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NCETA
Australia's National Research Centre on AOD Workforce Development

Illicit Drug Use and Harms in the NT: Qualitative Insights from Key Stakeholders

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Acknowledgement of Country

NCETA and Rural and Remote Health NT respectfully acknowledge the Traditional Owners and Custodians of the lands on which campuses are located, these are the Traditional lands of the Arrernte, Dagoman, First Nations of the South East, First Peoples of the River Murray and Mallee region, Jawoyn, Kaurna, Larrakia, Ngadjuri, Ngarrindjeri, Ramindjeri, Warumungu, Wardaman and Yolngu people. We honour their Elders past, present and emerging.

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- NT Department of Health, and respective hospital, health services and policy staff and executives

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Publication Disclaimer

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About NCETA

NCETA is based at Flinders University in South Australia and is a collaboration between the University and the Australian Government Department of Health and Aged Care. It is Australia's national research centre on alcohol and other drugs (AOD) workforce development with an international reputation as a catalyst for change in the AOD field. NCETA's areas of expertise include developing strategic resources and programs, and the provision of training and other workforce development approaches to cater for the needs of specialist AOD workers; frontline health and welfare workers; Aboriginal and Torres Strait Islander workers; community groups; mental health workers; police officers; and employer and employee groups.

The Centre focuses on supporting evidence-based change and specialises in change management processes and making complex and disparate information readily accessible to workers and organisations. We aim to advance the capacity of organisations and workers to respond to AOD-related problems. Our core business is the promotion of workforce development (WFD) principles, research and evaluation of effective practices; investigating prevalence, and effects of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and other organisations.

About Flinders Rural and Remote Health NT

Flinders Rural and Remote Health NT is a hub for innovative health research, education, and workforce development in the Northern Territory (NT). It has served the NT community in this way for the past 25 years, and has campuses based in Nhulunbuy, Darwin, Katherine, Tennant Creek and Alice Springs. All activities are driven by our values which focus on meeting the long-term and short-term needs of the NT community. Flinders in the NT delivers the Northern Territory Medical Program (NTMP), provides student placement and workforce capacity support through the University Department of Rural Health, and operates the Flinders NT Regional Training Hub, who in collaboration with stakeholders, is tasked to further develop capacity for NT medical specialist and rural generalist training, thereby addressing workforce need. Flinders in the NT also provides workforce development through multi-disciplinary postgraduate education (Remote Health Practice program), cultural awareness and other training. Our research in the NT sits at the nexus of rural and remote health, and Aboriginal and Torres Strait Islander health, with a rapidly growing Aboriginal and Torres Strait Islander research workforce.

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Abbreviations

AADANT – Association of Alcohol and Other Drug Agencies Northern Territory

ACCHS – Aboriginal community-controlled health service

ADF – Alcohol and Drug Foundation

AIHW – Australian Institute of Health and Welfare

AOD – Alcohol and other drugs

AODTS-NMDS – Alcohol and Other Drug Treatment Services – National Minimum Dataset

CATT – Crisis Assessment and Treatment

DBT – Dialectical behavioural therapy

ED – Emergency department

EDRS – Ecstasy and related Drugs Reporting System

F – Female

FASD – Foetal Alcohol Spectrum Disorder

IDDR – Illicit Drug Data Report

IDRS – Illicit Drug Reporting System

IV – Intravenous

M – Male

NCETA – National Centre for Education and Training on Addiction

NDSHS – National Drug Strategy Household Survey

NSP - Needle and syringe program

NGO – Non-government organisation

NT – Northern Territory

NR – Not reported

NTDOH – Northern Territory Department of Health

NTG – Northern Territory Government

PHN – Primary Health Network

SEWB – Social and Emotional Wellbeing

TC – Therapeutic Community

Executive summary

Introduction

NCETA and Rural and Remote Health NT were commissioned by the Alcohol and Drug Foundation (ADF) to undertake an NT Illicit Drugs Needs Review. This included three components:

1. A quantitative analysis of national datasets relating to illicit drugs use and harms in the NT.
2. A qualitative study of key stakeholder perspectives of illicit drugs use and harms in the NT.
3. A rapid review of evidence-based strategies associated with key populations identified in the quantitative and qualitative phases of the study.

This report focuses on the qualitative analysis. Ideally, it should be read in conjunction with the quantitative analysis and the rapid review.

The primary aim of this study was to generate a deeper understanding of the illicit drugs consumption, and needs to reduce harms in the NT from the perspectives of key stakeholders engaged in providing services for, or advocating on behalf of, people who use illicit drugs in the NT. It also provides some preliminary insights from people with direct lived experience of using illicit drugs in the NT.

Methods

This was a descriptive qualitative study that employed individual and dyadic semi-structured interviews that were conducted either online or face-to-face. Interviews were facilitated by researchers familiar with NT health contexts. Ethics approval was provided by the Human Research Ethics Committee of NT Department of Health and Menzies School of Health Research (Ref: 2023-4545).

A purposive sampling approach was adopted. Twenty-one participants were interviewed throughout the study period (April to May 2023). Participants were based in Darwin (*n*=13), Alice Springs (*n*=5), Katherine (*n*=2) and Tennant Creek (*n*=1), reflecting the majority of major centres in the NT. Efforts were made to ensure that a diverse range of stakeholder narratives were captured, including peak bodies; service providers from government, non-government organisations, and specialist Aboriginal Community-Controlled Organisations; health policy-actors and executives; and people with lived experience of illicit drugs use in the NT. Interview data were analysed using a constant comparative method and reflexive thematic analysis approach. Results have subsequently been clustered into thematic areas relating to illicit drug use patterns, harms associated with illicit drug use, perspectives of available programs and services, and priority areas for reducing future illicit drug use and harms.

Key findings

There were seven key findings that emerged from the analysis of interview data. These included:

Key Finding 1: There are diverse patterns of illicit drug use and harms across the NT.

There is considerable diversity of illicit drug use across NT communities and regions. Participants outlined cannabis as the most widely used and commonly available illicit substance across the NT, and males were more commonly seen to use illicit substances compared with females – consistent with the findings of the quantitative analysis. Participants explained that patterns of substance use varied in remote communities and was influenced by supply, availability, and population movement. Despite the focus on illicit substances for this review, some participants emphasised that reducing alcohol-related harms and use was a higher priority.

