North Australian Aboriginal Justice Agency

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Inquiry into a Northern Territory Harm Reduction Strategy for Addictive Behaviours

Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

Dated September 2018

Introduction

The North Australian Aboriginal Justice Agency (***NAAJA***) welcomes this inquiry into effective harm reduction strategies used to address health problems associated with illicit drug-use and other addictive behaviours as well as strategies for reducing the impact of these behaviours on families and the broader community in the Northern Territory (***NT***). NAAJA appreciates the opportunity to make a submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours.

Alcohol consumption and drug use are significant and disproportionate contributors to the harm, including homicide, violence and suicide, experienced by Aboriginal people compared with non-Aboriginal people.[1] Further, those who drink or use are vulnerable to substance misuse because of complex issues arising from trauma and disadvantage, which by extension, can result in contact with the criminal justice system. Unaddressed trauma in the Northern Territory is also commonly inter-generational. We are concerned also at the harm associated with systemic discrimination which appears to be embedded across systems where Aboriginal Territorians have high contact including, for example, the criminal justice system (and as indicated by the lack of reform or even a formal response to the Australian Law Reform Commission's Pathways to Justice report, amongst other related government inquiries and reports where NAAJA has made submissions). As such, the importance of treatment programs and support services aimed at reducing substance-based harm that **engage and empower** Aboriginal people is paramount. Equally, culturally appropriate treatment settings are vital, given that between 2014-15 65% of clients in the NT receiving treatment for their own substance use were Aboriginal Australians.[2]

Our brief submission does not necessarily intend to provide technical answers in this space, but to prompt thinking based on our experiences working across cultures and from a legal service and justice agency perspective.

About NAAJA

NAAJA provides high quality, culturally appropriate legal aid services to Aboriginal and Torres Strait Islander people in the NT. NAAJA was formed in February 2006, bringing together the Aboriginal Legal Services in Darwin (North Australian Aboriginal Legal Aid Service), Katherine (Katherine Regional Aboriginal Legal Aid Service) and Nhulunbuy (Miwatj Aboriginal Legal Service). In January 2018, NAAJA commenced services in the southern region of the Territory bringing together Alice Springs and Tennant Creek. NAAJA and its earlier bodies have been advocating for the rights of Aboriginal peoples in the NT since 1974.

NAAJA serves a positive role contributing to policy and law reform in areas impacting on Aboriginal peoples' legal rights and access to justice. NAAJA travels to remote communities across the Territory to provide legal advice, community legal education and consult with relevant groups to inform submissions.

[1] Central Australian Aboriginal Congress, *Submission to the Australian Law Reform Commission Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (4 September 2017) p.2.

[2] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2014-15* (2016) http://www.aihw.gov.au/.

Types of support that are available to individuals and/or their families who want to address addictive behaviour or substance misuse

In making this submission, NAAJA draws on its experience with a range of clients, including clients who have come into contact with the criminal justice system and are ordered to attend programs and services as part of criminal proceedings, those who have child protection concerns and wish to seek alcohol and other drug (***AOD***) treatment services, clients who wish to undertake rehabilitation in order to be taken off the Banned Drinker Register (***BDR***) as well as other clients who voluntarily seek the support provided by treatment programs.

Clients in remote communities and Katherine have extremely limited options in terms of available AOD treatment programs and services, including withdrawal management services, residential rehabilitation and community-based on-going care. At present, the only residential option in the region is the Venndale Rehabilitation and Withdrawal Centre (***Venndale***). The obvious disadvantages of having only one centre is that it may not be appropriate to every client's particular set of needs and the centre is often at capacity, meaning that many clients are turned away.

Further, not all communities have access to resident AOD workers (as AOD treatment is often limited to residential rehabilitation in urban centres), and, even where they do, the available AOD service may not service their needs. Due to the lack of intensive support in communities, clients living remotely are often required to travel to town centres to access more appropriate and intensive services and places which may not be appropriate according to their individual needs.

