(b) if the person arrested makes it impracticable by reason of his actions, for the member effecting the arrest to inform him of the offence for which he is arrested.

Division 4 Apprehension without arrest

127A Intoxicated person

For this Division, a person is ***intoxicated*** if:

(a) the person's speech, balance, coordination or behaviour appears to be noticeably impaired; and

(b) it is reasonable in the circumstances to believe the impairment results from the consumption or use of alcohol or a drug.

128 Circumstances in which a person may be apprehended

(1) A member may, without warrant, apprehend a person and take the person into custody if the member has reasonable grounds for believing:

(a) the person is intoxicated; and

(b) the person is in a public place or trespassing on private property; and

(c) because of the person's intoxication, the person:

(i) is unable to adequately care for himself or herself and it is not practicable at that time for the person to be cared for by someone else; or

(ii) may cause harm to himself or herself or someone else; or

(iii) may intimidate, alarm or cause substantial annoyance to people; or

(iv) is likely to commit an offence.

(2) For the purposes of carrying out his duties under subsection (1), a member may, without warrant, enter upon private property.

(2A) A member who takes a person into custody under subsection (1), or any other member, must establish the person's identity by taking and recording the person's name and other information relevant to the person's identification, including photographs, fingerprints and other biometric identifiers.

(3) A member of the Police Force who takes a person into custody under subsection (1) may:

(a) search or cause to be searched that person; and

(b) remove or cause to be removed from that person for safe keeping, until the person is released from custody, any money or valuables that are found on or about that person and any item on or about that person that is likely to cause harm to that person or any other person or that could be used by that person or any other person to cause harm to himself or another.

(4) For the purposes of subsection (3), the person of a woman shall not be searched except by a woman.

(5) All money or valuables taken from a person under subsection (3) shall be recorded in a register kept for that purpose and shall be returned to that person on receipt of a signature or other mark made by that person in the register.

(6) A member may use the force that is reasonably necessary to exercise a power under this section.

128A Referral for assessment under *Alcohol Mandatory Treatment Act*

(1) This section applies if:

(a) a person is apprehended and taken into custody under section 128; and

(b) the person is an adult; and

(c) the person:

(i) is not an involuntary patient under the *Mental Health and Related Services Act*; and

(ii) is not a reportable offender under the *Child Protection (Offender Reporting and Registration) Act*; and

(iii) is not subject to a continuing detention order or supervision order under the *Serious Sex Offenders Act*; and

(d) the person has been apprehended and taken into custody under section 128 on at least 2 occasions in:

(i) if a period has not been prescribed by regulations, the 2 month period immediately preceding the occasion of the apprehension of the person as mentioned in paragraph (a); or

(ii) if a period has been prescribed by regulations, the prescribed period immediately preceding the apprehension of the person as mentioned in paragraph (a); and

(e) an order under section 35 or 41 of the *Alcohol Mandatory Treatment Act* is not in force in relation to the person.

(2) In calculating the number of occasions on which the person has been apprehended and taken into custody for subsection (1)(d):

(a) if a mandatory treatment order has been made in relation to the person – any occasions on which the person has been apprehended and taken into custody before the expiry or revocation of the order are to be excluded; and

(b) if the person has been assessed under the *Alcohol Mandatory Treatment Act* and released without a mandatory treatment order being made – any occasions on which the person was apprehended and taken into custody before the assessment was conducted are to be excluded.

(3) The member who takes the person into custody, or any other member, must determine whether the person has been charged, or will, on release from custody, be charged with an offence against a law in force in the Territory the maximum penalty for which is or includes a period of imprisonment.

(4) If the person has not been and will not be charged as mentioned in subsection (3), a member must contact a senior assessment clinician to ascertain whether a suitable assessment facility has capacity to conduct an assessment of the person and a suitable treatment centre has capacity to treat the person.

(5) If the member is advised that there is a suitable assessment facility with capacity to conduct an assessment of the person, and a suitable treatment centre with capacity to treat the person:

(a) the member must arrange for the person to be taken to the facility in accordance with the *Alcohol Mandatory Treatment Act* as soon as practicable after it reasonably appears to the member that the person is no longer intoxicated; and

(b) sections 129, 131, 132 and 133 do not apply to the person.

(6) However, before the person is taken to the assessment facility, the member must inform the person of the following:

(a) the person is not under arrest in relation to any alleged offence;

(b) the person must be taken to an assessment facility for an assessment in accordance with the *Alcohol Mandatory Treatment Act*;

(c) the person will be able to contact the person's primary contact, guardian (if any) and another person on arrival at the facility.

(7) If either of the following apply, the person must be dealt with in accordance with this Division:

(a) the person has been or will be charged as mentioned in subsection (3);

(b) there is no capacity at a suitable assessment facility for the person to be assessed or at a suitable treatment centre for the person to be treated.

(8) In this section:

mandatory treatment order, see section 5 of the *Alcohol Mandatory Treatment Act*.

128B Referral of person subject to order under *Alcohol Mandatory Treatment Act*

(1) This section applies if:

(a) a person is apprehended and taken into custody under section 128; and

(b) a mandatory community treatment order applies to the person.

(2) The member who takes the person into custody, or another member, must determine whether the person has been charged, or will, on release from custody, be charged with an offence against a law in force in the Territory the maximum penalty for which is or includes a period of imprisonment.

(3) If the person has not been and will not be charged as mentioned in subsection (2), a member must contact a senior assessment clinician to ascertain whether a suitable assessment facility has capacity to conduct an assessment of the person and a suitable treatment centre has capacity to treat the person.

(4) If the member is advised that there is a suitable assessment facility with capacity to conduct an assessment of the person, and a suitable treatment centre with capacity to treat the person:

(a) the member must arrange for the person to be taken to the facility in accordance with the *Alcohol Mandatory Treatment Act* as soon as practicable after it reasonably appears to the member that the person is no longer intoxicated; and

(b) sections 129, 131, 132 and 133 do not apply to the person.

(5) If either of the following apply, the person must be dealt with in accordance with this Division:

(a) the person has been or will be charged as mentioned in subsection (2);

(b) there is no capacity at a suitable assessment facility for the person to be assessed or at a suitable treatment centre for the person to be treated.

(6) In this section:

mandatory community treatment order, see section 5 of the *Alcohol Mandatory Treatment Act*.

129 Period of apprehension

(1) Subject to this Division, a person who has been apprehended and taken into custody under section 128 shall be held in the custody of a member of the Police Force, but only for so long as it reasonably appears to the member of the Police Force in whose custody he is held that the person remains intoxicated.

(2) Subject to this Division, where it reasonably appears to a member of the Police Force in whose custody a person is held at the time under this section that the person is no longer intoxicated, the member shall, without any further or other authority than this subsection, release that person or cause him to be released from custody without his entering into any recognizance or bail.

MARY

The Northern Territory of Australia[1]

RECEIVED
25 JAN 2016
2.48 pm

Alcohol Mandatory Treatment Tribunal

APPLICATION IN RELATION TO PERSON TO WHOM A COMMUNITY TREATMENT ORDER DOES NOT APPLY – SECTION 32

Alcohol Mandatory Treatment Act 2013 — *Form MTT01*

Tribunal File No: 20160025 IJIS NO: 284757

This form is to be used by the applicant (Senior Assessment Clinician) and should have the Assessment Report and Transport Advice Notice (TAN) attached, if not already sent.

DETAILS OF ASSESSABLE PERSON

Name	[redacted]	Gender F [redacted]
Address	11/4 Undoolya Road, Alice Springs	Date of Birth 14/12/1987 [redacted]

DETAILS OF APPOINTED ADVOCATE (IF ANY)

Name	HWK E (MSP)	Phone

If not noted in the assessment report what order is recommended

- ■ Mandatory Residential Treatment Order
- ☐ Mandatory Community Treatment Order [redacted]
- ☐ Release Order

A copy of this application and a copy of the assessment report has been given to the following :

- ■ Assessable Person
- ☐ Legal Representative (if any)
- ☐ Primary Contact and/or Guardian (if any)

Was an interpreter used during the assessment process? No

Will an interpreter be required for the Tribunal hearing? No

Signature of Applicant
Date Signed: 25/01/2016

Received by Registrar
Date Filed: 25.1.16

Darwin Office – Cascom 2B Cascom Centre
17 Scaturchio St Casuarina NT 0810
PO Box 41860 Casuarina NT 0811
Phone : 8922 6560 Fax : 8922 6500
Email : AMT.Tribunal@nt.gov.au

Office Use Only

Date of Hearing - 27.1.16

Time of Hearing - 9.25am

Loaded in IJIS Y / N

Check Human Services for Welfare recipient (Y) N

Match (Y) N Report received (Y) N

[1]

ASSESSMENT REPORT
FOR ALCOHOL MANDATORY TREATMENT TRIBUNAL
Alcohol Mandatory Treatment Act 2013

PART A

Client Details

HRN	0693263		
Family name	[redacted]		
Given name/s	[redacted]		
Also known as?	N/A		
Date of birth	14/12/1987		
Residential address	11/4 Undoolya Rd, Alice Springs	**Region**	Central Australia
Telephone	Nil		
Ethnicity or Cultural Group	Indigenous Australian		
Preferred language(s)	Warlpiri, English		
Interpreter required	No	**Language/Dialect:**	English
Primary contact	[redacted]	**Telephone**	Unknown

PART B

Admission and absences

Date and time of admission to assessment facility	21/01/2016 – 0630hrs
Date/s and time/s of any absences from assessment facility	Nil
Date/s and time/s of any referral under section 32 of *Mental Health and Related Services Act*	N/A
Date and time of completion of assessment	23/01/2016 - 1700hrs

PART C

Assessment against criteria for Mandatory Treatment Order

(Section 10 of the Alcohol Mandatory Treatment Act 2013)

Assessment Summary and Recommendation:

On 21 January 2016, Ms was brought ASAAS by Northern Territory Police following four episodes of Protective Custody at Alice Springs Police Station within a two month period. This was Ms first presentation to ASAAS.

