhs 2005). This is the case for both Indigenous and non-Indigenous groups (1.7 times and 1.5 times the national average respectively). The per capita alcohol consumption of the NT, is reported to be the second highest in the world estimated at 15.1 litres of pure alcohol per year per capita, with Aboriginal and Torres Strait Islanders consuming approximately 16.9 litres (Ramamoorthi et al. 2015).

More recent research indicates that these rates may be an underestimate as national per capita consumption of alcohol has been increasing over time due to the increased alcohol content of alcohol products (Chikritzhs et al. 2011). This rate of consumption has translated into high rates of hospitalisation at more than twice the national rate (Jayaraj et al. 2012), with alcohol related injury rates remaining high at 63 per 100,000 for non-Indigenous and 414 per 100,000 for Indigenous people (NT Department of Health 2012) which is consistent with evidence of increasing alcohol-related harm at the national level (Chikritzhs et al. 2011).

Furthermore, alcohol-related deaths in the NT are three times the national average (NT Department of Health 2016) with studies showing alcohol costs the NT $642 million a year, or $4197 for every adult Territorian, almost 4.5 times the national cost of $943 per adult (i.e. alcohol-related health and hospitalisation costs, policing costs, courts and correctional services costs and loss of productivity) (NT Government 2013). From 2008-13 approximately 60% of police work involved alcohol-related issues such as assault (NT Police 2014) with 67% of all domestic violence involving alcohol (NT Department of Health 2016).

A number of programs have been implemented to address these problems including the Living with Alcohol Program, implemented between 1991 and 2000, which is still nationally considered best practice today (NT Government 2014:5). Additionally a series of Alcohol Management Plans (AMP) have been implemented in communities across the NT (e.g. d’Abbs et al. 2010 1,2). These plans focused on reducing harm and damage in the community by restricting consumption of alcohol either by geographical location or times when outlets could sell alcohol and by prohibiting public consumption of alcohol (d’Abbs et al. 2010, 2011). Evaluations of the impact of the reduction of the alcohol supply in remote Indigenous communities have found that this strategy has been effective in reducing serious injury in selected communities (Margolis et al. 2008).

In 2013 the NT Government passed the Alcohol Mandatory Treatment Act (AMT Act). The AMT Act focuses on protective custody orders as a pathway to treatment with the stated objectives of the AMT Act being to "stabilise and improve health, improve social functioning, restore capacity to make decisions and improve access to treatment for problem drinkers" (NT Government, 2013). This legislation, and the treatment program that flows from it, have been the subject of considerable public and professional debate (Lander, Gray, & Wilkes, 2015).

Policy context

Until recently, legislated mandatory treatment for people with drug and alcohol misuse problems has been relatively uncommon in Australia. However, this has started to change and the courts are increasingly using mandatory treatment to divert offenders with drug and/or alcohol abuse problems from the criminal justice system. Orders made compelling non-offenders to undergo involuntary treatment, as occurs in the Northern Territory, remain rare in Australia and internationally.

The AMT Act, introduced to address alcohol related antisocial behaviour in the NT, allows an administrative tribunal to order ‘civil commitment’ of individuals for mandatory (residential or community based) alcohol rehabilitation for up to 12 weeks. Civil commitment for alcohol and other drug (AOD) dependence is the “legally
sanctioned, involuntary commitment of a non-offender into treatment” (NSW Legislative Council Standing Committee on Social Issues 2004). The AMT Act allows people who are taken into ‘protective custody’ by the NT Police three or more times in two months to be referred by police for compulsory assessment for treatment for up to three months. The AMT clients are not prisoners as they have not been charged with a criminal offence and are not legally classified as an offender or as a prisoner.

The AMT program is intended to be a harm reduction strategy that permits mandatory treatment of problematic users of alcohol who are unlikely or unable to access treatment options voluntarily (NT Alcohol and Other Drug Services 2014:4). By adopting a harm reduction approach, the aim of the AMT program is to help some of the most chronic abusers of alcohol in the NT by getting assistance directly to those who are known to be at risk to themselves or others (NT Department of Health 2016). This strategy is intended to reduce the person’s substance abuse and thereby improve their health and overall quality of life, as well as reducing their potential for future antisocial behaviour and criminal justice involvement (NT Department of Health 2016).