Barriers and challenges that face Aboriginal people in accessing support for themselves or a family member

There are many barriers to AOD service and program access for Aboriginal people, ranging from:

a) **Financial cost** of the service, including travel costs and accommodation.
b) **Inaccessible location** of the service and lack of available transportation, particularly for clients in remote communities. The need to leave communities to access mainstream rehabilitation services is often a disincentive to entering treatment.
c) **Limited spots** in programs that do not coincide with a client's need to access the service. Long waiting times can also mean "lost opportunities for change for individuals with dependence and multiple life stressors."[3] For clients in prison, there are also limited opportunities to access prison-based programs and therapeutic services. Increased waiting times to access programs or inability of access due to disability with hearing loss or mental illness means that there is limited opportunity for rehabilitative support.[4] Further, a significant issue of concern is that we do not have a proper understanding of the extent of Fetal Alcohol Spectrum Disorder across the Northern Territory population and therefore we have no understanding from a systems perspective as to what suitable responses are included in the context of addictive behaviors.
d) **Language barriers** and lack of Aboriginal language interpreters;

[3] Dr Jonathan Brett et al, 'Mind the gap: what is the difference between alcohol treatment need and access for Aboriginal and Torres Strait Islander Australians?' (2016) p.5.
[4] NAAJA, *Submission to the Australian Law Reform Commission Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (October 2017) p.29.

e) The **inability of some services to accommodate the client's children or other family members.** NAAJA appreciates that some residential services in Darwin accommodate patients' children (such as The Council for Aboriginal Alcohol Program Services Aboriginal Corporation (***CAAPS***)) but not all. In Katherine however, Venndale does not cater for children, even where both parents are attending services. If a person is required to leave their community to access a service, they may not have anyone to take care of their children they are forced to leave behind. This can deter people from attending programs as they will only want to go if they can take their family – this is particularly the case for Aboriginal women who are the primary caretakers of young children and cannot afford to leave them for significant periods of time to undertake residential treatment programs.

   This deterrence is also often linked to child protection issues and clients' fear of leaving children behind to attend a service if there is a threat of their child being removed. One of NAAJA's civil lawyers in Katherine is aware of several clients who have been unable to take their children to Venndale or the accommodation at VTEC (next to Venndale) which has delayed reunification with their children.

f) **Related housing issues**. In accordance with the *Residential Tenancies Act* (NT), tenants are required to notify the Department of Housing if they are absent from their dwelling for more than 30 days. Further, tenants are required to inform the Department of extended absences in order to avoid repossession on the assumption the dwelling is abandoned.[5] One of NAAJA's clients secured a space at a CAAPS facility in Darwin but had to advise Housing of her intended absence and organise an inspection, which caused stress and delay. Further, it is a concern for some clients that if they are required to be away for a longer period than initially expected, this could lead to issues retaining their housing, which may deter them from seeking support or attending a program. The housing framework across the Territory should have clearly accessible pathways for those who are actively addressing their addiction issues particularly as accommodation is often an enabling factor for successful rehabilitation.

g) **Shame and stigma**. For Aboriginal people, shame in accessing AOD services and programs is informed by cultural aspects, as this can be seen to be admitting a person has a problem that is not supported appropriately by those in the person's network.

h) **Some services reserve available places** at their facilities either entirely or in part for people who are on court orders. For example, NAAJA has experienced difficulty in the past when trying to secure places for clients who are given urgent referrals to Venndale in Katherine. These circumstances mean that it is often more difficult for clients who wish to access services and programs on a voluntary basis. This leads to significant concerns in relation to the incentive (or disincentive) structure for access to services and criminal justice. Clear, accessible pathways for entry into programs is necessary for those who are not in contact with the criminal justice system.