Key Finding 2: There are priority populations impacted by illicit substance use, namely:

- Aboriginal and Torres Strait Islander people and communities
- Young people
- Socio-economically disadvantaged
- Transient and/or homeless ("long-grassers" and "river people")
- Those impacted by the criminalisation of illicit drug use
- Those living in rural and remote areas

Key Finding 3: Current routine data collection, monitoring, evaluation and research strategies provide an incomplete understanding of the patterns of illicit drug use and harms in the NT.

Participants outlined the need for better coverage of wastewater monitoring, with suggestions that additional testing sites outside of major urban areas would be beneficial. Participants also indicated that there was need to improve the monitoring and evaluation of AOD programs and services.

Key Finding 4: Harms from illicit drugs are wide-ranging and far-reaching. Yet. treatment services are currently prioritised over broader harm minimisation and prevention efforts.

Many participants described the 'ripple effect' of harms associated with illicit drug use. It started at an individual level, such as health and financial impacts, then led to family, community, and broader social impacts. There were several factors that were viewed to influence the extent to which harms occur from illicit drug use. They included:

- socio-cultural characteristics, such as past history of trauma
- co-occurring mental health conditions with illicit drug use
- poly-drug use.

The use of volatile substances was a particular concern because it was commonly seen in young children. Many participants pointed to the need for a renewed focus on harm reduction and prevention efforts, rather than focusing on the ‘pointy end’ [treatment services]. Engaging with existing leaders involved in the NT Harm Reduction Advisory Group, NT AIDS and Hepatitis Council, and the NT Lived Experience Network, were considered important for advancing this agenda.

Key Finding 5: While there are examples of collaboration between services,, it is claimed that there is insufficient resourcing and workforce capacity to provide high quality co-ordinated and integrated care to address the harms of illicit drugs use in the NT.

Participants described a fragmented system, and experienced challenges in collaborative, coordinated and/or person-centred care. Participants noted strengths and weaknesses across the sector, for example a key strength of Aboriginal and Community Controlled Health Services is that they are leading culturally tailored care across the NT. Generally, there were significant limitations for collaboration across the sector, in providing wrap around care for clients, and this was exacerbated by workforce issues. Continuing, coordinated care was described as challenging to achieve due to long wait lists, which are exacerbated by under-resourced services. Participants said residential rehabilitation services are generally tailored towards alcohol, rather than illicit substances. Alcohol and illicit drug interventions, including health promotion and harm minimisation efforts, should occur in synergy.

Key Finding 6: Growing a skilled and competent AOD and mental health workforce to address illicit drugs harms in the NT is important. Current challenges are wide-ranging and relate to workforce attraction and retention issues, an expansive geographical footprint, and limited professional development opportunities in the NT.

The most significant workforce challenge discussed was attracting and retaining a skilled illicit drug workforce. Several participants attributed this challenge to cost of living and housing availability. Specialist input through Addiction Medicine Specialists and/or increasing access to education and training to build capacity and capability of the non-specialist workforce were identified as important. One participant suggested that there needed to be more emphasis on creating opportunities for professional development, upskilling and growth across the sector as a workforce retention strategy. Participants noted the strength of existing peer-to-peer services, and suggested scaling up existing programs and services across the NT that are underpinned by peer-to-peer engagement to increase treatment and harm reduction service accessibility.

Key Finding 7: Policy and legislation mechanisms are not optimally used to reduce illicit drugs harms in the NT.

Participants called for reduced prohibition and criminalisation of illicit substances and administration equipment to reduce harms. For example, one participant noted that possession of smoking drug administration equipment is currently illegal and is associated with severe penalties, so instead participants often inject, increasing their risk of harms.

Introduction

Background

The term "illicit drug use" covers the use of a broad range of substances, including illegal drugs – drugs prohibited from manufacture, sale or possession in Australia, such as cannabis, cocaine, heroin and amphetamine-type stimulants (1). Illicit drug use also includes non-medical use of pharmaceuticals; and use of other legal or illegal psychoactive substances in a potentially harmful way (1). Illicit drug use is highly prevalent in the NT and the use of illicit drugs can be associated with significant harms for individuals, communities, and society.

The 2019 National Drug Strategy Household Survey reported that in the past 12 months, 19.6% of people over 14 years of age in the NT had consumed an illicit substance (2). In the NT, cannabis was the most used illicit drug in the past 12 months (15.9%), followed by cocaine (3.1%), ecstasy (3%) and meth/amphetamines (1.5%) (2). Extending on this data, the quantitative report conducted as part of this review has synthesised recent statistics from a range of datasets (3). People who use illicit drugs have higher rates of transmission of infectious diseases, and higher rates of hospitalisation compared to those who abstain (4). If hospitalised, people who use illicit drugs tend to experience worse hospital-associated outcomes, such as being more likely to be discharged against medical advice, more likely to be re-admitted, and have longer hospital stays (4).

Illicit drug use contributes to a range of social and economic impacts, including risky behaviour, criminal activity, family and domestic violence, contact with the criminal justice system, victimisation and trauma, financial costs, impacts on household expenditure, and lost productivity. The national social cost of illicit opioid use was estimated to cost $15.76 billion in 2015-16 and methamphetamine use was estimated to cost over $5 billion in 2013-14 (5). In the NT, mental illness, suicide and substance use disorders make up approximately 36% of the total burden of disease, which is three times the national average (6). Illicit drug use and harms are associated with substantial health, social and economic impacts and harm reduction is a priority outlined in Australia's National Drug Strategy 2017-2026 (7, 8).

The NT has a unique population and demographic context, which impacts illicit drug use and harms, access to programs and services, and related risk factors. Darwin, the Territory's capital city, is classified an outer regional area and all other areas are remote or very remote (9). People living in rural and remote areas are typically impacted by higher unemployment (more commonly younger people), lower income and education, limited access to health services, and limited social activities (10). These factors place people at a higher risk of illicit substance use and associated harms (10). Of the ~250,000 people living in the NT, approximately 30% identify as Aboriginal and/or Torres Strait Islander (11). Outside of Darwin, approximately seven out of 10 people identify as Aboriginal and/or Torres Strait Islander, and

this proportion increases with remoteness (12, 13). Those Aboriginal and Torres Strait Islander people who consume illicit substances are at a higher risk to experience disproportionate health-related harms (3). As such, the unique social and demographic context of the NT is an important consideration in understanding patterns of illicit drug use in the NT, and respective harm minimisation programs, services and policy responses.