Therefore, the AMT program has been established based on treatment, not punishment, as it is aimed at chronic drinkers with health problems rather than those who have committed a criminal offence (NT Government 2014). Those clients admitted to the AMT program have been subject to a protective custody order and the AMT offers a ‘least restrictive alternative' to incarceration in the justice system (NT Government 2014). If they are charged with an offence these clients progress through the criminal justice system rather than AMT.

The process for the AMT requires that the client, who has been taken into Police protective custody for the third time in two months, appear before the AMT Tribunal, after undergoing an assessment by medical staff. The tribunal will then determine if the person meets the criteria for mandatory treatment, and then refer the person to:

- treatment in a secure residential treatment service
- treatment in a community residential treatment service (where secure treatment is not warranted or available)
- other community management (including income management for eligible welfare recipients) (AMT Act, part 2, sections 11-12 2016).

During their treatment clients are offered a range of development programs, including life skills and work readiness programs. On completion of their treatment, clients are provided with an aftercare program of support for when they return home (NT Department of Health 2016).


Other states in Australia have also introduced policy that allows for mandated alcohol and other drug treatment for offenders. In Victoria the Severe Substance Dependence Treatment Act allows detention and treatment for up to 14 days for people with severe substance dependence as a last resort measure to provide lifesaving treatment. The New South Wales Drug and Alcohol Treatment Act, as in Victoria, is a last resort treatment option that allows initial

---

68 In the Northern Territory under S 128 of the Police Administration Act a person can be taken into protective custody if the police member believes that because of the person’s intoxication, the person: is unable to care for his or herself and cannot be cared for by someone else; may cause harm to his or herself or someone else; may intimidate, alarm, or cause substantial annoyance to others; or is likely to commit an offence.
detention for 28 days, with the option of extending to three months. In addition, the NSW criminal justice system offers the Magistrates Early Referral into Treatment (MERIT) program, which is a diversion approach for offenders with alcohol problems. Both NSW and Victorian statutes remove extended periods of incarceration, providing improved protection of patient rights based on international best practice (Lander et al. 2015). In Tasmania the Alcohol and Drug Dependency Act of 1968 is currently under review.

Mandatory treatment remains controversial because of the ethical issues associated with forced entry into treatment and detention in restrictive facilities when no sentence is being served and no offence has occurred. In the case of the NT, referral into the AMT program is initiated by the NT Police with the tribunal making decisions; however, the Senior Assessment Clinician (SAC) is only an advisor to this process. Entry into the AMT program does not allow for referral from other health professionals or community members (Sharp 2013) leading to concerns being raised that decision making should be based on a health criteria, rather than police referral (APONT 2014).

Many argue that coercion into treatment removes individuals’ rights to choice (Lander et al. 2015, Sharp 2013, Burke & Gregoire 2007, Kelly et al. 2005). However, mandatory treatment as an alternative to custodial sentence offers an opportunity to tackle alcohol problems that, without intervention, can develop into chronic and debilitating disorders with high costs to individuals, their families and the community at large (Burke & Gregoire 2007).

Lander et al. (2015) discuss the evidence, ethics, human rights and international guidelines related to mandatory alcohol treatment. They state the World Health Organization advises that mandatory treatment should be for short periods (until completion of withdrawal) and question the efficacy of the AMT Act, as well as its potential to discriminate against Indigenous people (Lander et al. 2015). Given the high rates of alcohol consumption, associated alcohol related injury rates and alcohol related deaths in the NT’s Aboriginal and Torres Strait Islander peoples, as a group they are at most risk of exposure to the repercussions of the AMT Act. Past experience tells us that mainstream policies have not had a significant influence on Indigenous alcohol problems. Rather, Indigenous-specific policies have had a greater impact on approaches to and understanding of alcohol misuse in this population (Brady 2007).

**Efficacy of mandatory treatment programs**

Research and evaluation establishing the efficacy of mandatory, or involuntary, treatment and minimum standards for an effective programmatic response is limited (Wundersitz 2007). Several systematic reviews of the use of compulsory residential treatment for chronic alcohol dependence in non-offenders have concluded that there was no evidence for its effectiveness. (Broadstock, Brinson, & Weston, 2008) (Lam & Allsop, 2012) (Pritchard, Mugavin, & Swan, 2007).