Treatment approaches that have been successful

NAAJA has received an abundance of positive feedback about Bushmob, a community-based, therapeutic service for high-risk young people aged 12 – 25 years who use alcohol and other

[5] Department of Housing and Community Development, *Extended Absences and Caretaker Arrangements Policy* (20 January 2017) https://dhcd.nt.gov.au/__data/assets/pdf_file/0019/266113/Extended-Absences-and-Caretaker-Arrangements-RELEASED-30-01-2017.pdf.

drugs and engage with the youth justice system. BushMob runs a residential treatment facility and program in Alice Springs (and also previously at Loves Creek Station).[6]

The program allows each participant the option of a support person who can stay with them for a few days when the program commences. Participants are required to undertake alcohol and other drug assessments, receive medical check-ups and counselling. The BushMob residential program professes to be an individualised service, tailored to meet the needs of young people living in Central Australia and guided by the community in which it operates.[7] The cultural component of the program is "a particularly good fit with the client group", as they know that the organisation has strong links with some of the Aboriginal leaders in the community – which means that they have trust in the program.[8]

Young people come from all over the NT to access services provided by BushMob. It is important to note that this is not by choice, but rather due to a lack of comparable facilities elsewhere in the NT, aside (and to an extent) from CAAPS in Darwin and the Mt Theo Program in Yuendumu.[9] Aboriginal people, particularly youth, should not be moved away from their country and community, however these movements are inevitable due to a lack of adequate NT regional service provision. The desert area, where BushMob is located, can be very different to the Top End and the lack of alternative options restricts individually tailored plans.

As such, NAAJA recommends that funding be made available to expand BushMob's model elsewhere in the NT. It is critical to note that this model would need to be modified to reflect local ownership and circumstances specific to each community. A sense of community ownership and inclusion is critical, especially in remote communities. For example, when BushMob was being set up, there were conversations with local community members and Elders to gauge interest in and support for the program. Once support was given, a community meeting was held, and a steering group of young people and adults was appointed to guide initial funding applications, vision and direction. Bushmob maintains its connection with Elders for feedback and oversight.[10]

Reasons why people do not complete their treatment programme

NAAJA submits that the abovementioned factors that act as barriers and challenges for Aboriginal people seeking support also explain why AOD treatment programs are often not completed.

In addition, incidents of self-discharge or "taking own leave" can explain why some clients do not complete an AOD program. Clients may take own leave for a number of reasons, including the absence of interpreters in facilities, a need to attend to children and other family matters,

[6] See http://www.bushmob.com.au/.

[7] Bushmob Aboriginal Corporation, *The Bushmob model of treatment for high risk children and Young People in the Northern Territory who use alcohol and other drugs, and engage in criminal and other anti-social behaviours* (2016) http://www.bushmob.com.au/wp-content/uploads/2016/12/Bushmob-Model-Final-061216.pdf.

[8] Bowchung Pty Ltd & Turning Point Alcohol and Drug Centre, *Review Of The Scope Range And Effectiveness Of Alcohol And Other Drugs Treatment Services In Alice Springs: Bushmob Incorporated* (December 2009) p.5. https://childdetentionnt.royalcommission.gov.au/NT-public-hearings/Documents/evidence-2017/evidence1june/Exh-484-009.pdf.

[9] Statement by Will MacGregor to the Royal Commission into the Protection and Detention of Children in the Northern Territory (9 May 2017), pp. 12-13 https://childdetentionnt.royalcommission.gov.au/NT-public-hearings/Documents/evidence-2017/evidence1june/Exh-484-000.pdf.

[10] Ibid.

not coping with being removed from their home and community, and rudeness and disrespectful interactions with staff that create beliefs around racism or misunderstanding.[11]

Services and programs lacking cultural competency is another reason why Aboriginal people may not complete AOD programs. The importance of culturally competency in services and programs delivered to Aboriginal persons is further explained below.