Qualitative research captures data not considered in the quantitative research paradigms and is often used to help contextualise and understand quantitative findings (14). A qualitative approach places emphasis on meanings, experiences and perspectives of those embedded in the context (14). This project utilises qualitative research methods to explore understandings of the complex topic of illicit drug use and harms from the view of stakeholders that have direct experience working with, or advocating on the behalf of, people that use illicit drugs in the NT. Understanding the harms associated with illicit drug use, including local priorities for reducing these harms, are crucial to inform and commission future harm reduction programs and services (7, 8). A locally relevant understanding of illicit drug use and harms across the NT can inform evidence-based programs and services to be more effective, efficient, and equitable.

NCETA and Rural and Remote Health NT were commissioned by the Alcohol and Drug Foundation (ADF) to undertake an Illicit Drugs Use Needs Review in the NT. This included three components:

1. A quantitative analysis of national datasets relating to illicit drugs use and harms in the NT.
2. A qualitative study of key stakeholder perspectives of illicit drugs use and harms in the NT.
3. A rapid review of evidence-based strategies associated with key populations identified in the quantitative and qualitative phases of the study.

This report focuses on the qualitative analysis. It should be read in conjunction with the quantitative analysis and the rapid review.

Methods

Study design and ethics

This qualitative descriptive study (15) employed one-on-one and dyadic semi-structured interviews that were conducted either online or face-to-face (16). This methodological approach was adopted to facilitate a description of perspectives and experiences of illicit drug use, harms and service needs, in the language of participants. This dual approach of online or face-to-face interviews also helped enable time-limited stakeholders who were geographically dispersed across the NT participate in the research. Ethics approval was provided by the Human Research Ethics Committee of NT Department of Health and Menzies School of Health Research (Ref: 2023-4545)

Sampling and recruitment

Eligible participants were adults with direct experience working with or advocating on behalf of people who use illicit drugs in the NT. We also engaged consumers from the NT Lived Experience Network to partially incorporate consumer voices in this project. A purposive sampling approach (14) was completed, leveraging the research team's previous experience working with local AOD stakeholders, and their understanding of the AOD service and policy contexts in the NT. Researchers brainstormed relevant organisations and individuals that could be involved in the qualitative Needs Review, and consulted with expert advisors about the proposed stakeholder list. Potential participants were then invited via email to participate in the study, and were provided with a study information sheet, and consent form. An interview time was subsequently scheduled with each stakeholder interested in participating. Oral or verbal consent was obtained prior to the interview taking place.

Recruitment was completed in a strategic order in recognition of the diversity of views and experiences between participants. First, members of the NT Lived Experience Network and representatives of NT AOD peak bodies and their member organisations were engaged. Next, specialist Aboriginal Community Controlled Organisations with expertise in AOD service delivery were engaged. Then, other AOD service providers, including a range of non-government and government employed clinicians and/or AOD workers. Finally, health professionals, policy staff, and executives within the NT Department of Health, who have an interest in minimising the harms of illicit drugs use in the NT, were engaged in the study. Lived experience participants were provided with compensation for their time. All other participants were volunteers, and no other incentives, reimbursement or honorariums were provided as part of this study.

Data collection

Socio-demographic data, such as participant age, current role, and length of experience in the AOD sector, were collected using a self-completed form. An interview guide was developed by the researchers, reviewed by an expert advisor, and then tested in a one-on-one pilot interview with a representative from AADANT. After this pilot interview, the interview guide was modified to explicitly include the concepts of illicit drug workforce needs, illicit drug program/service monitoring and evaluation, and probing questions about improving trauma-informed care and addressing the socio-cultural determinants associated with illicit drug use and harms. Probing questions were also informed by findings of the quantitative report, such as exploring views of identified at-risk client populations, such as young people, people in contact with the criminal justice system, and Aboriginal and Torres Strait Islander people. The interview commenced with an Acknowledgement of Country, followed by a short interview briefing and key interview questions (Interview guide: Appendix A).

Four researchers conducted interviews (JS, AB, NTK, BB). An interviewer was selected from the research team in response to participants' characteristics and researcher understandings of local context; for example NTK, a lived-experience Research Fellow led interviews with participants from the NT Lived Experience Network; and AB, an allied health academic in Central Australia led interviews with clinicians in Central Australia. The interview guide was used flexibly in response to participants' background, skills, and experiences. BB and SM attended interviews as observers, where they supported the interview facilitator, and assisted with debriefing and analysis. One-on-one interviews aimed to be approximately 30-45 minutes in duration, and dyadic interviews aimed to be approximately 45-60 minutes. All interviews were recorded using Microsoft Teams or an audio-recorder and were transcribed verbatim. A de-identified interview transcript was returned to each participant for verification before analysis.

Data analysis

Interview data were analysed using a constant comparative method and reflexive thematic analysis (17). The steps included in this thematic analysis were to: 1) become familiar with the data, 2) generate initial codes, 3) generate initial themes, 4) review themes, 5) define and name themes and 6) produce the report (18). One researcher (BB) listened to each interview recording and checked transcripts prior to sending them to participants for verification. In this step, the researcher became familiar with the data and identified initial codes. Then, researchers generated codes from each transcript in an inductive, data-driven approach. These codes were then synthesised to form initial themes. All researchers then reviewed and finalised these themes. Themes that related to illicit drug use patterns, harms associated with illicit drug use, perspectives of available programs and services, and priority areas for reducing future illicit drug use and harms were integrated into this report.

Results

Participants

A total of 51 participants were invited to participate in this study. There were 21 interview participants as shown in Table 1 (mean age: 47 ± 11 years, 4 Aboriginal and Torres Strait Islander people, 17 non-Indigenous people). The 30 non-responses or declines were generally due to tight project timeframes, and competing work demands. On average, interview durations were 40-min ± 14-min. Two one-on-one interviews were conducted face-to-face, and all other interviews were conducted online using Microsoft Teams videoconference (April to May 2023). Participants reported being in their current role or a similar role for nearly 10 years (mean: 9.1 ± 8.9 years) and tended to report living and working in the NT for over a decade (mean: 13.1 ± 7.9 years). Participants were based in Darwin (*n*=13), Alice Springs (*n*=5), Katherine (*n*=2) and Tennant Creek (*n*=1). A diverse range of government, non-government, Aboriginal Community-Controlled Organisations, and peak bodies perceived to have an interest in minimising the harms of illicit drug use in the NT participated in the study.