Where evidence has been developed internationally the comparability of mandatory/involuntary treatment programs between countries, and even within countries, is problematic because the treatment alternative may be applied at different stages of the criminal justice process to different types of offender, including to non-offenders who may be welfare recipients. The scope and approach of these mandatory treatment programs, their content and treatment approach, target groups and the level of legal coercion vary (Stevens 2004, Stevens et al. 2005, Macdonald et al. 2001). In addition, the research findings are often not comparable because of the diverse range of study methods applied, varying study participants and the variation across criteria developed to measure treatment effectiveness (Ip 2008).

It is also important to note that due to the paucity of research in the local setting, the evidence for mandatory alcohol treatment programs is primarily drawn from non-Indigenous settings (mostly the United States) and where treatment is provided in a very different context to that which exists in the NT. Concerns have been expressed that the majority of individuals referred to the AMT program in the NT are Indigenous (Lander et al. 2015). However, the body of evidence around treatment strategies for Indigenous Australians is lacking, as very few treatment programs have been formally or rigorously evaluated. The Australian Institute for Health and Welfare statement on harmful use of alcohol and other drugs needs to be considered and recommends a comprehensive approach to this complex, multi-causal problem by:

- addressing the underlying social determinants
- adopting a prevention/minimisation approach to harmful use
Literature review

- providing safe acute care for those intoxicated
- providing treatment for those who are dependent
- supporting those whose harmful alcohol use has left them disabled or cognitively impaired
- supporting those whose lives are affected by others harmful alcohol use (Gray & Wilkes 2010)

Alternatively, while there is reasonably good evidence to support voluntary alcohol treatment and early intervention strategies in non-Indigenous populations, this relates more directly to short treatment periods (Howard, Gordon & Jones 2014, Lander, Gray & Wilkes 2015). There is little research supporting longer-term alcohol mandatory treatment. However, as noted by Howard et al. (2014) in their recent systematic review of alcohol policy in Australia across all states, territories and levels of government covering the period between 2001 and 2013, this may be due to such treatment programs having been only recently introduced and therefore a lack of available evaluation research.

**Comparison between voluntary and mandatory treatment**

The United Nations Office for Drugs and Crime 69 advocates for a community-based approach to care with a health orientation to treatment that provides education, reliable information, motivational and behavioural counselling, social reintegration and reduced isolation and social exclusion. In the case of dependent individuals treatment should involve comprehensive social support, specific pharmacological and psychosocial treatment and aftercare. Findings have been mixed on the effectiveness of voluntary and mandated treatment programs and most studies have been undertaken in the correctional setting. For example, a meta-analysis by Pakhar et al. (2008) involving 129 studies found mandated treatment was ineffective, particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effect sizes regardless of setting. Furthermore, no significant long-term reduction in emergency department visits and hospital admissions was found following a 30 day mandatory inpatient alcohol detoxification program (Duong et al. 2009).

In the NT there are a limited number of evaluations that take into account alcohol treatment programs, due to the remoteness of the NT’s Indigenous communities and the mobility of Indigenous people (NT Government 2014). However, the experiences of Aboriginal and Torres Strait Islander people in other parts of Australia need to be considered. For example, a study of Indigenous residential programs conducted in 2002 provided recommendations for program improvement in terms of training and governance but no evidence based research in relation to the impact of the drug and alcohol treatment program for clients (Brady 2002).

In the NT the reporting of outcomes from alcohol management services is descriptive and narrative rather than evaluative and attempting to assess the outcomes of treatment. For example during 2012-13 a 40% completion rate was reported for residential rehabilitation services in the NT but this was not said to be indicative of any success of outcomes for clients. Additionally, evaluation of longer-term residential programs conducted within the NT has not been undertaken (e.g. the Council for Aboriginal Alcohol Program Services 12 week residential program).