The Department of Health Rights Statement was read to Ms upon arrival and she confirmed her understanding of the statement following this. Ms has had full access to a telephone during her time at ASAAS.

This assessment was undertaken by Senior Assessment Clinician (SAC) Mr Kent Fiddymont. Mr Fiddymont spoke with the client, clinical staff from ASAAS, local service providers such as Sobering Up Shelter, Northern Territory Police and reviewed available Northern Territory Electronic Health Records.

Ms was born in Alice Springs Hospital. She reports that she attended Yeperenye school until her early teens when she got married and moved out bush to an outstation to help her father in law. Ms reports that she has not previously been employed and receives financial assistance in the form of a Centrelink payment. She has a Basics Card.

Ms is currently living with a friend, , in Alice Springs. Her sister also lives at the same address with three children. She has been living here since 2012 and others at the same address are reported to be sober and do not approve of Ms 's alcohol intake habits.

Ms reports that her parents passed away some time ago. Ms also reports that she has six siblings, two brothers and four sisters. They are currently based in Alice Springs and Ms is in regular contact with them. Ms also reports that she has been married twice and reports four children. One son to her first husband and two sons and a daughter to her second husband. Her first son is in foster care with her own family and she is in regular contact with him. Ms 's second husband is currently incarcerated in Alice Springs Correctional Centre reportedly related to a breached Domestic Violence Order against Ms . Their children are currently in foster care by his family in Hermannsburg. She sees them intermittently.

Ms reports that she started drinking at the age of eighteen with her family and has continued to drink intermittently until the current day. She reports that she ceased drinking alcohol whilst pregnant with her eldest son, and recommenced when her first husband passed away. (Ms was no longer married to him, and he had since remarried). It should be noted that Health Records show that Ms presented to services highly intoxicated on a number of occasions whilst pregnant with her subsequent children. Ms reports usually drinking four to five cans of beer in a sitting, which usually takes place weekly on pay day or whenever friends have money available. She reports that she never gets the 'grog shakes' and does not require a morning drink, but drinks water or juice the following day. When asked about the lack of correlation between reported amounts of alcohol consumed and BrAC's at the Watch house, Ms said that she has a weak system and usually gets drunk after about two beers.

Reviewing Electronic Health Records show that Ms [redacted] presented to Alice Springs Emergency Department whilst intoxicated fourteen times within the past twelve months. Three of these were relating to Ms [redacted] being assaulted whilst intoxicated. BrAC's noted during this period range between 0.253 and 0.326.

As previously noted, Ms [redacted] has four children. Ms [redacted] has reported that she ceased drinking alcohol whilst pregnant with her first son Justin, now twelve years old. Ms [redacted]'s other three children, Delisha, four years old, Solomon, two years old, and Sylvester, seven months old, have all been investigated for showing signs of Foetal Alcohol Spectrum Disorder (FASD). During Ms [redacted]'s last pregnancy, she presented to Alice Springs Emergency Department ten times whilst intoxicated, with BrAC's ranging from 0.191 to 0.283, with the final presentation at 38 weeks gestation, in June 2015.

Ms [redacted] reports smoking cigarettes when she is consuming alcohol, however denies any marijuana or other drug use.

Ms [redacted] reports that she has not spent any time incarcerated.

Ms [redacted] reports that he has not previously undertaken treatment for alcohol or drug related problems.

There are no cultural issues of note and it appears that Ms [redacted] is in good standing with her community.

Ms [redacted] suffers from cataracts and retinal detachment, leaving her almost without sight. This process started about 2013 from unknown causes and Ms [redacted] is currently awaiting further treatment, scheduled to take place in Adelaide in late February 2016. Ms [redacted] has said to ASAAS staff throughout her visit that she remains of the attitude that she does not wish to attend treatment at this time. Ms [redacted] has been visited by ADSCA during her time at ASAAS and has agreed to engage with a councillor if she is to receive a community treatment order. Ms [redacted] reiterates that she finds new environments difficult with her lack of sight, and has expressed a wish to cut down. Ms [redacted] reports that she requires a helper for activities of daily living, and during her time at ASAAS has had staff assistance for moving around the facility.

The SAC has spoken with CAAAPU Mandatory Treatment and they are willing to accept Ms [redacted] if a Mandatory Residential Treatment Order is granted. They will assist Ms [redacted] as required for activities of daily living. CAAAPU staff have also said that there should be no issue granting Ms [redacted] leave for her eye surgery in Adelaide at the end of February if required.

Based on my assessment of Ms [redacted], I am of the opinion that she fulfils the criteria for a mandatory treatment order. I outline the basis for my opinion against each criterion below.

Kent Fiddymont (SAC) 23 January 2016

(a) ADULT

Confirmation that client an adult?*	Yes
Basis for confirming that client is an adult (include all sources)	Police TAN notice. PCIS CCIS CARESYS

(b) ALCOHOL MISUSE

Is client misusing alcohol?	Yes
Basis for opinion (include tools, measures and standards used)	Ms [redacted] reports to consume approximately six standard drinks in an episode. NOTE: Although this number is reported by Ms [redacted], BrAC's recorded in the watch house are as high as 0.392, indicating an immense under reporting. This is in excess of the NHMSC Guidelines which recommend no more than two standard drinks daily. In the past twelve months Ms [redacted] has had: • 8 Protective Custody episodes • 14 Alcohol related presentations to Alice Springs Emergency Department. • 6 overnight stays at Sobering up Shelter. NOTE: • Local service providers report that although Ms [redacted] is often unkempt, she is reported to be Cooperative when she presents. • Of the 14 presentations to Alice Springs Emergency Department, three were related to having been assaulted. • Between October 2014 and June 2015, Ms [redacted] presented to Alice Springs Emergency Department ten times, with BrAC's reported to be between 0.191 and 0.283 whilst pregnant. • Breath Alcohol Content (BrAC) readings taken from the Police TAN notification form. 09/12/2015 BrAC 0.392 18/12/2015 BrAC Refused 25/12/2015 BrAC 0.318 20/01/2016 BrAC 0.316

Assessment Tools used show:

AUDIT, A total score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption

Alcohol Audit	**14/40**
Consumption Score	8/12
Dependence Score	0/20
Alcohol related Problems	6/8

DSM IV criteria for Alcohol dependence/alcohol abuse, criteria met when client meets 3 or more of the following during a 12 month period:

Ms [redacted] indicated a 'yes 'to the following of the DSM-IV criteria for dependence, and evidence shows that the client meets the criteria for the DSM IV alcohol dependence.

Criteria 1:Tolerance:need to drink more to get the same effect

Criteria Met

Ms [redacted]'s BrAC's taken in protective custody have regularly been excessively high which can indicate that Ms [redacted] is regularly drinking to a large level indicating some level of tolerance.

Criteria 2:Withdrawal or morning drink

Criteria Not Met

Ms [redacted] reports that she never experiences 'grog shakes'/'grog sickness' and she never needs a morning drink. There is no evidence to suggest otherwise.

Criteria 3: Impaired control: drink more or longer than intended.

Criteria Met

Ms [redacted] reports that she drinks six cans of beer, once a week. BrAC's and presentations to the watch house and Alice Springs Emergency Department suggest that it is highly unlikely that this is the case, indicating that Ms [redacted] is likely drinking more and for longer than intended.

Criteria 4: Persistent desire or unsuccessful effort to cut down:

Criteria Not Met

Ms [redacted] has not attended any treatment for alcohol use to date. Ms [redacted] reports that during her first pregnancy, she ceased drinking. There is no evidence to suggest that this did not take place, which shows that previously, Ms [redacted] has

	successfully cut down. **Criteria 5: A great deal of time is spent on activities necessary to obtain alcohol, use alcohol or recover from its effects.** Criteria Met Ms [redacted] presents to local service providers on a semi regular basis. With the BrAC's noted in the watch house and Alice Springs Emergency, there is evidence that a great deal of time is spent using alcohol and recovering from its effects. **Criteria 6: Important social, occupational or recreational activities are given up or reduced because of alcohol use.** Criteria Met Ms [redacted] presented to Alice Springs Emergency Department ten times whilst intoxicated and pregnant in 2014/2015. Health providers noted that there was a lack of attendance for Ms [redacted]'s eye appointments. **Criteria 7: Continued use despite acknowledgement of problems caused by drinking** Criteria Met Ms [redacted] understands that drinking excessive amounts puts her health and the health of a foetus at risk; however she continued to drink alcohol throughout multiple pregnancies and continues to drink to a high level.

(c) LOSS OF CAPACITY TO MAKE APPROPRIATE DECISIONS ABOUT WELFARE/ALCOHOL USE

Has client lost capacity to make appropriate decisions about their alcohol use or personal welfare, due to their alcohol misuse?	Yes
Basis for opinion (include tools, measures and standards used)	There is evidence to suggest that Ms [redacted] has lost the capacity to make appropriate decisions about her alcohol use and personal welfare. Ms [redacted] understands that drinking excessive amounts puts her health and the health of a foetus at risk; however she continues to drink alcohol. This is reportedly not on a daily basis although the quantity that Ms [redacted] drinks in a single sitting gives the opinion that she has lost the capacity to make appropriate decisions about her alcohol use. Ms [redacted] reports, and health records show that Ms [redacted] has been the victim of assault from a number of different family members whilst intoxicated. Ms [redacted] presented to ASAAS and throughout her stay has shown no reason to suggest that low intelligence, developmental delay or anti-social attitudes are present. The assessor could not locate any evidence to suggest that Ms [redacted] has a predisposition to violence, either under the influence of alcohol or not, and local service providers reported that Ms [redacted] always presented in a cooperative manner.