Table 1: Participant Characteristics

Interview type	Number of Participants	Age (yrs)	Gender	Role	Location	Total Interview duration (mins)
5 x Dyadic	10	Mean: 49 Range: 35-62 NR (*n*=1)	M=5 F=5	Peak Body=3 NTG Clinician=2 NGO AOD Service Provider=3 NTDOH Executive=2	Darwin and surrounds=7 Katherine=2 Alice Springs=1	217
11 x One-on-one	11	Mean: 46 Range: 27-62 NR (*n*=1)	M=4 F=7	Lived Experience=4 ACCHS AOD Provider=1 Peak Body=1 NTG Clinician=4 NTDOH Executive=1	Darwin and surrounds=6 Alice Springs=4 Tennant Creek=1	441

Abbreviations: ACCHS, Aboriginal community-controlled health service; AOD, Alcohol and Other Drugs; F, Female; M, Male; NR, Not reported; NGO, Non-government organisation; NTDOH, Northern Territory Department of Health; NTG, Northern Territory Government.

The following sections include themes that have been organised to align with the aims of this review: to explore illicit drug use patterns, harms associated with illicit drug use, perspectives on currently available AOD programs and services, and priority areas for reducing future illicit drug use and harms. All themes are discussed below and supported by illustrative quotations.

Illicit drug use patterns in the NT

Participants outlined cannabis as the most widely used and commonly available illicit substance across the NT, consistent with the findings of the quantitative analysis (3). However, some participants felt the level of illicit drug use is much higher than what is reported in quantitative datasets, due to limitations of current data collection and reporting systems:

> *"I think personally [illicit drug use] is one of those ones that's under reported." (P7, Non-government Organisation (NGO) AOD Service Provider, Alice Springs)*

> *"I agree with P7 in that we don't have great data that is sort of up to date and representative of local using patterns for methamphetamine and/or cannabis to be fair… We have a lot of self-report. We have treatment services. We've got national datasets and we've got household surveys, but they don't represent up to date [illicit drug] using patterns in the NT because those people aren't answering those phones and aren't engaging in those national surveys and our local data collection systems aren't fantastic… The two drugs we have issues with up here, or high levels of prevalence, is cannabis and methamphetamine. Our using trends don't mirror anything that happens down South." (P6, Peak Body, Darwin)*

> *"Cannabis is probably the most prevalent problem. It's just incredibly high. If you look at our use of cannabis, it's higher in the NT than anywhere in Australia, and it's even higher when you look at remote, Indigenous community." (P12, NTDOH Executive, Darwin)*

> *"I know that we are the… I don't know if premier is the right word… we use more cannabis than anybody else in Australia… Central Australia is a cannabis hub." (P17, NTG Clinician, Alice Springs)*

Despite ecstasy and cocaine being the second and third most used substance in quantitative datasets (by prevalence) (3), these were rarely discussed by participants. Meth/amphetamines, illicit pharmaceuticals, and other illicit substances such as volatile solvents were more frequently identified when discussing use and harms:

> *"There's no heroin in the NT unless people bring it in themselves and keep it to themselves. But there is no heroin market in the NT. All opioids are prescribed opioid analgesics... And the two other main drugs, there's steroids, that seems to be quite popular, and methamphetamine. Crystal meth is the largest drug by far amongst the injecting drug community. That's it. There's a tiny bit of cocaine. We have issues with the wastewater surveys that suggest that Darwin has the highest cocaine use in the country. And they refused to tell us where they collect that wastewater from, but it must be under [blinded] nightclub. Because there is so little cocaine in the NT." (P2, Peak Body, Darwin)*

“Ganja [cannabis] *is used widely recreationally, and for some people, daily. And to a certain extent, our society’s acceptance of that and not being such a big deal unless it’s having big impact on the person – like they can’t afford it and they’re stealing. And then the other one that I’m probably most aware of in the NT context is methamphetamine. I know people who’ve said they’ve tried it and were like, ‘wow, this is scary. What kind of hold it has on me?’” (P20, Lived Experience, Darwin)*

Participants expressed that illicit drug use patterns are influenced by drug supply, availability, and accessibility. Cannabis use was often observed in the context of other substance use particularly alcohol consumption. Illicit drugs, such as meth/amphetamines were suggested to be most accessible in urban centres:

“If we look at drug of choice, it’s usually alcohol. But then if you if you dive down, they go, I smoke every now and then or whatever. So, the secondary drug of choice is usually cannabis.” (P10, ACCHS AOD Provider, Alice Springs)”

“The logistics of getting illicit drugs here would seem more challenging than the larger population centres… We see a lot more [illicit drug use] in the urban centres purely because of access. The one road through the middle, you tend to get your touch points up the highway of places where we’ll see methamphetamine available or other illicit drugs. Cannabis tends to be spread across the whole Territory by all reports, and by the data captured by the police.” (P1, Peak Body, Darwin)

Cost was described as a key component of access and was particularly important within a population with high rates of unemployment, unstable income, and inadequate housing. Restriction of movement, such as from the COVID-19 pandemic and weather events were reported to limit access and increase cost. In the Top End, flooding during the wet season can reduce accessibility to illicit substances by reducing supply, increasing cost, and restricting people’s movement:

“The profitability of it for people dealing might be a driver in that the prices up here are considerably higher than in other jurisdictions, so there is some incentivisation there for people wanting to push [sell] illicit drugs. So, we hear with methamphetamine, especially during the pandemic, the prices were absolutely crazy. We were hearing that people would be using thousands of dollars a week just with that substance. Cannabis was really high in price as well. And that tends to fluctuate seasonally as well depending on availability from places bringing it in.” (P1, Peak Body, Darwin)

“Yeah, [during the wet season there is a reduction in illicit drug use] especially for remote communities mainly because the accessibility to the remote communities is reduced so much. So, there’s not a lot of options for people driving things in.” (P1, Peak Body, Darwin)

“Supply is intermittent in the NT. Especially after COVID. There’s a lot of registered informants in the NT. So, whenever large batches do arrive, usually someone ends up getting arrested and then it all disappears again. And it’s [methamphetamine]

averaging at about $250 a point in Darwin, which is just outrageously expensive." (P2, Peak body, Darwin)

Major events across the NT also tend to influence illicit substance use and harm patterns, such as the Finke Desert Race (in Alice Springs) or music festivals like Bass in the Grass (in Darwin):