Drawing on the international evidence base, studies argue that compared to voluntary treatment, mandatory treatment has been associated with higher rates of entry into and retention in treatment (Burke & Gregoire 2007). Several studies also report better outcomes for individuals who complete mandatory treatment relative to voluntary treatment (Burke & Gregoire 2007, Flaherty & Jousif 2002, Perron & Bright 2008). Research from the United States by Kelly et al. (2005), with one and five year follow up, reported that mandated individuals experienced outcomes equal to or better than those undertaking voluntary alcohol and other drug (AOD) treatment. This study examined treatment perceptions and satisfaction as well as pre- and post-treatment changes in multiple areas, such as coping skills, substance use, arrests and employment status. Mandated individuals perceived the treatment environment in a similar way to non-mandated individuals and improved equally or more than other individuals in their substance use outcomes (Kelly et al. 2005). It is worth noting that this study related to correctional settings and to people who had offended.

69 [Http://www.unodc.org/]
Brady (2010) discusses the challenges faced by alcohol treatment programs, including the issue of mandated places creating the perception that to go into rehabilitation one must engage in the legal system. This can deter voluntary treatment as the facility becomes viewed as a restricted place. Another flow on effect of coercion into treatment is a resistance to treatment and impaired therapeutic relationships with healthcare workers (Burke & Gregoire 2007). A US study of substance users found that the largest effect on treatment outcomes was seen in short-term residential programs (average duration of eight weeks) (N=986), compared to long-term (up to six months) (N=881) and outpatient treatment (N=1439) (Perron & Bright 2008). This study found legally coerced, or involuntary, persons in short-term residential treatment, less than eight weeks, had lower drop out and consistently higher survival rates than other modalities. The findings also noted that long-term treatment may not be as effective due to the difficulty in completing treatment of this duration. Perron & Bright (2008) also discussed the difficulty in predicting how effective treatment will be, as mandatory treatment appears to be more effective for some people than others.

Furthermore, it appears that involuntary clients, although receiving more treatment, may not make gains due to the overall quality of care provided compared to voluntary clients who are better positioned to make choices about their treatment and advocate on their own behalf. However, this may relate to differences between individuals in resistance to forced treatment or the skill level of practitioners rather than the mandatory nature of treatment itself (Burke & Gregoire 2007). Another consideration is that clients report greater treatment satisfaction if the program is responsive to their individual needs (Perron & Bright 2008). Once again these studies related to the correctional/offender context.

While evidence suggests mandatory treatment programs show high retention rates and equal or better substance abuse outcomes compared to voluntary treatment, there are many considerations in how such programs should be delivered. Key approaches involve individualised care, responsive service provision, specially trained practitioners (to overcome barriers that arise from mandated treatment) and appropriate program duration (which will differ between individuals).

**Residential treatment programs and the Indigenous community**

The NT Government has made significant investment in treatment services such as voluntary and mandated residential treatment and more flexible models of care for individuals in remote communities (NT Government 2014: 6–7). Across the NT there are a number of government and non-government AOD agencies delivering a range of prevention, intervention and treatment services (refer Appendix A). These programs and services include assessment services, residential care, treatment, supervised withdrawal and aftercare services.

In addition to the services funded through the NT Government, a number of Aboriginal Community Controlled Health Services in both urban and remote settings offer specialist alcohol prevention, support and treatment services in the context of social and emotional and wellbeing programs. These programs are Australian Government funded, and for voluntary participants or population level interventions.

The Alcohol Treatment Guidelines for Indigenous Australians (2014) provide a comprehensive approach to the clinical management of alcohol problems with an emphasis on developing a holistic care plan inclusive of treatment for general health, mental health and social issues (such as family commitments, housing, financial management, transport, child care etc). Culturally respectful treatment settings are paramount as between 2014–15 65% of clients in the NT receiving treatment for their own substance use were Indigenous Australians (AIHW 2016). Although limited scientific evidence is available improved outcomes have also been noted with reduced alcohol consumption, when tailored family-based interventions developed with input from Indigenous communities have been adopted (Calabria et al. 2010)

Brady (2010) explored the history of Indigenous residential treatment programs and approaches for strengthening and supporting such programs. During the 1990s, Australian Indigenous residential treatment programs were heavily influenced by the Canadian approach – using traditional healing and cultural practice as a foundation for treatment (Brady 2010). This saw a transition away from a more holistic approach (primary and secondary alcohol prevention, and community-based action), toward a reliance on residential facilities as places of healing. In the services evaluated, many Indigenous facilities have since seen traditional practices, such as smoking ceremonies, fall out of use, though this may not be the case in the Northern Territory. They also face other challenges, such as overcoming the perception of mandated places being the only option to enter treatment programs, and increasing efforts to access mainstream therapeutic communities and adapt practices to make services more attractive to
Indigenous clients (Brady 2010). Programs also need to be flexible to cater for the wide range of backgrounds and geographical regions for Indigenous clients.