(d) RISK TO CLIENT OR OTHERS FROM ALCOHOL MISUSE

Is the client's alcohol misuse a risk to the health, safety or welfare of themselves or others?	Yes
Basis for opinion (include tools, measures and standards used)	Ms [redacted] medical history is recorded as: • Retinal Detachment • Cataracts There was no evidence found to link Ms [redacted]'s current or past medical history to excessive alcohol intake, however these health issues will continue to worsen if Ms [redacted] continues to miss appointments. A medical examination by ASAAS Doctor Anthea Miller reported no new findings. Blood results including liver function tests were grossly normal, giving evidence that Ms [redacted] alcohol consumption is causing a detectable health decline at this time. It should be noted that Ms [redacted] is reported to have missed a number of eye appointments. Section 19 (2):a of the Alcohol Mandatory Treatment Act requires the SAC to deem if the client fulfils the criteria for care in the community under the Mental Health Act. A broad search of the available sources revealed that Ms [redacted] has no documented history of mental health problems. The assessor attempted to follow up on the "mental health treatment" noted on the TAN but could not find any further information. There was no evidence to show that she has had previous contact with Mental Health Services in the Northern Territory. During her time at ASAAS staff observed no signs and Ms [redacted] expressed no symptoms that a review by the mental health team was necessary. A mental health assessment undertaken by clinical staff during Ms [redacted]'s time at ASAAS reported that tidy appearance and good hygiene was noted on arrival, Ms [redacted] presented with somewhat agreeable mannerisms. Ms [redacted] was essentially approachable and calm. Ms [redacted]'s sentences followed a logical flow and showed linear thought patterns. No illusions or hallucinations were voiced or noted. Ms [redacted]'s mood and affect were congruent, showing neither overt positivity nor negativity. Ms [redacted] was oriented to time, place and person throughout, and showed rational insight when discussing her current situation and future plans. It was deemed that Ms [redacted] did not meet the criteria to

	receive care in the community under the Mental Health Act. No signs of malnutrition noted throughout visit. As mentioned earlier, Ms [redacted] has four children in the foster care with family. Research shows Breath Alcohol Content (BrAC) of 0.30 – 0.39 can lead to severe central nervous system depression, unconsciousness and the possibility of death.

(e) CAPACITY OF CLIENT TO BENEFIT FROM MANDATORY TREATMENT ORDER

Would the client benefit from a mandatory treatment order?	Yes
Basis for opinion (include tools, measures and standards used)	Although Ms [redacted] reports drinking alcohol weekly, and it appears that currently her health is not directly suffering, the amounts of alcohol that Ms [redacted] is drinking can have serious implications on health with time. As mentioned earlier, Ms [redacted] is presenting at Alice Springs Emergency Department frequently and help, support, education and assistance surrounding her excessive alcohol consumption would help both her physical and social situations. As outlined previously, Ms [redacted] has an extensive history alcohol abuse with minimal opportunity for treatment as Ms [redacted] has not wished to attend or engage. Ms [redacted]'s alcohol abuse has had serious consequences on three of her children to date. Since arriving at ASAAS, Ms [redacted] has remained of the attitude that she does not wish to attend a treatment program. The SAC has spoken with CAAAPU clinical staff and they would be happy to have her attend under a mandatory residential treatment order.

(f) LESS RESTRICTIVE INTERVENTIONS ARE NOT REASONABLY AVAILABLE TO DEAL WITH RISK

Are less restrictive interventions reasonably available to deal with risk?	No
Basis for opinion (include tools, measures and standards used)	At this time, a release order would not be suitable as Ms has an extensive documented history relating to excessive alcohol intake which has had serious consequences on at least three others. Ms has had local service providers attempt to assist her in reducing her alcohol intake for many years, including during three pregnancies. Ms has not engaged with these services which gives strong reasoning that she will not engage with a community treatment provider. Ms has said that she finds new situations difficult, however during her time at ASAAS, she appears to have adapted quickly to new surroundings with no distress expressed or noted by staff. CAAAPU are happy to assist Ms in a new environment if a mandatory residential treatment order is to be made. There were no notes in electronic health records to say that Ms was assisted in getting to Alice Springs Hospital on the majority of occasions, showing that there is a high likelihood that Ms can make her way around town with minimal assistance. As previously discussed, CAAAPU staff have reported that they would be pleased to have her attend and currently have a bed available for Ms. People and organisations contacted for information: Ms – Client ASAAS – Clinical staff Sobering Up Shelter – Staff Northern Territory Police Electronic Health Records

PART D

Treatment Plan
(Section 22(3)(c) of the *Alcohol Mandatory Treatment Act 2013*)

NOTE: This part is only completed if the person fulfils the criteria for a mandatory treatment order.

Appropriate treatment for client	Mandatory Residential Treatment Order.
Declared treatment providers with available capacity to offer appropriate treatment	☐ Darwin Alcohol Assessment and Treatment Service ☐ Nhulunbuy Alcohol and Other Drugs Rehabilitation Service ☒ Central Australian Aboriginal Alcohol Programmes Unit ☐ Central Australian Aboriginal Congress ☐ Barkly Region Alcohol & Drug Abuse Advisory Group ☐ Drug and Alcohol Services Association Alice Springs ☐ Holyoake Alice Springs ☐ Kalano Community Association ☐ Mission Australia ☐ Bushmob (under 25) ☐ Catholic Care ☐ Council for Aboriginal Alcohol Program Services ☐ Banyan House ☐ Amity Community Services ☐ Salvation Army ☐ Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties Corporation (FORWAARD)

23/01/2016

The Northern Territory of Australia

RECEIVED
9 MAY 2016
BY: 10.10 am

Alcohol Mandatory Treatment Tribunal

APPLICATION IN RELATION TO PERSON WITH CURRENT COMMUNITY TREATMENT ORDER

Alcohol Mandatory Treatment Act 2013 *Form MTT02*

Tribunal File No: 20160168. IJIS No: 136729

DETAILS OF PERSON

Name	[redacted]	Gender Female
Address	House 4, Abbotts Camp. Alice Springs	Date of Birth 02/12/1972

DETAILS OF LEGAL REPRESENTATIVE (IF ANY)

Name	HWLE-TW.	Phone
Mailing Address		Email Address

Please indicate what action you are seeking from the Tribunal:-

- [x] Revoke the mandatory community treatment order and make a mandatory residential treatment order
- [ ] Vary the mandatory community treatment order and make an order for the affected person to be released
- [ ] Make no change to the mandatory community treatment order and make an order for the affected person to be released
- [ ] Revoke the mandatory community treatment order and make an order for the person to be released

Will an interpreter be required for the Tribunal hearing? No

Please attach any information in support of this application.

Ms Maneri has breached the conditions of her current Community Treatment Order issued on 09/03/2016.

Please find the attached assessments done during her current admission to ASAAS on 04/05/2016.

Signature of Applicant

Date Signed:08/05/2016

M. Baldwin

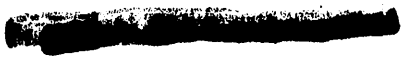
Received by Registrar

Date Filed: 9/5/16.

Darwin Office – Cascom 2 Cascom Centre
Scaturchio St Casuarina NT 0810
PO Box 41860 Casuarina NT 0811

Phone : 8922 6560 Fax : 8922 6500
Email : AMT.Tribunal@nt.gov.au

Office Use Only Date of Hearing – 10/5/16 Time of Hearing –	



ASSESSMENT REPORT
FOR ALCOHOL MANDATORY TREATMENT TRIBUNAL
Alcohol Mandatory Treatment Act 2013

PART A

Client Details

HRN	0616730		
Family name	[redacted]		
Given name/s	[redacted]		
Also known as?			
Date of birth	02/12/1972 (43 yo)		
Residential address	House 4, Abbotts Camp. Alice Springs	**Region**	Central Australia
Telephone	NA		
Ethnicity or Cultural Group	Indigenous Australian		
Preferred language(s)	Pitjantjatjara, English		
Interpreter required	No	**Language/Dialect:**	Pitjantjatjara
Primary contact	[redacted] (Aunty)	**Telephone**	Per Utju PHC 89567308

PART B

Admission and absences

Date and time of admission to assessment facility	04/05/2016 10:05 am
Date/s and time/s of any absences from assessment facility	Nil
Date/s and time/s of any referral under section 32 of *Mental Health and Related Services Act*	Nil
Date and time of completion of assessment	08/05/2016 09:00am

PART C

Assessment against criteria for Mandatory Treatment Order

(Section 10 of the Alcohol Mandatory Treatment Act 2013)

Assessment Summary and Recommendation: Ms [redacted]

On 4th May 2016, Ms [redacted] was brought into ASASS by Northern Territory Police following breach of her Community Treatment Order to Central Australian Aboriginal Congress (CAAAC) . This is Ms [redacted]s second presentation to ASAAS.

The Department of Health Rights Statement was read to [redacted] upon arrival to ASAAS. This was subsequently explained. Senior Assessment Clinician (SAC) Mr Jooby Mani confirmed Ms [redacted] understanding of the statement. Ms [redacted] was given a copy of the rights statement and of the Community visitor Program Brochure. Ms [redacted] has had full access to a telephone during her time at ASAAS.
An Interpreter was not used for the assessments as Ms [redacted] English is noted to be good.