> *"These other city-based substances apply especially when we consider festivals like Bass in the Grass and those types of festivals happening. Or when we have the Finke Desert Race weekend, where people are coming from interstate, that's when we're seeing more novel substances used within our community." (P15, NTG Clinician, Alice Springs)*

However, illicit drug use and harms trends were reported to be dynamic, particularly in remote communities, and treatment services reported to experience waves of specific substance-related presentations:

> *"Trends are always changing. I mean when you look at VSA [Volatile Substance Abuse] … we see trends of that, it will be quiet for a while, and then all of a sudden that will pick up somewhere. It will just spike in a community." (P7, NGO AOD Service Provider, Alice Springs)*

Despite the focus on illicit substances for this review, some participants emphasised that reducing alcohol-related harms and use was a larger priority. Illicit substance use was often reported to occur alongside alcohol use, with participants frequently citing alcohol as the most common drug of concern for people seeking AOD treatment services, and a significant determinant of drug-associated harms. Therefore, alcohol and illicit drug interventions, including health promotion and harm minimisation efforts should occur in synergy.

> *"When I speak of the Aboriginal and Torres Strait Islander community generally, there is quite a large cohort there that is marijuana and alcohol [co-consumption]. When we speak of, the predominant, white educated person in that 30 to 40 we see a lot more alcohol use." (P8, NGO AOD Service Provider, Darwin)*

> *"I would just say it's not about the illicit drugs, it's about, it's about alcohol… Illicit drugs, in my view, are very low on that list of issues that we would like to see addressed." (P4, NTG Clinician, Katherine)*

> *"My personal belief is that alcohol has been the biggest sinner. But it's not in the illicit zone." (P15, NTG Clinician, Alice Springs)*

Regional differences

Participants noted there is considerable diversity of illicit drug use across NT communities and regions: "*You've got different levels of drug consumption depending on community you go in…" (P9, NGO AOD Service Provider, Darwin)*. In Central Australia, Cannabis and meth/amphetamine were the two commonly reported illicit substances used:

> *"In Alice, drugs are reasonably expensive, the same as any remote area. If you go out to Tennant or anything like that, that's just going to get more and more… I think about*

whether it being readily available, methamphetamine and cannabis are probably your main two and alcohol obviously." (P10, ACCHS AOD Provider, Alice Springs)

In Tennant Creek, "ganja" [cannabis] was perceived to be the most common illicit substance used, as compared to stimulants and opioids.

"I understand that different areas of the NT have a different footprint on the sort of illicit drugs that we see use of. In Tennant Creek, well for the illicits, it's very much focused on… ganja. We don't see much of opiate or 'Ice' [crystal methamphetamine] use, but I do hear that it's more common, for example, up around Darwin and Alice Springs." (P16, NTG Clinician, Tennant Creek)

Similarly, in Katherine, cannabis was identified as a commonly used and easily accessible illicit substance, in addition to polydrug use, and non-prescriptive use of prescribed pharmaceuticals:

"Mostly its alcohol and marijuana. That's what people are admitting to. Sometimes they will say that they've used other drugs as well. And that is usually some sort of meth…I mean, there was a little spate of DMT [Dimethyltryptamine]. That was with high school students, and that was being mixed… so you have the mixture of the marijuana in a joint with something else, which will be some kind of crystal, which they don't always know exactly what they're getting." (P4, NTG Clinician, Katherine)

"Prescription opiates as well and benzodiazepines. So, there's been a real big issue, as an aside, with prescription drug misuse locally [in Katherine] and in remote settings, especially with high turnover of staff and a repeat prescription of that." (P5, NTG Clinician, Katherine)

Patterns of substance use varied in remote communities and was influenced by supply, availability, and population movement, with a seemingly symbiotic relationship between alcohol and illicit drugs use:

"Methamphetamines are starting to do a bit of a creep into remote communities, and typically, my impression at that time was that it was coming in via mainstream living Indigenous people from the city who were coming back to check out their roots, and bringing with them some of these substances and then passing it onwards. Not in a huge amount, but it was enough to make me a little bit more wary of it." (P15, NTG Clinician, Alice Springs)

"We see drug replacement pretty commonly and there's probably several different types of scenarios where we see it. Remote communities are one area that we do hear a lot, when cannabis goes out of communities, we see upticks in use of other substances, primarily alcohol but also volatile substance use goes up when the cannabis goes out of communities. Methamphetamine tends to be one that people use if they can't get other things as well as the primary drug of concern. So, other forms of speed or amphetamine, MDMA. There is relatively low levels of cocaine and things like that, but yeah, it's seems to be primarily driven by what's available. So, we see a bit of the news around that, but yeah, certainly replacement of cannabis with alcohol is pretty widespread. Especially in those dry communities and when there's busts and things like that." (P1, Peak Body, Darwin)

Priority populations

Aboriginal and Torres Strait Islander people were frequently identified as a priority population for care. The term 'Aboriginal' is commonly used in the NT but is generally representative of Aboriginal and Torres Strait Islander people. When asked about the best investments towards reducing illicit drug use and harms in the NT, one participant said:

> *"We certainly need to be contextualising for the NT context, working in collaboration with our Aboriginal community-controlled sector to ensure there's the right cultural context in place, especially around demand and harm reduction elements, to get really well informed about what's going to work for those populations that are currently most vulnerable and at risk. We see the highest rates of illicit drug use in the Aboriginal population" (P1, Peak Body, Darwin)*

Participants noted that males were more commonly seen to use illicit substances compared with females:

> *"Yeah, the gender constellation would definitely… the burden would be on men. The male population. That said, particularly within Aboriginal and Torres Strait Islander context, it's a problem in both genders. But yeah, it's more men than women." (P12, NTDOH Executive, Darwin)*

> *"When you're talking amphetamine use, look, I'm guessing, but it would probably be 80/20 (male/female). Marijuana. Now, it's just weighted a little bit more towards men." (P4, NTG Clinician, Katherine).*

When asked about priority populations groups to address illicit drug use and harms, participants identified the following:

People who are young

When considering young people, participants tended to refer to school-aged children, and people under 18 years of age, although some discussion involved young people up to 29 years of age. Young people in their twenties were more commonly discussed in the treatment population (e.g., residential rehabilitation services):

> *"The 25 to 27 year olds are the ones that seem to be problematic. The high majority of people we see at the moment is probably around 25. That could be just because most have come from prison too, so it's part of the offending attached to their drug use or domestic violence." (P10, ACCHO AOD Service Provider, Alice Springs)*