As Brady (2002, p.18) states, it is important to remember that “Aboriginal programs need to be flexible to cater for clients from a wide range of backgrounds, and too much rigidity would be counterproductive”. Putt, Payne and Milner (2005) discuss the use of the criminal justice system to implement interventions for Indigenous alcohol problems at a local level. They explain this requires an intensive holistic approach that will be significantly challenging to implement successfully. The report highlights the need for programs to address underlying factors that lead to substance abuse, such as unemployment, living arrangements and level of education (Putt et al. 2005). In addition, harm-reduction strategies must be responsive to the substance use patterns of certain groups in specific geographical locations, and be tailored to suit Indigenous compared to non-Indigenous clients (Putt et al. 2005). While this report relates to those already engaged in the legal system, these concepts can be applied to early interventions and alcohol and other drug treatment independently of the legal system.

Barriers to treatment for Indigenous population have been identified as:

- a lack of early intervention strategies
- limited aftercare services
- limited capacity for dealing with comorbidities (mental health issues)
- inaccessibility of mainstream services because they are deemed inappropriate or are unavailable (this highlights the need to adapt culturally)
- Aboriginal controlled health services often suffering from a lack of resources, qualified staff and short-term funding cycles (Wilson et al. 2010).

To be effective interventions should (see Wilson et al. 2010; Gray & Wilkes 2010; Brady 2002):

- have the support of and be controlled by local communities
- provide a safe alcohol free environment
- be designed specifically for the needs of a particular community and sub-groups within the community
- be culturally sensitive and appropriate
- provide resources to cater for clients with complex needs
- provide education regarding strategies for maintaining moderate or a lifestyle free of alcohol to match the client’s needs
- encourage open reflection and discussion of personal issues related to use
- promote a healthy lifestyle
- provide assistance with a range of issues associated with community living and daily living skills
- be part of a planned, integrated set of interventions
- be delivered by Indigenous people
- offer peer support and encouragement
- provide ongoing aftercare and home visits following discharge from treatment.

The importance of partnerships in care and treatment is also highlighted, for example Brady (2002) suggests that receptivity to treatment will be enhanced for Indigenous people if Aboriginal services have significant input to program design and delivery. Effective partnerships between researchers and health services is identified as critical to supporting meaningful evaluation of the transfer and implementation of health services and programs to Indigenous settings (McCalman et al. 2012).

Further to the above, the importance of individualised approaches has been identified as a key element of successful programs (McMillan et al. 2008, Tate, McQuaid & Brown 2005). In particular these studies note the
importance of individualised treatment plans and programs, which are responsive to influences on treatment outcome such as social determinants of health (including culture), life stressors and appropriate diagnosis of concurrent mental illness. Clients also report greater treatment satisfaction if an alcohol treatment program is responsive to their individual needs, which is more likely to be achieved the longer the treatment time (Perron & Bright 2008).

**Importance of aftercare in the treatment process**

Aftercare plans represent the final stage of the AMT program, are voluntary, tailored to support the individual with employment and/or return to their community, and critical to ensure the AMT does not become a revolving door (APONT 2014). Extensive research supports the importance of relapse prevention strategies as an important component of any alcohol treatment program particularly in preparation for discharge and the aftercare phase (refer APA 2000, Gray & Wilkes 2010, McLellan 2002). Reduction of harmful alcohol consumption needs to include broad strategies to address the underlying social factors that predispose towards, or protect against, harmful alcohol use (Gray & Wilkes 2010). Good aftercare and social support systems, including accommodation away from other drug and alcohol users, is identified as more likely to support users to abstain following treatment (Polcin et al. 2010). This form of aftercare also involved monitoring on a regular basis, early detection of potential problems, referral to appropriate services, and referral back to treatment as required (National Indigenous Drug and Alcohol Committee (NIDAC) 2014).