The assessment was undertaken by Senior Assessment Clinician, Mr Jooby Mani . Mr Mani spoke with the client, clinical staff from ASAAS, Northern Territory Police, and a review of the available Northern Territory Electronic Health Records was conducted. Information was also requested form local service providers, Sobering Up Shelter and Social and Emotional Well Being Branch of Congress.

A detailed history of Ms [redacted] back ground was given by Ms Bell on her first presentation on 3rd May 2016 which was described as,

Background
Ms [redacted] was born in Alice Springs and was raised by her parents in Utju (Areyonga). Utju is located 240 km west of Alice Springs, on the western edge of Western Aranda traditional lands and the northern edge of the Pitjantjatjara lands.Utju is an alcohol restricted community.

Ms [redacted] reports she maintains positive relationships with family at Utju.

Primary Drug Use and Pattern
Ms [redacted] reports she first tried alcohol at the age of about 16 with her family. Ms [redacted] reported only drinking intermittently when visiting Alice Springs but at times at high-risk levels when she was living in Utju. However Ms [redacted] reports she moved to Alice Springs some years ago (unsure of exact time-frames) and since then reports she drinks on days when she has access to funds to pay for this and will often pool funds with others in order to continue drinking more, specifically on "pay-days".

Ms [redacted]i reports she regularly drinks on 3-5 days per week with a group of about 5 other female family members whose usual routine is to 'shout' each other large quantities of take-away alcohol on their respective pay-days. Ms [redacted]i reports once she starts drink alcohol she finds it very difficult to moderate her use.

Ms [redacted]i reports her main social activities revolve around the use of alcohol with this group of peers and as she lives in the household of her Cousin, [redacted]ll, who does not allow drinking in her house she is often in public places intoxicated.

While in ASAAS Ms [redacted]s reports of how much and what she drinks, and its effects varied markedly. Ms [redacted]i reported to Dr Leavy, ASAAS Medical Officer, she drinks alcohol daily and usually up to 10 beers and wine and admitted to blackouts and morning drink 'eye-openers'. However Ms [redacted]i denied ever experiencing blackouts or having a morning drink to the assessor, Ms Bell, ASAAS SAC, and reported only drinking white wine and spirits but denied drinking beer. Ms [redacted]i consistently denied ever experiencing significant withdrawal symptoms and consistently denied ever consuming methylates spirits.

Ms [redacted]i reports she does not drink at all when in Utju and does visit this community at times but was clearly adamant she does not wish to return to live in Utju. Ms [redacted] reported she drinks alcohol to high risk levels on 3-5 days per week but never consumes alcohol on Sundays.

Other Drug Use and Pattern

Ms [redacted]i reports never smoking cigarettes or using tobacco products and denies ever smoking cannabis or any other illicit drug use. Ms [redacted]i denies ever engaging in volatile substance use.

Treatment History

Ms [redacted]i denies ever being referred to or engaging with Alcohol and Other Drugs (AOD) Services and there is no record of referral to community AOD services in the available health record however it is noted a referral was made in August 2015 to the Alice Springs Hospital AOD team while she was an in-patient for unrelated issues. Ms [redacted]i was discharged on oral thiamine.

Ms [redacted]i denied ever being a client of a residential rehabilitation service, information from both Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) and Aranda House is pending.

Ms [redacted]i denied ever being to the Sobering up Shelter. However a report from this service stated Ms [redacted]i has presented once in the past 12 months with 16 lifetime presentations and was brough in by police, usually stays with no other issues noted. Ms [redacted]i reported being aware of SSSS but never having engagement with this service previously; information from this service is also pending at time of assessment report completion due to the weekend.

Ms [redacted]i has not previously been referred to Alcohol and other Drugs Services Central Australia (ADSCA).

Accommodation

Ms [redacted]i has lived for most of her adult life predominantly in Utju, while visiting Alice Springs regularly and often staying for some time in Alice Springs. Ms [redacted]i reports she has lived mostly in Alice Springs for the past several years and intends to continue to live in Alice Springs.

When in Alice Springs Ms [redacted] reports she lives with her Cousin, Ms [redacted], at House 8 Abbotts Camp. Ms [redacted]i reports this is a non-drinking household however there are other houses in this Town Camp where alcohol is consumed.

Ms [redacted] reports she stays with her mother, [redacted], at house 82 when she visits Utju Community, but that she does not wish to live in Utju.

Family Issues and Significant Others

Ms [redacted] Father died many years ago but when she was an adult. Ms [redacted]i reports her father was a big drinker of alcohol. Ms [redacted]i reports her mother lives in Utju and is a non-drinker. Ms [redacted]i reports she has a brother who lives in Alice Springs and sometimes drinks heavily. Ms [redacted]i also has two sisters one of whom lives in Utju and is a occasional heavy drinker when she visits Alice Springs and another sister who lives in Alice Springs and does not drinks alcohol very much.

Ms [redacted]i reports her husband, who was also from Utju died some years ago and she does not currently have a partner.

Ms [redacted]i reports having two adult male children, twin boys of about 26 years of age who she reports as being supportive and live in Utju and worry about her drinking. Ms [redacted]i reports she has one infant granddaughter who also lives in Utju.

Ms [redacted]i reports having extended family members in Utju who she visits from time-to-time. Ms [redacted]i reports she maintains positive relationships with close and extended family members.

Ms [redacted]i reports her main social group consists of female family members whose main social activity is consuming alcohol and attending church on Sundays.

Cultural Issues

Ms [redacted] denied any current cultural issues. However it is unclear why Ms [redacted] was so insistent on not returning to Utju on a longer term basis (3 months of a CTO).

Education / Employment

Ms [redacted]i reports she attended primary school in Utju and then completed year 9 in Yirara College in Alice Springs. Ms [redacted]i can speak good basic English.

Ms [redacted] was uncertain of the details but believes she may have participated in a training program provided by "CDP" may years ago at Utju, possibly tourism related.

Ms [redacted] reports she has never previously worked in paid employment. Ms [redacted] reports she receives financial assistance in the form of Centrelink payments and has a Basics Card.

Leisure and Recreation

Ms [redacted] reports that she enjoys cooking, and church activities when in Alice Springs and spending time with female family members. When Ms [redacted] is in Utju she also enjoys taking care of children and BBQ Kangaroo tail but when she is in Alice Springs she mostly drinks with others.

Legal Issues

Ms [redacted] denies having any previous, current or outstanding legal issues and there was nothing to indicate this was not the case.

Mental Health

Ms [redacted] denied ever wishing to harm or kill herself or having mental health issues and no evidence of involvement with Mental Health services was located during this assessment in a review of the available heath records. There was no indication that a review by the Mental Health team was required during her stay in ASAAS.

Health Issues

Current Health Issues:

- *Type II diabetes – poorly controlled*
- *Chronic Kidney Disease – Stage I*
- *ETOH Abuse (noted in ASH Discharge summary 27 August 2015)*
- *Low magnesium levels*
- *Deranged Liver Function Tests*

Previous Health Issues:

- *LLL Pneumonia – Heamophilus influenza (August 2015.) Please refer to attached documents for ASH Discharge summary – referred to ASH AOD Team and discharged on oral thiamine.*
- *Limb pain – ASH ED (8 August 2015. Left prior to medical review)*
- *Tubo-ovarian cyst – January 2015 requiring hospitalisation (Took Own Leave prior to full diagnostic work-up – medium level risk and refused to return to ASH for readmission)*
- *Low Haemaglobin and anaemia*
- *STI 2013 and 2014*
- *Laparotomy secondary to abdominal stab wound*
- *Pelvic Inflammatory Disease*
- *Fractured metacarpal left hand – 21/2/12*
- *Carbuncles requiring surgery and IV antibiotics (March & April 2014– self-discharged against medical advice)*

- *MVA February 2010 – left acetabular fracture*
- *Possible haematemesis April 2013.*
- *Large fatty liver (per ultrasound April 2013 and CT January 2015)*
- *Deranged Liver Function Tests*
- *Cholelithiasis (January 2015)*
- *Infected wound to left heel 7.1.2016*

Please refer to attached documents for ASH ED discharge summary from 28 April 2013 when client was transferred to ASH ED from the Watch House due to acute alcohol related health risks.

Previous and recent Liver Function test results indicate regular high risk alcohol use: Normal range GGT < 43

- *28.3.2013 GGT 126*
- *25.8.15 GGT 86*
- *3.3.16 GGT 152*

Ms [redacted] has regularluy failed to comply with routine follow-up for diabetes management and medications at CAAC or Urju PHC.

From CAAC Notes:

- *18.8.2014 – "alcohol consumption level unsafe – needs intervention"*
- *13.8.2014 – "...stated that the pain started after drinking alcohol"*

From Utju Health Service Aboriginal Corporation notes:

- *2.10.2014 – "...goes to town drinking a lot does not want to take meds.."*

From PCIS Notes:

- *27.4.2014 – "Uncompliant with medications"*
- *7.1.2016 – "Denied any health problems, regular medications...noted that she is on metformin and ramipril but client stated she takes them only when she is not drinking, but then stated that she drinks everyday.*
- *2.3.2016 – "...states she doesn't take her meds"*

Multiple notes of client being transient between Alice Springs and Areyonga Community with some evidence her main place of accommodation is Alice Springs.