Participants highlighted the importance of engaging people early in life with education about reducing illicit drug use and harms:

> *"The young people, that's where you need to target because that's where we need to start. And, like I always say, education is very important, especially with our young mob, because that's when they're most vulnerable." (P7, NGO AOD Service Provider, Alice Springs)*

A different participant described the importance of working with the community to genuinely engage young people in meaningful activities, not necessarily illicit drug education and treatment, and this highlights the importance of addressing the determinants of illicit drug use within priority populations:

> *"It needs to be a community-led approach, and it doesn't need to address a drug and alcohol problem. It doesn't necessarily need to be more alcohol and drug services. It means, employment opportunities, meaningful activities for people to do with their time. Engagement programs, the opportunity to feel genuine connection and empowerment; for using your time meaningfully in a community so like… I'm thinking about young people. The disconnected". (P20, Lived Experience, Darwin)*

In Central Australia and remote communities, cannabis use was viewed as a social norm, and this was of concern because of its impact on young people and illicit drug use:

> *"For young people, in particular, in Alice Springs, but also in remote communities… There's anecdotally, and in terms of treatment contact that I have with young people, there does seem to be a lot of cannabis use, from quite early ages and a lot of perhaps, introduction to use and normalisation of use at a young age, through generations, so, older relatives use so it's more normalised for younger people to use." (P14, NTG Clinician, Alice Springs)*

Participants were also concerned about the behaviours and determinants around illicit substance use in young people. One participant noted the potential influence of trauma and/or a lack of meaningful engagement in community activities on children's volatile substance use and associated behaviours, like aggression and crime. One clinician expressed that health education approaches were not sufficient for addressing illicit drug use and harms among young people:

> *"We still do have reports of people sniffing petrol. If it's low aromatic fuel, which is Opal fuel, its usually children, or juveniles, youth. The concern is not that they're actually going to do themselves physiological harm to their brain… or respiratory problems obviously inhaling no oxygen… the concern is more the behaviours, so why is the child thinking that sniffing something like that is a positive thing to do, or that they're so bored or, they're trying to escape trauma. There seems to be an awareness that it's not good for you and you shouldn't do it. It isn't necessarily that the education out there isn't robust enough around the fact that sniffing is harmful and damaging, that it's not something that we want children to do. There is that knowledge and information out there. But I don't think that's enough of a deterrent for young people... The other thing that goes hand in hand with that is behaviours that people are concerned about, being aggressive breaking into police at people's places. But whether that's because of sniffing or whether it's because of trauma and whether what comes first the chicken or the egg? Or probably a bit of both. (P17, NTG clinician, Alice Springs)*

There was strong commentary about the lack of illicit drugs services tailored to the needs of youth across the NT (particularly Aboriginal youth), and where they do exist, notably poor utilisation by youth. Participants identified a clear need to expand services to be more responsive to young people, in tandem with providing more culturally safe and responsive program and service delivery.

> *"We don't have that much in Darwin that's dedicated to young people and drug use specifically. From the project that AADANT did a couple of years ago, it really identified that. A lot of young people use [illicit] drugs, but they don't need treatment. Treatments for people who have dependency, in terms of best bang for your buck, and treatment matching. But often youth workers don't feel experienced enough or qualified enough to really manage or talk about drug-related harm in the context of all the behaviours that a young person has, and often think that referring them to a treatment service is going to be better for that young person. But often the young person is just trying a substance on for size, having a few harms related but probably is not dependent and may not develop a dependency, therefore does not need rehabilitation at that level… Volatile substances sits around that… and we don't have anything. Again, Alice Springs has got [name of NGO]. We've [referring to Darwin] got nothing at all specifically. Young people are getting referred to [residential rehabilitation service] if they need to detoxification of anything, really. Umm, and they have volatile substance detoxing there as well. But as far as I know, we don't have a dedicated youth program apart from Headspace, which is more mental health and doesn't really always work that well for Aboriginal young people." (P6, Peak Body, Darwin)*

> *"[In Darwin] We did open up the age group early last year to go down to 14 and we keep hearing that there's a really big need for young people at in that cohort and even younger. But to be honest, since we've lowered the age, we haven't seen a large presentation. We do get a lot of… we've had quite a bit of contact around the need for education in remote communities for volatile substance use. But yeah, a lot of that tends to be outside of our scope. But for presentations here in Darwin, one-on-one contact between the age of yeah, 14 and 18, even though our age bracket allows for it, it's quite low." (P8, NGO AOD Service Provider, Darwin)*

One participant proposed the idea of integrating illicit drug use and harm reduction initiatives with non-traditional AOD services, such as education and youth programs:

> *"There's a lot of youth work going on in communities. Wadeye has got a big youth program out there, dedicated workers, but again, they're not dedicated to AOD, but it's all obviously in all the work that they do." (P6, Peak body, Darwin)*

People who are socio-economically disadvantaged

People who are socio-economically disadvantaged were described as a priority population due to their vulnerability to harms from illicit substance use. A wide range of issues were viewed to exacerbate illicit drug use and harms within this population, including fixed income, trauma, mental health, homelessness. Several participants elaborated on this:

> *"Easy access to free, clean injecting equipment is something… we've got needle and syringe programs [NSPs] around, but a lot of the time, say people in [lower socio-economic suburbs in the greater Darwin region]; they don't have a vehicle to easily get up to the NSP to get clean syringes, so they're risking infections by reusing their own equipment. There's possible sharing of injecting equipment. I know that with my hep C clinic work, we've had a cluster of people that we cleared of hep C that have now been reinfected. It's about being able to get clear information out there. It's about*

[being] able to get ease of access of it. We've got the best equipped needle and syringe programs in Australia here in the NT and yet being able to get to get your equipment is often challenging. And the prices that the chemist charge for clean injecting equipment is ridiculous. It's quite expensive." (P18, Lived Experience, Darwin)

"The vulnerabilities associated with illicit substance use, particularly around people that don't have a socio-economic or relationship support or network, are exacerbated. So, that tends to be what we see more in the Northern Territory. So, you know, again, we wouldn't see people that are using methamphetamine occasionally and work full time and sort of causing them social harms, but the people that are already very vulnerable, homelessness, you know, fixed income, trauma, mental health issues, homelessness, significant relationship issues, legal issues, tend to be the people that will present to places like ED departments and AOD services, either in situational relationship crisis, or with legal issues that they want to address. But those people tend to experience the harms from substances exponentially compared to people that live in a stable, appropriate, supportive, stable relationship, income assured environment" (P17, NTG Clinician, Alice Springs)