Given the NT data referred to earlier in this review highlights that Indigenous Australians are at highest risk for entering the AMT program, the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy (2014-2019) needs to be considered. The strategy recommends, as a priority, culturally appropriate solutions that reflect local cultural norms, practices and sensitivities. In parallel, research also indicates that evidence-based mainstream interventions should incorporate culturally specific interventions, wherever possible, depending on the specific needs of the person seeking treatment (NIDAC 2014). According to treatment guidelines outlined by NIDAC (2014), culturally specific interventions:

- provide teachings on how to attain and maintain connection with creation
- are grounded in an understanding of historical factors, including traditional life, colonisation and its ongoing effects
- utilise Aboriginal family systems approach to care, control and responsibility
- support traditional ways of learning
- use a strengths-based approach
- include traditional medicines, bush tucker, healers and elders
- use approaches such as ‘out bush’ and ‘returning to country’ which recognise the healing effects of the land.

When developing a treatment care plan the Guidelines for the Treatment of Alcohol Problems (2009) identify it is important to work closely with the individual to carefully plan long-term follow up aftercare to prevent relapse, as no single intervention is effective for all people with alcohol problems. Engaging the client in treatment is predictive of positive treatment outcomes but is based on pre-treatment motivation, severity of the disorder, previous treatment experiences, strength of the therapeutic relationship to name a few. The guidelines further note that quality aftercare is needed, including skilled counselling and support which takes a holistic and integrated approach considering not only the alcohol use but also comorbidities, housing and financial needs, and the family and community context.
Literature review reference list


Australian Government Department of Health Guidelines for the Treatment of Alcohol Problems


d’Abbs, P, Ivory, B, Senior, K, Cunningham, T & Fitz, J 2010. Aboriginal Drinking Camps in and around Katherine, NT: causes, consequences and implications, Menzies School of Health Research, Darwin.


## Appendix B  Stakeholder engagement

### Stakeholders consulted

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Darwin</th>
<th>Katherine</th>
<th>Alice Springs</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT Police Protective Custody</td>
<td>Superintendent</td>
<td>Superintendent</td>
<td>Superintendent</td>
</tr>
<tr>
<td>Assessment Centre Managers</td>
<td>Department of Health (DoH) staff at Darwin Alcohol Assessment and Treatment Service (DAATTS) Stringybark Centre</td>
<td>DoH staff at Mandatory Alcohol Reform Service (MARS)</td>
<td>DoH staff at Alice Springs Alcohol Assessment Service (ASASS)</td>
</tr>
<tr>
<td>Senior Assessment Clinicians</td>
<td>DoH staff</td>
<td>DoH staff</td>
<td>DoH staff</td>
</tr>
<tr>
<td>Senior Treatment Clinicians</td>
<td>DoH staff</td>
<td>DoH staff</td>
<td>DoH staff</td>
</tr>
<tr>
<td>Mandatory Residential Treatment Providers</td>
<td>Saltbush Mob</td>
<td>Central Australian Aboriginal Alcohol Programs Unit (CAAAPU)</td>
<td>Drug and Alcohol Services Australia (DASA)</td>
</tr>
<tr>
<td>Residential Community Treatment Order Providers</td>
<td>Council for Aboriginal Alcohol Program Services (CAAPS), Banyan, Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD), Amity, Salvation Army</td>
<td>Kalano, Venndale</td>
<td></td>
</tr>
<tr>
<td>Community Treatment Order Providers</td>
<td>CatholicCare, Mission Australia</td>
<td>Venndale</td>
<td>CAAC, Alcohol and Other Drug Services Central Australia (ADSCA), DASA</td>
</tr>
<tr>
<td>Advocates</td>
<td>North Australian Aboriginal Justice Agency (NAAJA)</td>
<td>NAAJA and private advocates</td>
<td></td>
</tr>
<tr>
<td>AMT Tribunal</td>
<td>Registrar, President and Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Visitor</td>
<td>Principal Visitor, CVP Manager and Community Visitors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Consultation sessions and timing