Client's Attitude to Alcohol Use and Motivation to Change

Ms [redacted] has expressed a limited understanding into the long-term and acute harms of high risk alcohol use and has apparent had very limited previous opportunities to gain insight into these risks. While at ASAAS Ms [redacted] has indicated she would like to access assistance in reducing the risk of experiencing alcohol related harms. Ms [redacted] stated she did not wish to go to CAAAPU and although open to the idea of residential rehabilitation treatment at Aranda House (as she currently has a female cousin attending there) stated she would much prefer to have the opportunity to engage with a community based AOD service.

Ms [redacted] reports she would like to drink less alcohol and avoid future contact with police for intoxication but was unable to articulate the means by which she would do so. Ms [redacted] reports a high level of motivation and willingness to access appropriate support. Ms [redacted] reports her son's in Utju do worry about her alcohol use in Alice Springs and she would like to visit with them more frequently.

Ms [redacted] has breached the conditions of the Community Treatment Order, Community treatment Order with Congress.

1. Ms [redacted] has not participated and received treatment from Congress Twice Weekly.
2. Ms [redacted] presented to the Alice Springs Watch house with a BAL of 0.265.
3. Ms [redacted] reports that she now resides at House No 4 Abbotts Camp.
4. Ms [redacted] reports that she has associated with people who consume alcohol.

SEWB reports that, Ms [redacted] was provided support with Housing and Centrelink. Ms [redacted] reports that she has submitted an application for a house at Percy Ct.

Ms [redacted] self-reports that she find it very hard to abstain from alcohol whilst residing at her current address due to the pressure from her friends. She is waiting for a house at Percy Court.

Recommendation

Based on my assessment of Ms [redacted], I am of the opinion that she does fulfil the criteria for a mandatory treatment order under the AMT Act.
I recommend a variation of her Community Treatment order to Mandatory Residential treatment Order to CAAAPU. I outline the basis for my opinion against each criterion below.

08/05/2016

Jooby Mani
Senior Assessment Clinician

(a) ADULT

Confirmation that client an adult?*	Yes
Basis for confirming that client is an adult (include all sources)	Client confirmed her DoB Police TAN notice. PCIS CCIS

(b) ALCOHOL MISUSE

Is client misusing alcohol?	Yes
Basis for opinion (include tools, measures and standards used)	Ms [redacted] reports to consume around 15 standard drinks in a single sitting (5 Bottles of Chardonnay with 3 people). Drinks approximately 1-2 bottle's herself if available. • *Breath Alcohol Content (BrAC) readings taken from the Police TAN notification form.* 03/05/2016 BrAC 0.265 Since the past Mandatory Community Treatment order on 09/03/2016 Ms [redacted] has had • 1 protective custody on 03/05/2016 • No sober up shelter presentations. *In the past twelve months Ms [redacted] has had:* • *4 Protective Custody episodes (4 in the past 6 months)* • *1 presentation to the Sobering up Shelter. (16 lifetime presentations)* • *Breath Alcohol Content (BrAC) readings taken from the Police TAN notification form on her first presentation,* *02/02/2016 BrAC Refused* *28/02/2016 BrAC 0.243* *02/03/2016 BrAC 0.245* **Assessment Tools (05/05/2016)** **Alcohol Audit 20/40** Consumption Score 7/12 Dependence Score 7/12 Alcohol related Problems 6/16 **AUDIT, A total score of 20 or more indicates: High Risk definite harm,**

also likely to be alcohol dependent.
(NOTE this is a self-reporting tool)
Ms [redacted] Scored 4/16 when self-reporting its clear that she is under reported to question No 10 of the Alcohol Audit.
(Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
Ms [redacted] answered "Yes, but not in the last year"

DSM IV criteria for Alcohol dependence/alcohol abuse, criteria met when client meets 3 or more of the following during a 12 month period:

Criteria: MET

This is a self-reporting tool and Ms [redacted] indicated a 'yes 'to four of the DSM-IV criteria for dependence.

Criteria 1: Tolerance: need to drink more to get the same effect: Criteria **Met**

Drinks Chardonnay weekly when paid . Shares some times with 3 people. Drinks 1-2 bottles approximately herself if available.

Criteria 2: Withdrawal or morning drink: **Not Met**

Criteria 3: Impaired control: drink more or longer than intended: **Criteria Met**

Reports that she is unable to stop till it is all gone.

Criteria 4: Persistent desire or unsuccessful effort to cut down: **Criteria Met.**

Ms [redacted] has been given a Community Treatment Order with Congress. (SEWB report attached)

Criteria 5: A great deal of time is spent on activities necessary to obtain alcohol, use alcohol or recover from its effects:

Criteria **Met**

Ms [redacted] reports that sometimes this is correct.

Criteria 6: Important social, occupational or recreational activities are given up or reduced because of alcohol use:

Criteria **Met**

Ms [redacted] reports , " I sleep a lot when I am drunk, I forget and I don't do much."

Criteria 7: Continued use despite acknowledgement of problems caused by drinking:**Criteria Met**

Ms [redacted] is aware of the effects of alcohol on her health, physical and physiological wellbeing . But she continues to drink despite the knowledge of the harm.

(C) LOSS OF CAPACITY TO MAKE APPROPRIATE DECISIONS ABOUT WELFARE/ALCOHOL USE

Has client lost capacity to make appropriate decisions about their alcohol use or personal welfare, due to their alcohol misuse?	Yes
Basis for opinion (include tools, measures and standards used)	In addition to Ms Bell's (SAC) report on06/03/2016, there is further evidence Ms [redacted] has lost the capacity to make appropriate decisions about her alcohol use. Ms [redacted]'s high risk alcohol use also impacts upon her ability to make appropriate decisions regarding her personal welfare particularly in relationship to her significant health issues. Ms [redacted] has breached all parts of her current Community treatment Order with Congress. 1. Ms [redacted] has not participated and received treatment from Congress Twice Weekly. 2. Ms [redacted] presented to the Alice Springs Watch house with a BAL of 0.265 . 3. Ms [redacted] reports that she now resides at House No 4 Abbotts Camp. 4. Ms [redacted] reports that she has associated with people who consume alcohol. SEWB reports that, Ms [redacted] was provided support with Housing and Centrelink. Ms [redacted] reports that she has submitted an application for a house at Percy Ct? Ms [redacted]'s BAL on her presentation to Alice Springs watch house was 0.265%. Ms [redacted] still continues to drink despite knowledge of having health issues which is likely to be exacerbated by alcohol. Ms [redacted] still continues to drink even after her involvement with the Social and Emotional Wellbeing Branch of Congress .

(d) RISK TO CLIENT OR OTHES FROM ALCOHOL MISUSE

Is the client's alcohol misuse a risk to the health, safety or welfare of themselves or others?	Yes
Basis for opinion (include tools, measures and standards used)	Ms [redacted]'s medical history is recorded • Type II diabetes – poorly controlled • Chronic Kidney Disease – Stage I • ETOH Abuse (noted in ASH Discharge summary 27 August 2015) • Low magnesium levels • Deranged Liver Function Tests • Fatty Liver (per CT scan August 2015) All of these conditions are likely to be worsened or caused by high risk alcohol use. Ms [redacted]'s consistently high BAL readings indicate she is drinking to very high risk levels frequently. Recent Blood results including liver function tests indicated Ms [redacted]'s alcohol consumption has caused a detectable health decline and a high reason to believe that Ms [redacted] is drinking to high risk levels. **Liver Function Test's,** <u>Liver Function Test on 03/05/2016</u> Bilirubin (T) 9 umol/L (<21) Alk. Phos. 130 + U/L (30-110) Al. T 54 + U/L (5-42) G.G.T. 152 + U/L (<43) Protein 81 g/L (64-84) Albumin 38 g/L (37-48) Globulin 43 + g/L (23-39) <u>Liver Function Test On 25/08/2015</u> Liver function tests (Heparin plasma) Bilirubin (T) 15 umol/L <21 Alk. Phos. 134+ U/L 30-110 Al. T 36 U/L 5-42 G.G.T. 86+ U/L <43 Protein 75 g/L 64-84 Albumin 35- g/L 37-48 Globulin 40+ g/L 23-39 Social risks noted include risk of loss of contact with her family (children, mother and grandchild) in Areyonga. Lack of housing which makes her more prone to be in the company of people who drink alcohol.

	Research shows Breath Alcohol Content (BrAC) of 0.20 – 0.29 can lead to severe motor impairment, impaired sensations, loss of consciousness, memory blackout, and loss of understanding.

(e) CAPACITY OF CLIENT TO BENEFIT FROM MANDATORY TREATMENT ORDER

Would the client benefit from a mandatory treatment order?	Yes
Basis for opinion (include tools, measures and standards used)	Ms [redacted] reports drinking alcohol to high risk levels regularly and for years. This is causing or contributing to her experiencing significant health harms. Ms [redacted] reports she finds it very difficult to not drink alcohol. Ms [redacted] has and is experiencing negative health and social consequences due to this high-risk alcohol use pattern. From the available health records this level of alcohol use harms appears to be escalating (Liver Function Test) Although Ms [redacted] appears to have limited insight into the significant potential health/social/legal consequences of her current high risk alcohol use she is motivated to seek supports to assist her in addressing these. However Ms [redacted] also reports she is unlikely to be able to independently access AOD Services without significant support. Ms [redacted] has supportive non-drinking family members and would like to develop the skills and knowledge necessary in order to assist her in reducing the risk of experiencing further harms from high risk alcohol consumption. Due to the entrenched high-risk alcohol use pattern Ms [redacted] has had it is unlikely she will manage to successfully address these risks without specialist long-term AOD support and assistance. Ms [redacted] has demonstrated a limited ability to meaningfully engage with appropriate health services in the past as evidenced by her poor diabetes control and poor compliance with appropriate treatment. Ms [redacted] reports that it is very hard for her to abstain from alcohol considering her social situations . Ms [redacted] Reports that she is not able to cope with the peer pressure and stay away from alcohol while residing at the current address. A RUDAS score of 28/30 (on 06/05/2016) assessment done by Dr Leavy shows that Ms [redacted] has the capacity to benefit from Treatment.