How to improve the availability and delivery of treatment programmes

Cultural Competency

a) Importance of culturally competent AOD programs and services for Aboriginal people

Cultural competency is "integral to delivering services to Aboriginal people."[12] Not only that, a connection to culture through meaning, family, spirituality and identity has been proven to be effective in treatment of AOD use with Aboriginal people.[13] Unfortunately however, there remains a shortage of culturally appropriate AOD rehabilitation programs and services for Aboriginal people in the NT.[14]

Whilst there appears to be no commonly understood meaning for the term 'cultural competency' in legal or health service delivery, cultural competency is increasingly recognised for its importance in services accommodating Aboriginal viewpoints. It is Aboriginal people who determine what is culturally competent. Aboriginal approaches to communication can differ significantly to that of the dominant culture, so there needs to be nuanced considerations of how these views are accommodated into services and systems. From a health perspective, people in control and who have choices have improved health outcomes. Direct discrimination adversely effects health outcomes. What shapes addictive behaviours is complex and largely misunderstood, particularly from the nuance of an Aboriginal position. It appears relevant to consider the role that institutionalised or systemic discrimination serves given the significant power imbalance, the lack of agency for Aboriginal people to serve meaningful roles within these systems and how these systems generally don't take into account the nuanced views of Aboriginal people who seek to exert more control.

In a recent submission to the alcohol policy and legislation review, NAAJA emphasised the importance of cultural competency to empower Aboriginal people in response to social issues, such as alcohol.[15] Whilst cultural competency and responses to substance abuse is a complex area, this framework can offer guidance and direction for improved service and treatment program design. A guiding principle of NAAJA's cultural competency work is "the cultural

[11] See NAAJA, *Submission to Department of Health NT Consultations on National Take Own Leave Project* (March 2017). See also, *Aboriginal and Torres Strait Islander Health Performance Framework* (2014 Report), p. 142 https://www.pmc.gov.au/sites/default/files/publications/Aboriginal_and_Torres_Strait_Islander_HPF_2014%20-%20edited%2016%20June2015.pdf.

[12] NAAJA, *Submission to Department of Health NT Consultations on National Take Own Leave Project* (March 2017).

[13] See, eg, National Indigenous Drug and Alcohol Committee*, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples* (June 2014) p.9; Closing the Gap Clearinghouse,*Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people* (Issue Paper 12, 2014).

[14] APONT, *Submission to the House of Representatives Standing Committee on Indigenous Affairs Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait communities* (17 April 2014) p.29.

[15] NAAJA, *Submission to the Expert Panel, Alcohol Policies and Legislation Review* (July 2017) pp. 28-29.

landscape in the NT is rich and diverse and we value this diversity".[16] This guiding principle is explained as follows:

> Whilst there are some common bonds between all Aboriginal peoples in the NT there is also significant diversity including languages, culture, history, families, geography, and proximity to service centres, and so on. Whilst many programs, policies and approaches refer to Aboriginal people as a single group, NAAJA recognises this diversity and seeks to put in place programs, policies and approaches to accommodate this diversity.

In NAAJA's observation, many programs and approaches which seek to enable people to more effectively address their addictive behaviors do not adequately resource and take into account the need to accommodate this principle of cultural diversity. That is, they don't enable taking 'the family or community along with them' in addressing the causal factors underpinning these behaviors.

Existing programs and services, including the following, comprise the status quo for dealing with substance abuse in the NT:

- Residential rehabilitation led by Aboriginal community-controlled organisations (however in our direct experience we understand from time to time there is a shortage of beds and capacity at these centres, particularly in Katherine and remote communities); and
- Limited programs such as placing AOD workers across communities with limited resources and detached from culturally adapted programs.

NAAJA respectfully submits that this framework is insufficient in meeting the complex, diverse and varied needs of Aboriginal people in dealing with substance abuse. That is, these programs and services collectively are too disconnected from the diversity and richness of the Aboriginal cultural landscape in the NT to effect more meaningful change and harm reduction. In our submission, the suitability of existing AOD treatment requires consideration and cultural adjustment, in order to given Aboriginal people meaningful agency.

It is important to recognise that there is no "one size fits all" approach to therapeutic services for Aboriginal people. In a statement to the recent Royal Commission into the Protection and Detention of Children in the Northern Territory, one of NAAJA's civil lawyers commented on the appropriateness of Western concepts of "talk therapy" for Aboriginal clients.[17] Talk therapy may indeed work well for some people, however NAAJA has seen reluctance by some clients to participate in this type of treatment because they feel like they are repeating themselves, feel shame or anxiety in the treatment provider's environment, or struggle to open up.