<table>
<thead>
<tr>
<th>Consultation forum</th>
<th>Stakeholder group</th>
<th>Location</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMT service system walk through</td>
<td>NT Police, Department of Health and service provider</td>
<td>Darwin, Alice Springs</td>
<td>December 2015 to January 2016</td>
</tr>
<tr>
<td>Program logic workshop</td>
<td>NT Government staff who were pivotal in designing and implementing the AMT services</td>
<td>Darwin</td>
<td>February 2016</td>
</tr>
<tr>
<td>Initial evaluation workshop</td>
<td>Regional AMT service providers</td>
<td>Darwin</td>
<td>March 2016</td>
</tr>
<tr>
<td>Evaluation information session</td>
<td>AOD service providers and wider community</td>
<td>Darwin</td>
<td>March 2016</td>
</tr>
<tr>
<td>Focus group/individual meeting</td>
<td>AMT Tribunal Registrar</td>
<td>Darwin</td>
<td>March 2016</td>
</tr>
<tr>
<td>Focus group/individual meeting</td>
<td>Regional AMT service providers</td>
<td>Darwin</td>
<td>May to August 2016</td>
</tr>
<tr>
<td></td>
<td>AOD service providers and wider community</td>
<td>Darwin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alice Springs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Katherine</td>
<td></td>
</tr>
<tr>
<td>Individual meetings</td>
<td>Government departments</td>
<td>Darwin</td>
<td>August to November 2016</td>
</tr>
<tr>
<td>Focus group</td>
<td>Advocates</td>
<td>Darwin</td>
<td>November 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Katherine</td>
<td></td>
</tr>
<tr>
<td>Focus group</td>
<td>Aboriginal Interpreter Service</td>
<td>Darwin</td>
<td>November 2016</td>
</tr>
<tr>
<td>Focus group</td>
<td>AMT Tribunal</td>
<td>Darwin</td>
<td>November 2016</td>
</tr>
<tr>
<td>Evaluation themes workshop</td>
<td>AOD service providers and wider community</td>
<td>Darwin</td>
<td>November 2016</td>
</tr>
<tr>
<td></td>
<td>Regional AMT service providers</td>
<td>Darwin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alice Springs</td>
<td></td>
</tr>
<tr>
<td>Client outcomes data workshop</td>
<td>AMT Evaluation Steering Committee and data experts</td>
<td>Darwin</td>
<td>December 2016</td>
</tr>
</tbody>
</table>
Appendix C  Program Logic

Alcohol Mandatory Treatment Program Retrospective Program Logic

Need
- Reduce anti-social behaviour associated with repeat and public drunkenness
- Management of people with a chronic alcohol condition to reduce harm to self and others and to prevent individuals entering the criminal justice system

Objectives
- Reduce levels of people repeatedly intoxicated in public ‘clean up the streets’
- Diminish anti-social behaviour
- Reduce risk of alcohol related harm to self and others
- Assist people to get help with substance abuse and health concerns

Intended Program Outcomes
- Assist and protect from harm misusers of alcohol, and others
- Stabilisation and improvement in health
- Improvement in social functioning through appropriate therapeutic and other life and work skills interventions
- Restoration of capacity to make decisions about alcohol use and personal welfare
- Improvement in access to ongoing treatment to reduce the risk of relapse.

<table>
<thead>
<tr>
<th>Key AMT area</th>
<th>Activities/Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apprehension and triage</td>
<td>Decision about most appropriate option for the protection of the intoxicated person</td>
<td>Police make decision to: • move person on • arrest person • tip out alcohol (no further action) • drop person home or to accommodation • take person to sober-up shelter</td>
<td>Intoxicated person in the most appropriate place for their own and other’s safety.</td>
</tr>
</tbody>
</table>
## Program Logic

<table>
<thead>
<tr>
<th>Key AMT area</th>
<th>Activities/Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• taker person into protective custody</td>
<td>• Individual meets trigger for mandatory treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• take person to hospital.</td>
<td>• Assessment centre agrees to the transport of individual from protective custody to the assessment centre, and beds are available</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective custody – watch house</td>
<td>Police make decision to take individual into protective custody at the watch house upon identification that the adult:</td>
<td>• is misusing alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• has lost the capacity to make appropriate decisions about his or her alcohol use or personal welfare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• is a risk to the health, safety or welfare of themselves or others</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• the person would benefit from a mandatory treatment order</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• there are no less restrictive interventions reasonably available</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Police conduct positive identification of individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Police conduct risk assessment or individual which includes health assessment by the watch house nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Police contacts assessment facility if person meets AMT trigger of three protective custody episodes in two months.</td>
<td></td>
</tr>
<tr>
<td>Referral and assessment</td>
<td>Transport Advice Notice Form (TAN)</td>
<td>• transport client</td>
<td>• safe transport to assessment centre</td>
</tr>
<tr>
<td></td>
<td>• Fill out TAN form</td>
<td>• transfer custody (responsibility) from NT Police to NT Health</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td>• rights statement explained to person</td>
<td>• decision made that the person would benefit from a mandatory treatment order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• person becomes sober and is supported to safely withdraw</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• breathalyse to determine medicine for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• accredited clinical assessor (SAC)</td>
<td></td>
</tr>
</tbody>
</table>
### Program Logic