(f) LESS RESTRICTIVE INTERVENTIONS ARE NOT REASONABLY AVAILABLE TO DEAL WITH RISK.

Are less restrictive interventions reasonably available to deal with risk?	No
Basis for opinion (include tools, measures and standards used)	At this time, a release order would not be suitable as Ms readily admits to an entrenched and long-term pattern of regularly drinking to high risk levels. Ms has a long history of poor compliance and follow-up with appropriate health services and as such a Release Order with a voluntary referral to community AOD Services is unlikely to be an option reasonable available to deal with risk. Ms readily reports she does not believe she will be able to effectively reduce her alcohol use without significant levels of support. A release order in no-way assists Ms to address these risks. A Residential Treatment Order is recommended at this time as Ms has breached the conditions of the Community Treatment Order and Ms self reports that it will be difficult for her to abstain from alcohol in her current social situations. MS reports that she don't wish to go to CAAAPU (I don't live at that side?) but the assessor has no other options available at the time of report. Beds were not available for a Residential Treatment order to DASA (Arranda House) at the time of assessment but the assessor will try to find if there is bed available near to time of Ms s tribunal. (Abbotts camp where Ms currently lives is close to DASA) People and organisations contacted for information: Ms – Client ASAAS – Clinical staff Sobering Up Shelter Safe and Sober Support Services Northern Territory Police Electronic Health Records CAAAPU Staff.

PART D

Treatment Plan
(Section 22(3) (c) of the *Alcohol Mandatory Treatment Act 2013*)

NOTE: This part is only completed if the person fulfils the criteria for a mandatory treatment order.

Appropriate treatment for client	Mandatory Residential treatment Order.
Declared treatment providers with available capacity to offer appropriate treatment	☐ Darwin Alcohol Assessment and Treatment Service ☐ Nhulunbuy Alcohol and Other Drugs Rehabilitation Service ☒ Central Australian Aboriginal Alcohol Programmes Unit ☐ Central Australian Aboriginal Congress ☐ Barkly Region Alcohol & Drug Abuse Advisory Group ☐ Drug and Alcohol Services Association Alice Springs ☐ Holyoake Alice Springs ☐ Kalano Community Association ☐ Mission Australia ☐ Bushmob (under 25) ☐ Catholic Care ☐ Council for Aboriginal Alcohol Program Services ☐ Banyan House ☐ Amity Community Services ☐ Salvation Army ☐ Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties Corporation (FORWAARD)

Senior Assessment Clinician:

Jooby Mani
Dated: 08/05/2015

☐ *Lodged with Tribunal at hours on.*
☐ *Form placed on Clinical File no:*

The Northern Territory of Australia

RECEIVED
14 MAY 2016
BY: 8:46pm

Alcohol Mandatory Treatment Tribunal

APPLICATION IN RELATION TO PERSON TO WHOM A COMMUNITY TREATMENT ORDER DOES NOT APPLY

Alcohol Mandatory Treatment Act 2013 — *Form MTT01*

Tribunal File No: 20160175 IJIS No: 425 696.

This form is to be used by the applicant (Senior Assessment Clinician) and should have the Assessment Report and Transport Advice Notice (TAN) attached, if not already sent.

DETAILS OF ASSESSABLE PERSON

Name	[redacted]	Gender M ~~F~~ M
Address	NFA – Darwin.	Date of Birth 11/01/1980.

DETAILS OF LEGAL REPRESENTATIVE (IF ANY)

Name	HWLE-AK	Phone

If not noted in the assessment report what order is recommended

- [x] Mandatory Residential Treatment Order
- [ ] Mandatory Community Treatment Order
- [ ] Release Order

A copy of this application and a copy of the assessment report has been given to the following:

- [x] Assessable Person
- [ ] Legal Representative (if any)
- [ ] Primary Contact and/or Guardian (if any)

Was an interpreter used during the assessment process? (Y) / N

Will an interpreter be required for the Tribunal hearing? (Y) / N

Fiona Webster

Signature of Applicant

Date Signed: 14/5/2016.

W. Babbler

Received by Registrar

Date Filed: 16/5/16

Darwin Office – Cascom 2 Cascom Centre
17 Scaturchio St Casuarina NT 0810
PO Box 41860 Casuarina NT 0811

Phone : 8922 6560 Fax : 8922 6500
Email : AMT.Tribunal@nt.gov.au

Office Use Only

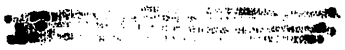
Date of Hearing – 17/5/16

Time of Hearing – 11.00am

Loaded in IJIS (Y) / N

Check Human Services for Welfare recipient (Y) / N

Match (Y) / N Report received (Y) / N



Northern Territory Government

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ASSESSMENT REPORT FOR ALCOHOL MANDATORY TREATMENT TRIBUNAL

Alcohol Mandatory Treatment Act 2013

PART A — Client Details

HRN	0923536		
Family name	[redacted]		
Given name/s	[redacted]		
Preferred name:			
Also known as?	Not applicable		
Date of birth	11/01/1980		
Residential address	NFA	**Region**	NT
Telephone	Not applicable		
Ethnicity or Cultural Group	Indigenous		
Preferred language(s)	Kriol		
Preferred gender	Male		
Interpreter required	Yes — **Language/Dialect:**	Kriol	
Primary contact	[redacted] (sister)	**Telephone**	Current Saltbush Client

PART B — Admission and absences

Date and time of admission to assessment facility	0605hrs 11th May 2016
Date/s and time/s of any absences from assessment facility	Not applicable
Date/s and time/s of any referral under section 32 of *Mental Health and Related Services Act*	Not applicable
Date and time of completion of assessment	06.05am 14th May 2016

PART C **Assessment against criteria for Mandatory Treatment Order**
(Section 10 of the Alcohol Mandatory Treatment Act 2013)

Assessment Summary and Recommendation:

Background / Presenting Issue

On 11th May 2016, Mr [redacted], 36 years of age, was brought into Darwin Addiction Assessment Service (DAAS) by police following four episodes of Police Protective Custody (PPC) at Darwin Police Station in a two month period.

On admission to DAAS the Department of Health (DoH) Rights Statement was read to Mr [redacted] who signed the statement and confirmed his understanding of the document.

The Rights Statement was repeated to Mr [redacted] by Fiona Webster, Senior Assessment Clinician (SAC).

Mr [redacted] signed a Release of Information Authority and confirmed his understanding of the document. Mr [redacted] has had full access to a telephone whilst at DAAS.

This is the third presentation Mr [redacted] has had at DAAS.

Interpreter

Mr [redacted] was offered the use of an Interpreter from the Aboriginal Interpreter Service (AIS) for the assessment and Tribunal hearing. An Interpreter was booked for both.

On 13th May AIS Interpreter [redacted] attended the assessment and interpreted in Kriol.

Primary drug use and pattern

Mr [redacted] reports he began drinking at age 18 and has regularly consumed alcohol since this time.

Mr [redacted] reports that since returning to Darwin in December 2015 he has been drinking 1 x 2 litres casks of chardonnay (20 standard drinks) daily. He reports returning to Darwin following a short stay in Ngukurr on completion of his last Mandatory Residential Treatment Order (MRTO). He reports his reason for returning to Darwin is that he does not have much to do with his family there.

Mr [redacted] reports usually commencing drinking at 1000hrs and ceases when there is no alcohol left. He initially reported that he drinks with family and friends in the long grass around Casuarina, however when questioned further admitted that he always drinks and sleeps by himself and that family have nothing to do with him except when money was needed.

Mr [redacted] reports that he is aware that his use of alcohol is interfering with his family relationships; no one in Mr [redacted] family who live in stable accommodation in Darwin and in Ngukurr want him to stay with them because of his alcohol use.

Mr [redacted] reports he also has many other family members from Ngukurr with drinking problems now in Darwin to drink and his sister [redacted] has been granted a MRTO for three months on the 13th May 2016.

Mr [redacted] reports his only periods of abstinence have been when he has run out of money or when his family do not share with him.

Other drug use and pattern

Mr [redacted] reports occasionally smoking tobacco, but not daily as depends on available funds. Client found difficult to estimate amount as has decreased to half his use from 12 months ago. He denies any other drug use.

Treatment history

This is Mr [redacted] third admission to DAAS.

July to September 2014: Received a three month MRTO to DAAS Which was not completed as absconded twice during the order.

July to September 2015: Received a three month MRTO from Tribunal to Saltbush Mob. Mr [redacted] reports on completion of the order he went to Ngukurr but returned to Darwin around Christmas time. On his return to Darwin he resumed drinking alcohol.

Mr [redacted] reports fond memories of his previous admissions with SBM stating that he would like to return here again for further treatment and training. SBM Senior Treatment Clinician (STC) Mr Peter Ashley and SBM Supervisor Helen Bayne-Thompson reported that Mr [redacted] engaged with all teaching programs and associated well with staff and other clients during his last admission to SBM.

Previous assessments state Mr [redacted] reported that he had attended CAAPS for AOD treatment in the past however when questioned about this he stated that he meant DAATS not CAAPS as he has only been to treatment since the AMT Act was introduced.

Accommodation

Mr [redacted] reports he was born at Katherine and grew up at Ngukurr community. He reports that he frequently moves between Darwin, Katherine and Mataranka.