Further, reception of therapeutic services may be improved if people are able to access those services in an environment where they feel comfortable. A lawyer from NAAJA's Katherine office has observed this in her own practice, in situations where she has far more effective conversations with clients in their own homes than in the environment of a formal office. Also, residential rehabilitation can be good to break the cycle of consumption, but change will be

[16] NAAJA has developed a '*Cultural Competency Framework 2017 - 2020'* as a strategic outline of how we operate as an organisation providing a culturally appropriate service. The Framework sets out a number of key strategies and actions which reflect a meaningful commitment to developing cultural competency.

[17] See Statement by Brianna Lea Bell (Solicitor, NAAJA Civil Section) to the *Royal Commission into the Protection and Detention of Children in the Northern Territory* (26 May 2017).

more sustainable if it is learned, supported and implemented within a person's usual environment, including all of life's normal temptations.[18]

NAAJA recommends that more funding be diverted to culturally competent AOD rehabilitation services, including voluntary services, across all regions in the NT. There is a need for long term trials of more culturally appropriate methods of rehabilitation as well as the provision of funding to a rehabilitation provider in partnership with an Aboriginal community organisation to jointly develop "on country" rehabilitation programs that not only educate people about the harm of substance abuse and strategies to resist temptation, but also help people heal their spirit and re-connect with their country.[19] Programs that take into account culture need to be tested and tried differently including Aboriginal led review and evaluation mechanisms built in. NAAJA recommends that AOD programs and services are supported to implement ongoing cultural competency frameworks, to ensure that Aboriginal participants have access to services such as interpreters and Aboriginal case workers. By investing in, and building robust frameworks including improved accountability mechanisms to ensure the more nuanced approaches are understood and incorporated, there will be an improved understanding of how to better address addictive behaviors.

b) Trauma, addictive behaviours and Aboriginal people

Often in Aboriginal settings, trauma is unacknowledged as a contributing factor to high rates of substance misuse.[20] It must be understood that Aboriginal communities often carry the burden of intergenerational and ongoing trauma resulting from colonisation and historic and ongoing government policies, institutional racism, discrimination and the effects of entrenched disadvantage and disconnection from traditional lands, languages and cultural practices. Alcohol and substance misuse has been associated with this trauma experienced by Aboriginal persons, as it is often used as a coping mechanism for dealing with unresolved trauma and psychological distress.[21] Trauma has profound impacts on the physical and mental health and wellbeing of individuals as well as the broader community.

NAAJA endorses the recommendations put forward by AMSANT to this inquiry, namely that culturally responsive trauma-informed care should be adopted by all organisations providing services to people with addictive behaviours and an effective harm reduction strategy must seek to address the social determinants, including housing, family violence, discrimination and racism.

c) The importance of programs and services that accommodate families

As identified above, there is a need for more residential rehabilitation facilities in the NT which can accommodate families. AOD-related issues can be experienced by both parents of a child.

[18] Ibid p.18.

[19] Ibid.

[20] Pat Dudgeon, Marshall Watson and Christopher Holland, 'Trauma in the Aboriginal and Torres Strait Islander Population' 3(1) *Australian Clinical Psychologist* 19, 27.

[21] AMSANT, *Submission to the Alcohol Policies and Legislation Review in the NT* (July 2017) p.7 https://alcoholreform.nt.gov.au/__data/assets/pdf_file/0012/439977/Aboriginal-Medical-Services-Alliance-NT-Submission.pdf.

If this is the case, one partner will have to remain out of treatment, which can cause more stress on the family.[22]

Parents may be disinclined to seek out or accept rehabilitation if they fear that there is a risk of their children being removed. As such, there is demand for the provision of spaces in facilities where parents can rehabilitate with their families and avoid exacerbating existing trauma through the removal of their children.