"So non-beverage alcohol [e.g., consumption of hand sanitiser or mouthwash described by participants in Central Australia] is a significant issue, particularly in Central Australia, particularly across an Indigenous demographic, and particularly across people who are homeless/fixed income. Who would access cheap or free if it was stolen alcohol product rather than purchase it from a supplier. Secondary supply alcohol plays into the illicit substance use as well, because it's not legally obtained. And that's also a significant problem in Central Australia, albeit, it's far more expensive than the alcohol you can buy through legal outlets, as such be self-limiting, because it's so much more expensive, anywhere from double to four times the price. But it's accessible 24-hours a day. So, if you want to have a drink at eight o'clock in the morning, secondary supply is available. Whereas other than that, you have to wait until you can buy a drink at the pub or take away alcohol, which is restricted obviously." (P17, NTG Clinician, Alice Springs)

People who are transient and/or homeless, including "Long grass mob" and "River people"

Participants emphasised the significant unmet need to reduce illicit drug harms and use among people who are transient and/or homeless. The transient, homeless Aboriginal and Torres Strait Islander population were referred to as the "long grass mob" by people in the Top End and were identified as a priority for targeted harm minimisation efforts. Transient/homeless people in Central Australia are colloquially referred to as "River people" due to camping in dry riverbeds. Participants identified that there is a clear gap in services for those experiencing homelessness, in both urban and remote settings. Participants also highlighted that there are existing organisations that could draw upon partnerships and scale up their services to meet this unmet need, if further funding is provided.

"There's a large transient homeless or semi-homeless population. If we think about that long grass population, our general homeless population, that's a huge risk, and we haven't really had sophisticated services to deal with that. In a lot of Eastern states,

there are homeless outreach teams and we clearly don't do that. So, we've got a transient population, which is often hard to engage with and monitor. That would be another at-risk group. I mean obviously there's lots of subcultures that are of interest… but the bulk of our burden would be within the remote [population], within the Aboriginal and Torres Strait Islander [population], and within our transient homeless population." (P12, NTDOH Executive, Darwin)

"We need outreach in the NT, especially Darwin has an issue that's a little different to the rest of the country – 30% of the population are Indigenous and a lot are living 'on country' in communities. Now a lot will pack up and come to Darwin for a holiday, to meet up with relatives, there's nothing evil in that. They are coming from communities. They don't have large amounts of money. They go and live in what we call the 'long grass'. They get the nickname 'long grassers'. There's injecting drug use starting up amongst the long grassers and they don't come into the NSP at all. Yes, they might have a friend or someone who's concerned about them or come in and pick up equipment to take to them and distribute. But, we don't see them in the NSP at all, so we had no engagement with them. A lot of inappropriate disposal is starting to happen around town, which gives us no end of grief, and it's very difficult to do anything about it. With a bit more funding we can link in with people, like [Darwin Aboriginal-controlled service], to try and do some outreach with this cohort. But at the moment it's just a pipe dream. There's no way in God's Earth we can afford to go and do outreach. We couldn't even pay the wages. It's just not happening." (P2, Peak body, Darwin)

"When I was in my outreach capacity, 9 times out of 10, the last thing I'm dealing with is with the drug use. I'm looking at the bio-psychosocial model. I'm looking at, do they have a safe place to live, do they have food, clothing, all these basic needs and a lot of times, we work with people who are homeless and unfortunately, a lot of the Indigenous populations are quite transient as well. So sometimes if you can lose track of them." (P7, NGO Service Provider, Alice Springs)

People impacted by the criminalisation of illicit drug use

People impacted by the criminalisation of illicit drug use were viewed to be in a 'cycle' of harm, with the potential for this to extend to families and communities. Reflecting on people who are disproportionately impacted by the criminalisation of illicit drug use in the NT, one participated commented:

"We're seeing a lot of people in and out of the prison system and it is that constant cycling just going around. Especially with the young ones as well, that learned behaviour, they're watching the old ones, fighting and arguing or whether it's jealousy. I mean that's one of the biggest issues that I've seen for many, many years, especially [in the] Indigenous population, is jealousy. It's one of the biggest things why we see people who might be in prison because the partners are jealous seeing each other." (P6, Peak body, Darwin)

Participants also called for reduced prohibition and criminalisation of illicit substances and administration equipment to reduce harms. For example, one participant noted that possession of smoking drug administration equipment is currently illegal and is associated with severe penalties, so instead participants often inject, increasing their risk of harms.

"…harms caused by prohibition and criminalisation of drugs (and illicit alcohol). This is a vital consideration as a primary driver of crime, stigma, treatment hesitancy and adulterated supply. A significant amount of the harms caused by AOD can be attributed to this and we must start treating AOD use as a health concern not a criminal one." (P1, Peak Body, Darwin)

"In the NT, under the Misuse of Drugs Act, it is illegal to possess any implement for the administration of a dangerous drug except a hypodermic syringe. Now that exception makes brilliant sense, of course, and thank God they had that in there. But 'Ice' pipes, you know, ball pipes, safe smoking kits are totally illegal…I mean, if you get arrested with one and you've got some previous convictions, you'll go to prison. So, because people know people have gone to prison for being in possession of a ball pipe, they're not using it. People who would smoke meth are actually injecting, and there's a cohort of young people, particularly around Palmerston, who scared the living hell out of us because they are injecting meth and they're not injectors. They don't know what they're doing. They don't engage with us because they're not injectors" (P2, Peak Body, Darwin)

One participant identified the opportunity to increase access to therapeutic interventions for those engaged in the prison system.