Mr [redacted] reports while in Darwin he long grasses around the Moil shops and Casuarina Shopping Centre areas.

Mr [redacted] reports that he does not wish to return full-time to Ngukurr and found it difficult to explain any reason why, when questioned further Mr [redacted] stated that his family did not drink in Ngukurr and did not want him there if he continued to drink.

Family issues significant others

Mr [redacted] reports no close ties with family, except to occasionally seeing them around Casuarina and when they want money.

Mr [redacted] reports that he has two mothers in Ngukurr, [redacted] and [redacted] who he believes would want him to return to Ngukurr however he states that he does not speak much to them and would prefer to remain in Darwin.

[redacted] reports that he has brothers and sisters in Darwin whom consume alcohol and states that his sister [redacted] is a current resident in SBM. He refrained from commenting further during assessment about his family members.

Cultural issues

Mr [redacted] does not engage in cultural activities whilst he is drinking, and Mr [redacted] reported to assessor that he is not really involved in cultural events when back in community because he is not included at times.

Education

Mr [redacted] reports he went to primary school at Ngukurr and did not attend secondary school.

Employment

Mr [redacted] reports that he is currently unemployed and is in receipt of New Start Allowance from Centrelink.

Mr [redacted] reports previously working for the Community Development Employment Program (CDEP) from the age of 18 years old (employment duration unknown by client).

Mr [redacted] has mentioned to DAAS staff during this admission that he would like to receive training for employment at SBM and states that he would like to get a job cutting grass and gardening as he is lonely and wants to be busy.

Leisure and recreation

Mr [redacted] reports that he enjoys fishing, hunting and storytelling when he visits his family in Ngukurr, however reports when he is in Darwin he does not engage in these activities due to his alcohol use.

Legal

July 2015 three days incarceration for a breach of bail (IJIS)
Fines for public drinking (IJIS)

Mr [redacted] reports he has no current legal issues that he is aware of.

Goals

Mr [redacted] has voiced that he would like a more stable life with a job and somewhere safe to stay. He talked about learning new skills and would like an opportunity to work at SBM cutting the grass.

Mr [redacted] reports he does not want to return long-term to Ngukurr and would prefer to be somewhere where he has a job and is needed.

Based on my assessment of the above named person, I am of the opinion that they fulfil the criteria for a Mandatory Residential Treatment Order. I outline the basis for my opinion against each criterion below.

Fiona Webster
Senior Assessment Clinician
13/05/2016

(a) ADULT

Confirmation that client is an adult?	Yes
Basis for confirming that client is an adult (include all sources)	Confirmation from Mr [redacted] and a search of electronic information was used to ascertain he is an adult, including: Police transport advice notice (TAN) Primary Care Information System (PCIS)

(b) ALCOHOL MISUSE

Is client misusing alcohol?	Yes
Basis for opinion (include tools, measures and standards used)	Mr [redacted] reports that he consumes approximately 20 standard drinks per day; 7 days a week. This is in excess of the NHMRC Guidelines, which recommend no more than two standard drinks daily and no more than four standard drinks on a single occasion. In the past twelve months Mr [redacted] has had: • 11 PPC episodes • three alcohol presentation to ED in 12 months • Breath Alcohol Content (BrAC) readings taken from the Police TAN notification form. 10/04/2016 BrAC 0185. 12/04/2016 BrAC 0.192 10/05/2016 BrAC 0.302 **Assessment Tools used show:** **AUDIT: A total score of 8-15 indicates a strong likelihood of risky or hazardous alcohol consumption** **AUDIT: A total score of 16-19 indicates a strong likelihood of high risk or harmful alcohol consumption** **AUDIT: A total score of 20 or more indicates a strong likelihood of high risk of definite harm and almost certainly**

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[redacted]

[redacted]

[redacted]

alcohol dependence

Alcohol Audit	29/40
Consumption Score	12/12
Dependence Score	06/12
Alcohol related Problems	11/16

DSM IV criteria for alcohol dependence/alcohol abuse, criteria met when client meets three or more of the following during a 12 month period:

Mr [redacted] meets all of the seven DSM-IV criteria for alcohol dependence as described below.

Criteria 1: Tolerance, the need to drink more to get the same effect

Notes from PCIS in the watch house indicate that Mr [redacted] was "pleasant and cooperative, speech coherent, walking unaided" with the below BrAC of:

10/04/2016	BrAC	0185.
12/04/2016	BrAC	0.192
10/05/2016	BrAC	0.302

This indicates a degree of tolerance to alcohol

Criteria met

Criteria 2: Withdrawal or morning drink

Mr [redacted] denies experiencing any symptoms of withdrawal after a session of drinking, however during this admission to DAAS he has experienced mild withdrawal symptoms, which have been managed with Diazepam.

Criteria met

Criteria 3: Impaired control: drink more or longer than intended

Mr [redacted] states that he drinks by himself and that he regularly falls over when intoxicated resulting in occasional injuries. Mr [redacted] has also obtained injuries post assaults whilst intoxicated as indicated by electronic medical records.

Mr [redacted] was not able to provide and answer to this however he has had 11 PPC episodes in the last 12 months which would indicate impaired control as he comes to the attention of the

	Police when intoxicated. Criteria met **Criteria 4: Persistent desire or unsuccessful effort to cut down** Mr [redacted] reports he has been unable to cut down his alcohol intake by himself. He reports that he abstained from drinking for approximately two months following the completion of his last MRTO at SBM. Criteria met **Criteria 5: A great deal of time is spent on activities necessary to obtain alcohol, use alcohol or recover from its' effects** Mr [redacted] reports spending his day long grassing and consuming alcohol. He starts drinking at 1000hrs and continues most of the day.. Criteria met **Criteria 6: Important social, occupational or recreational activities are given up or reduced because of alcohol use** Mr [redacted] reports he does not partake in traditional cultural activities whilst drinking alcohol. He states he has not worked for years and he has no training in anything to get him a job. Mr [redacted] reports his social activities are comprised of drinking alcohol by himself, and occasionally with family and friends in the long grass. Mr [redacted] reports that he is not involved in any recreational activities because of his solitary life and is not involved with many other people. Criteria met **Criteria 7: Continued use despite acknowledgement of problems caused by drinking** Brief interventions and services have been provided in the past at the Darwin Watch House, Katherine Emergency Department (ED) and has completed two MRTO's Despite this he consumes to consume alcohol at high risk

	levels. Mr [redacted] acknowledges the impact and problems caused by drinking particularly in regards to his relationship with his family in Ngukurr. Mr [redacted] reports he is unable to cut down or stop at this time and has requested help with his drinking. He reports he would like to attend SBM to develop new skills. Criteria met

(c) LOSS OF CAPACITY TO MAKE APPROPRIATE DECISIONS ABOUT WELFARE/ALCOHOL USE

Has client lost capacity to make appropriate decisions about their alcohol use or personal welfare, due to their alcohol misuse?	Yes
Basis for opinion **(include tools, measures and standards used)**	Mr [redacted] makes inappropriate decisions regarding his alcohol use and personal welfare by consuming alcohol in an open environment such as the long grass, which places him at risk of assaults and injuries whilst intoxicated. When intoxicated Mr [redacted] comes to the attention of the police, which results in him being placed in PPC and being brought to DAAS. <u>Risk assessment</u> Mr [redacted] has a noted cognitive impairment. DAAS MO Dr Christine Watson suggests that guardianship should be considered because of vulnerability. Mr [redacted] also reports that family take his welfare income and leave him behind. RUDAS score on 23/09/14 with an Interpreter was 19/30. Mr [redacted] has had 6 PPC episodes in the past six months, many with high BrACs. He does not make reasonable decisions regarding his health as he has sustained injuries from falls whilst intoxicated. Mr [redacted] has permanent damage to his left arm as a result of not receiving timely treatment following a fall whilst intoxicated. Mr [redacted] has damaged relationships with his family as a result of his alcohol consumption and previous assessments note that Mr [redacted] is not welcome by family living in Ngukurr and Darwin. <u>Legal history</u> Nil current issues, (IJIS system) noted that Mr [redacted] has had public drinking fines and a breach of bail relating to fines resulting in a three day prison stay 10/07/2015.

(d) RISK TO CLIENT OR OTHERS FROM ALCOHOL MISUSE

Is the client's alcohol misuse a risk to the health, safety or welfare of themselves or others?	Yes
Basis for opinion (include tools, measures and standards used)	Health- Medical assessment Mr [redacted] has had one confirmed alcohol related ED presentation for alcohol intoxication since completing his MRTO at SBM in September 2015. Cognitive impairment with RUDAS score on 23/09/14 with an interpreter was 19/30. DAAS MO Dr Christine Watson suggests (11/05/2016) that Mr [redacted] cognitive impairment is unlikely to be resolved during three months rehabilitation treatment should he receive an MRTO to SBM, however it would allow time for him to be assessed to be managed by Adult Guardianship. Reported hematemesis events 2000 and 2011 with no further investigation as took own leave before scope attended. Early renal disease - raised ACR Mr [redacted] lifestyle may result in significant compromise to his health because of his social isolation, and neglected relationships with other family and friends. Mr [redacted] is also at risk for malnutrition as he states many times that he has no money. Prescribed Medications at DAAS Multivitamins Folic acid Thiamine Diazepam Effects of drinking on clients health Research shows a BrAC of 0.10 – 0.19 can lead to anger, impaired control and impaired reaction times. Or Research shows a BrAC of 0.20 – 0.29 can lead to severe motor impairment, impaired sensations, loss of consciousness, memory blackout and loss of understanding. Or Research shows a BrAC of 0.30 – 0.39 can lead to severe central nervous system depression, unconsciousness and the possibility of death. Health – Psychological presentation

	Mr [redacted] engaged well during the assessment with nursing staff and other clients. Mr [redacted] denied any self-harm thoughts, suicidal ideation or perceptual disturbances. Nil mental health concerns during the assessment.