Further, family therapy has been proved as an effective culturally-specific form of counselling for those with AOD conditions.[23] Family members experience emotional, spiritual and health-related harm as a result of persons' substance misuse. Further, involving supportive family members can aid in empowering the person and making them more responsive to positive change,[24] as opposed to isolating the person from their family and community in circumstances where they must leave their families to access treatment.

d) Broader advantages of culturally competent AOD programs and services

Studies have noted improved outcomes with reduced alcohol and other drug consumption, when tailored family-based interventions developed with input from Aboriginal communities have been adopted.[25] For example, one study's evaluation of a program demonstrated a positive impact on mental health and substance use through the involvement of Elders caring for young people on their land.[26]

Further, prioritising cultural competency in AOD services and programs would go a way to retaining Aboriginal patients. For example, there has been a significant reported reduction in take own leave rates at Katherine hospital in recent years (with only 4% of Aboriginal patients taking own leave in 2017) due to the introduction of highly trained specialist doctors who are invested in the community, interpreters being used regularly and families of Aboriginal patients being consulted on complex treatment plans.[27] Such an approach may yield similar results were it to be adopted in the delivery of AOD programs and services to Aboriginal people and their families.

Aboriginal AOD workers and the need for cultural training

To improve access to support services for Aboriginal people, there should be increased funding for AOD workers in remote Aboriginal communities, and particularly to expand the

[22] National Drug Research Institute, *Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions* (Revised August 2014) p.7-8.

[23] AMSANT, *A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory* (Revised 2011) p.6.

[24] Central Australian Aboriginal Congress, *An evidence-based approach to providing AOD treatment to Aboriginal people and their families* (2015) p.2.

[25] See, eg, Calabria, B et al, 'Epidemiology of alcohol-related burden of disease among Indigenous Australians' (2010) 34(1) *Australian and New Zealand Journal of Public Health*,pp.47-51; Preuss K, Brown JN, 'Stopping petrol sniffing in remote Aboriginal Australia: key elements of the Mt Theo Program' (2006) 25(3) *Drug and Alcohol Review,* pp. 189–193.

[26] Nagel T, Robinson G, Condon J, Trauer T, 'Approach to treatment of mental illness and substance dependence in remote Indigenous communities: results of a mixed methods study' (2009) 17(4) *The Australian Journal of Rural Health* 174.

[27] See, eg, Hagar Cohen, 'How Katherine Hospital, once Australia's worst for Indigenous Health, became one of the best, *ABC News* (28 March 2017) http://www.abc.net.au/news/2017-03-28/katherine-hospital-from-worst-in-the-country-to-one-of-the-best/8392792.

Aboriginal AOD workforce. The employment of Aboriginal people, in both Aboriginal-specific programs and mainstream programs, contributes to the development and maintenance of culturally competent services.[28]

NAAJA supports the recommendation put forward by the National Indigenous Drug and Alcohol Committee, namely that non-Aboriginal AOD workers need to be culturally competent.[29] There should be mandatory cultural competency training for AOD workers, and, for those working in remote communities, training should be adapted to the local context so that it is community-specific. Further, appropriate salaries, career pathways, training, mentoring and supervision, and other forms of support are important for strengthening the AOD workforce, particularly the Aboriginal workforce where a lack of such support is noted.[30]

Holistic, individualised approach to treatment

The *Alcohol Treatment Guidelines for Indigenous Australians* (2014) provides a comprehensive approach to the clinical management of AOD problems with an emphasis on developing a holistic care plan inclusive of treatment for general health, mental health and social issues.