<table>
<thead>
<tr>
<th>Key AMT area</th>
<th>Activities/Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>clinical direction for service</td>
<td>individual</td>
<td>independent oversight of the assessment centre operations (check advocacy role in legislation)</td>
</tr>
<tr>
<td></td>
<td>medical practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New workforce (staff, training, recruitment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>interpreters</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>breathalyser</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Visitors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMT Tribunal</td>
<td>tribunal members</td>
<td>tribunal is the ultimate decision maker</td>
<td>provision of a fair and due process</td>
</tr>
<tr>
<td></td>
<td>assessment report</td>
<td>obliged to select the least restrictive option for treatment</td>
<td>decision regarding client’s treatment – mandatory residential treatment or community treatment</td>
</tr>
<tr>
<td></td>
<td>video conferencing facilities</td>
<td>make decision and give reasons tribunal hearing transcripts and recordings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>data</td>
<td>send notices to the federal government regarding income management.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>support person/advocate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>appeal mechanism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>Mandatory treatment</td>
<td>safe environment</td>
<td>abstinence of drinking and education about the harmful effects of excessive drinking</td>
</tr>
<tr>
<td></td>
<td>safe and secure residential treatment centres that are fit for purpose</td>
<td>individual care plan</td>
<td>reduction of harm to self and others</td>
</tr>
</tbody>
</table>
### Program Logic

<table>
<thead>
<tr>
<th>Key AMT area</th>
<th>Activities/Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|              | • primary health facilities and treatment services and engagement with community based resources (AMS etc)  
• Community Visitor Program visits  
• new workforce  
  o treatment clinician  
  o treatment manager  
  o support workers  
• business systems (IJIS etc)  
• AOD harm reduction program  
  o Application of therapy – AOD  
  o Life and work skills  
  o Health  
• CCIS and PCIS  
• client’s financial contribution  
• liaison with family/community. | • therapeutic program  
• banning from alcohol  
• activity program  
• primary health care received  
• authorised leave  
• CV reports to treatment clinician  
• completed tribunal order  
• aftercare plan and safe place to go  
• referrals to community services for aftercare. | • improved health  
• improved lifestyle choices  
• work readiness  
• connectedness to health services  
• improved AOD sector capability and resources. |
|              |                   |         |          |
| Community residential treatment  
• service agreements and contracts  
• day or residential programs/outreach  
• client’s financial contribution. | • banning use of alcohol  
• therapeutic program  
• activity program  
• connecting and referral to services. | • abstinence of drinking and education about the harmful effects of excessive drinking  
• reduction of harm to self and others  
• improved health  
• improved lifestyle choices  
• work readiness  
• connectedness to health services. |
| Community treatment  
• existing service agreements and contracts | • banning use of alcohol  
• therapeutic program  
• activity program | • education about safe drinking  
• reduction of harm to self and others  
• improved health |
## Program Logic

<table>
<thead>
<tr>
<th>Key AMT area</th>
<th>Activities/Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• day or residential programs/outreach.</td>
<td>• connecting and referral to services.</td>
<td>• improved lifestyle choices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• work readiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• connectedness to health services.</td>
</tr>
<tr>
<td>Aftercare</td>
<td>Voluntary aftercare plan and services</td>
<td>• opportunity for individual to be supported.</td>
<td>• ongoing support to the client.</td>
</tr>
<tr>
<td></td>
<td>• existing services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport on release</td>
<td>• safe release and journey.</td>
<td>• safe return to place of choice.</td>
</tr>
<tr>
<td></td>
<td>• travel is organised</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• some departmental support.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>