(e) CAPACITY OF CLIENT TO BENEFIT FROM MANDATORY TREATMENT ORDER

Would the client benefit from a mandatory treatment order?	Yes
Basis for opinion (include tools, measures and standards used)	MRTO to Saltbush Mob: Mr [redacted] is currently in the contemplative stage of change. He reports he does think he has a problem with drinking and does want to cease his alcohol use. He also acknowledges the impact of his alcohol use on his health and social welfare. Mr [redacted] meets seven of the seven criteria for alcohol dependence as per DSM IV. Mr [redacted] would benefit from an MRTO as it will provide him with an extended period of abstinence from drinking to: - Improve his general wellbeing and investigate future guardianship as recommended by DAAS MO. - Assist him to understand and resolve any underlying issues related to his high risk drinking levels - Increase his capacity to recognise and understand the negative consequences of drinking at high risk levels - Assist him to acquire a vocation in greens keeping through the SMB aftercare work program training (which has been requested by Mr [redacted] himself).

(f) LESS RESTRICTIVE INTERVENTIONS REASONABLY AVAILABLE TO DEAL WITH RISK

Are less restrictive interventions reasonably available to deal with risk?	No
Basis for opinion (include tools, measures and standards used)	Risk management plan / Treatment options • Mr [redacted] is cognitively impaired • Mr [redacted] does not have stable accommodation, but lives in the long grass. • Mr [redacted] does not have a non-drinking support person. • Mr [redacted] does not have telephone access or reliable transport and is unlikely to be able to connect with a community treatment service or an outreach service for weekly counselling. Guardianship investigation has been discussed with STC Mr Peter Ashley as an option with nil issues raised by Mr Ashley. Clients Request regarding Treatment Mr [redacted] has requested a residential order since arriving to DAAS as he has identified that he continues to have a problem with alcohol and wishes to obtain future employment to occupy himself. Persons consulted for information Mr [redacted]: client Fiona Webster: DAAS SAC Dr Christine Watson: DAAS MO Angela Huddleston: DAAS ALO Bernadette Nethercott: AIS Interpreter -

PART D

Treatment Plan
(Section 22(3)(c) of the *Alcohol Mandatory Treatment Act 2013*)
Details of the treatment service program have been discussed with client.
Please refer to the attached program outline.

Appropriate treatment for client	Mandatory Residential Treatment Order
Declared treatment providers with available capacity to offer appropriate treatment	☒ Saltbush Mob Darwin ☐ Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) ☐ Central Australian Aboriginal Congress [redacted] ☐ Barkly Region Alcohol & Drug Abuse Advisory Group (BRADAAG) ☐ Drug and Alcohol Services Association Alice Springs [redacted] ☐ Holyoake Alice Springs ☐ Kalano Community Association ☐ Mission Australia ☐ Bushmob (under 25) ☐ Catholic Care ☐ Council for Aboriginal Alcohol Program Services(CAAPS) ☐ Banyan House ☐ Amity Community Services ☐ Salvation Army (Sunrise Centre) [redacted] ☐ Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties Corporation (FORWAARD)

Signature of Senior Assessment Clinician [redacted]

Fiona Webster

Date:

☒ *Lodged with Tribunal at ——2000 hours on 14/05/2016.*
☐ *Form placed on Clinical File no:*

Magazine

Treating alcoholics - with wine

By Linda Pressly
BBC News, Ottawa

7 July 2016 Magazine

wanted was the effect. I don't drink that stuff anymore - it makes me feel sick to think of it. And I drink much less here."

Wine is brewed at the Oaks

If anyone shows signs of intoxication, they will not be served.

"It doesn't happen very often, but if they're drunk, I ask them to go to their room and take a nap," says Lucia Ali, one of the frontline staff at the Oaks who works the bar.

Find out more

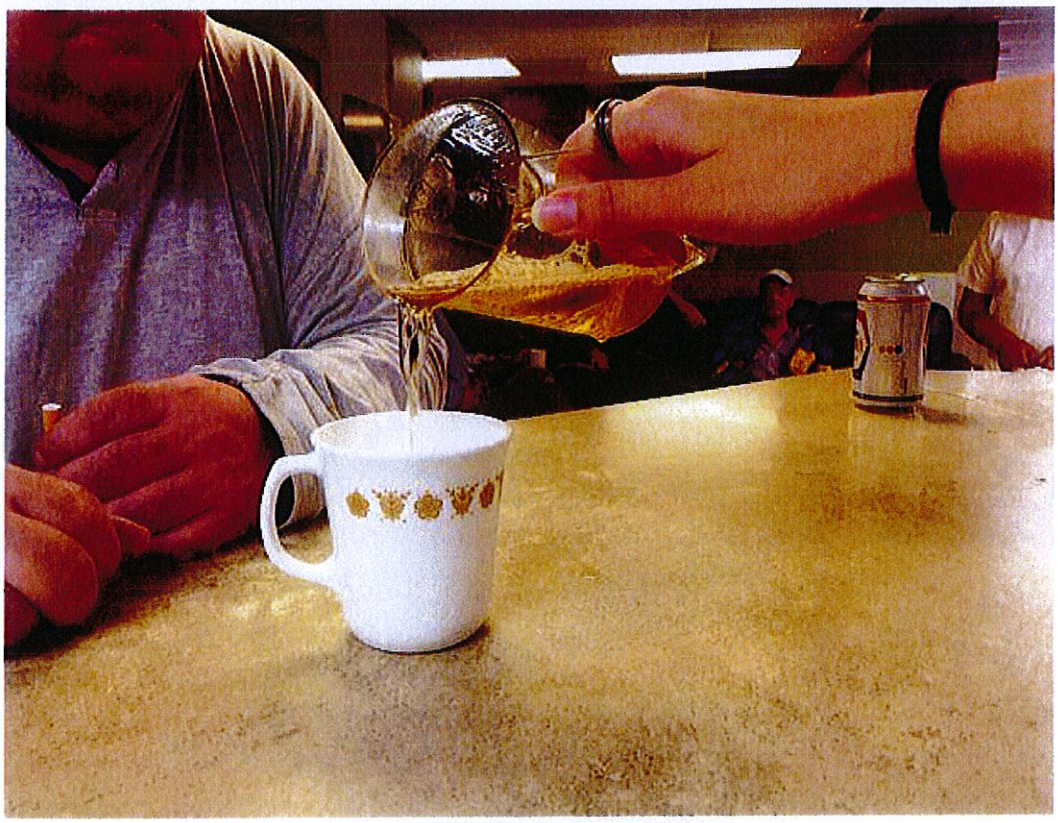
Linda Pressly's report The City Giving Wine to Alcoholics can also be heard on Assignment on the BBC World Service - **click here for transmission times**. You can catch up on the **Catch up on BBC iPlayer Radio**

Ottawa's Managed Alcohol Program - or MAP - was designed to address the needs of homeless people who had tried to stop drinking and failed. The scheme was the brainchild of a group of health professionals around 15 years ago.

and the Oaks opened in 2010. But the approach was controversial.

"I got death threats," remembers Dr Turnbull who continues to be the physician in charge at the Oaks.

divided about harm reduction
Dr Jeff Turnbull, Physician in charge



"The addiction community is very divided about harm reduction. There are some proponents who feel so strongly about abstinence as the only treatment for alcoholism, they just couldn't see an alternative."

The Oaks' residents contribute to the cost of their keep - and the wine - through pensions and state benefits. After collecting their drinks from the counter, they amble into the common area, or take their drinks to the courtyard outside and light up a cigarette.

They chat with their friends, play cards - or sit, sipping and staring into space. There is a TV room, and a computer. There are outings and shopping trips. One of the staff runs a gentle keep-fit class. It is a calm, stable environment, and it has enabled many to flourish. Some have re-established contact with their families; others are hoping to volunteer or even go back to

"I'd say a minimum of half a dozen times a shift we get calls like this one," says Sgt Boucher. "It's sad that this man's life has come to this, but alcohol is a demon he's going to have to deal with all his life."

Lifelong alcoholics are an enormous drain on public resources.

"One of our clients was in the emergency department 191 times in the six months preceding coming onto the MAP," says Dr Turnbull. "And that was just in our hospital. He could've been in other healthcare facilities during that time as well."

Dr Jeff Turnbull

No one study about the MAP has crunched the numbers fully, but it is not unrealistic to assume that the city of Ottawa has saved millions of dollars.

"There's a profound reduction in 911 calls, hospital emergency visits, paramedic and police encounters," says Dr Turnbull.

"I was prosecuted for unintentional manslaughter. I got in a car wreck, and unfortunately I ended up killing a woman. It stays with me every day."

Too often, regret and shame cast a shadow over alcoholic lives. But there is also hope.

Back at the Oaks, another queue forms for the hourly "pour". Corinne Jackson has lived here for nearly six years, but she is not waiting in line. It is three months since she had the hourly glass of Californian white.

"I started to get sicker and sicker. And I thought - I just don't want to do that anymore. I turned 50 last year, and I don't want to be another person that dies here too young."

Corinne Jackson

After 18 years of heavy drinking, Corinne put the brakes on.

"Alcohol ruined many of my relationships. I had a job at one of the nicest hotels in Ottawa - I lost that," she says.

Corinne's partner lives at the Oaks with her - he stopped the hourly pour last year. But the couple have not stopped drinking altogether.