NAAJA endorses this approach in recognition of the need for programs to address underlying factors that lead to substance abuse, such as unemployment, housing arrangements and levels of education, family commitments, and child care etc. 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 Aboriginal compared to non-Aboriginal clients.[31]

Further, the importance of individualised approaches has been identified as a key element of successful programs delivered to Aboriginal persons. In particular, 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.[32] Clients also reported greater satisfaction if a treatment program was responsive to their individual needs. [33]

Genuine, Aboriginal-led programs and services

There is adequate evidence to demonstrate that well-resourced programs that are owned and run by Aboriginal communities are more successful than generic, short-term, and sometimes inflexible programs imposed on communities.[34]

Resources must be allocated to engaging with Aboriginal-controlled organisations and key AOD stakeholders through consultation regarding options for addiction services in order to develop best practice models. There is a need to evaluate how to better involve Aboriginal

[28] AMSANT, *Priorities for Aboriginal Primary Health Care in the Northern Territory* (May 2016) p.17.
[29] NIDAC, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples* (June 2014) p.20-21.
[30] Ibid.
[31] PwC's Indigenous Consulting with Menzies School of Health Research, *Evaluation of the Alcohol Mandatory Treatment Program* (Northern Territory Department of Health, January 2017) p. 102.
[32] Perron, B & Bright, C,. 'The influence of legal coercion on dropout from substance abuse treatment: Results from a national survey' (2008) 92(1) *Drug and Alcohol Dependence*pp.123-131.
[33] Ibid.
[34] Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, *Little are Children are Sacred* (2007), p.53.

elders and communities in the design and delivery of AOD programs and services, as well as in Aboriginal clients' exit from these addiction services and the process of community re-integration. It is submitted that Aboriginal community-controlled organisations are best placed to offer continuity in the type of holistic care required for Aboriginal clients.[35] Further, it has been shown that residential rehabilitation (whether voluntary or mandatory) without counselling and/or diversion support in communities, has a high relapse rate.[36] As such, post-treatment community aftercare should be an essential component of AOD treatment programs.

The importance of partnerships in care and treatment has been recognised, and it has been suggested that receptivity to treatment is enhanced if Aboriginal-controlled organisations have significant input in relation to program design and delivery.[37] Effective partnerships between researchers and health services has been identified as critical to supporting meaningful evaluation of the transfer and implementation of health services and programs to Aboriginal settings.[38]

Greater funding to establish facilities in remote Aboriginal communities and cover travel costs and accommodation

There is an urgent need for greater investment to ensure that AOD programs and services are accessible for all people in the NT, regardless of where they live. NAAJA submits that there is great need to expand services and programs available to Aboriginal persons living in remote communities, on the basis that community-based programs are more accessible and appropriate for Aboriginal clients, as explained above. Services, both residential and non-residential, need to be both culturally secure and to provide holistic, evidence-based care.[39] The government should provide additional funding to enable the spread of proven, evidence-based programs, such as Bushmob. For example, the government could develop a dedicated program of supporting community-led and driven initiatives that relate to healing and substance misuse by investing in and resourcing cultural authority and local initiatives.

NAAJA recommends that, to facilitate access, funding is made available for AOD services and programs to cover the cost of a client's transport and accommodation, where for example, they meet certain criteria.

[35] APONT, *Submission to the House of Representatives Standing Committee on Indigenous Affairs Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait communities* (17 April 2014) p.27.

[36] See, eg, Department of Health and Ageing, *Australian Treatment Guidelines for Alcohol problems* (2010); Gray D, Saggers S, Wilkes E, Allsop S, Ober C. 2010 Managing alcohol-related problems among Indigenous Australians: what the literature tells us. Aust N Z J Public Health. 2010 Jul; 34 Suppl 1:S34-5.v.

[37] Brady, M,*Indigenous residential treatment programs for drug and alcohol problems: Current status and options for improvement* (Discussion Paper 236, 2002)..

[38] McCalman, J, Tsey, K, Clifford, A, Earles, W, Shakeshaft, A & Bainbridge, R., *Applying what works: a systematic search of the transfer and implementation of promising Indigenous health services and programs* (2012) http://www.biomedicalcentral.com/1471-2458/12/600.

[39] Dr Jonathan Brett et al, *Mind the gap: what is the difference between alcohol treatment need and access for Aboriginal and Torres Strait Islander Australians?* (2016) p.5.