"My experience of doing frontline work here when people are in the prison system and then come into residential rehabilitation, they often are really therapeutically I. Because they're not getting a lot of good therapeutic interventions in the prison system. So you know, it's different to down South where people are exposed to quite a lot of therapeutic interventions. So, when they come into a residential setting, they have some understanding or baseline understanding of therapeutic interventions, dependency, working with a counsellor, all those kinds of things. But my experience in [P7], you might have much more to say about this, a lot of the people that I work directly with, where you had to start from zero, and build into developing an understanding of the therapeutic relationship required to do treatment with a person. I don't know if I've articulated that very clearly, but there's a lot of time that goes into that before you can actually start to get some momentum going around rehabilitation…So, if they if they had that in prison, if they got a bit more exposure to some therapeutic interventions in the prison system because so many of them end up in the rehabilitation services in Alice Springs, Tennant Creek, Katherine and Darwin. Umm, it would be a much better integrated system and process both for the workers and for the people, the service users." (P6, Peak Body, Darwin)

People living in remote areas

The contextual factors of living remotely were viewed by participants to increase the susceptibility of people living remotely to illicit drug use and harms. One participant described the additional health and social costs of illicit substances for people in remote communities:

"The biggest problems are just the cost of drugs, especially when you've got communities living below the poverty line and people receiving unemployment benefits and they're paying astronomical amount just to pay for their addictions. You see in the remote clinics kids that have failure to thrive and malnutrition because

> *families don't have the food to feed their kids because they're spending their money on addiction. What were some of the biggest devastations that you'll see in some of the remote communities is that people that are spending all their money on their addiction rather than going to the shop and buying food for their kids, just the price the price of say ganja [cannabis] are in remote communities (P19, Lived Experience, Darwin)*

One clinician in Tennant Creek hospital found that the presentation of harms associated with illicit substance use among people living in remote areas, was increased when families and groups come into town for events. The participant described binging on illicit substances as socially norm and 'expected' when travelling into town.

> *"When you've got people visiting Tennant Creek from remote communities, it is often in conjunction with things like stressor events, like funerals, where you're more likely to be exposed to those sorts of behaviours...I'm not seeing what it's like out in community, like, when people go back out bush, I mean, since a lot of those communities are dry [where legislation means alcohol is prohibited]. I imagine it settles down, for example, back out to [community], whereas, when the [clan] mob… well they're actually very well known for going on big binges when they go into town, but even [clan]… you there's communities, who, coming in are like, 'alright, let's hit the pubs'. It is very much a binge while we're here thing, but I wouldn't say that it's not similar for people living in town, though. If there's an event on, then there's a binge, it's just that expectation." (P16, NTG Clinician, Tennant Creek)*

While identifying people living in remote areas of the NT as a priority population for minimising illicit drug use and harms, they were also viewed to be a complex, hard to reach population to engage harm minimisation efforts.

> *"…prevention and psychosocial interventions are so important, but particularly with our large Aboriginal and remote population, the problems are complex and the answers are complex." (P12, NTDOH Executive, Darwin)*

In the same way as engaging homeless and transient populations, participants highlighted the need and significant gap for outreach treatment services to ensure that care is delivered where the client lives. This was perceived as more likely to be successful, due to higher engagement, and the service model that is underpinned by connection to culture and country.

> *"When you look at remote, especially remote communities, you're asking people to go off country, to come to Alice Springs to attend rehabilitation… and there's a lot of whole other issues that come with that… If you got people on their own country, Aboriginal people, running those sort of programs from that community, you will find maybe more of a higher success rate than having them in town." (P7, NGO AOD Service Provider, Alice Springs)*

Harms associated with illicit drug use in the NT

Many participants described the 'ripple effect' of harms associated with illicit drug use. It started at an individual level, such as health and financial impacts, then led to family,

community, and broader social impacts. Financial costs to health and social care systems (particularly patient travel) were also frequently highlighted.

> *"You can go on all day about that [illicit drug harms]. The harms that you see, whether you look at that person individually or do you look at them as a whole, as a family. Because there's that whole ripple effect, and it affects the community." (P7, NGO AOD Service Provider, Alice Springs)*

> *"So financial harm is obviously a big one for a lot of people. A lot of people can't afford to continue to use [substances], and there's also social impacts of that. In the Aboriginal community, we see a lot of humbugging for money for cannabis use, which then creates a divide within the community that they're constantly humbugging for money. That's the biggest social impact, which is obviously derived from a financial impact." (P8, NGO AOD Service Provider, Darwin)*

> *"The other issue is the use of methamphetamine, 'Ice'. Having worked broadly as a psychiatrist in various settings, opiate and IV [Intravenous] drug use is an important issue. I've worked in substitution programs, but the anti-social nature of 'Ice' use, means it has huge ramifications just of being such an externaliser, so by that I mean: you're much more likely to end up in ED [Emergency department], violent criminal activity, with police involvement in someone that's intoxicated with 'Ice'. This is reflected nationally, and it's [also] reflected in the NT. That's having a huge burden of not just disease, but psychosocial burden, and burden on the public health system…we're seeing much more higher rates of hospitalisations, need for care flights, and transport for drug related violent crime, so to me it would be 'Ice' and cannabis would be the two central pillars of problems in the community." (P12, NTDOH Executive, Darwin)*

Use of volatile substances were of particular concern because it was commonly seen in young children, and issues were raised about the severity of harms that may occur, such as irreversible brain damage, coma or death.

> *"You've got young children dying from volatile substance abuse, and that's just out of desperation." (P11, NTDOH Executive, Darwin)*

> *And when it comes to the petrol sniffing, I've only ever seen that. Well, very rarely, but both times it was 11 to 13 year old Aboriginal kids. So, quite young." (P16, NTG Clinician, Tennant Creek)*

> *"Volatile substances are probably the most harmful, because basically people are becoming... the lack of oxygen to the brain doing the volatile substances…. They're probably here [in an AOD rehabilitation service] for alcohol, but they might have have had a brain injury from sniffing ten years ago." (P10, ACCHS AOD Provider, Alice Springs)*

There were several factors that were viewed to influence the extent to which harms occur from illicit drug use. They included:

- socio-cultural characteristics, such as past history of trauma
- co-occurring mental health conditions with illicit drug use
- poly-drug use.

Each of these are discussed further below.

Socio-cultural characteristics, such as past history of trauma

Participants reported harms occurring more frequently and at a higher severity among people with a past history of trauma, and those who experience detrimental impacts from a lack of action to address the social determinants of health. One participant described the impact of the convergence of illicit substance use and trauma as 'explosive':

> *"The issues that underpin harmful use in the NT are not universal across the country. So, there are obviously culturally specific issues, which the intersection of trauma histories and untreated trauma histories and methamphetamine is a really risky intersection in terms of harm. So, when a really complex trauma history intersects with high level methamphetamine use, it's often very explosive, and that's when people end up in the prison system and when they end up in [AOD Rehabilitation Service]]." (P7, NGO Service Provider, Alice Springs)*

> *"97% of our clients here all have domestic violence histories or active orders. Which is the other shocking stat…And usually that will be directly associated with alcohol use and lack of impulse control, things like that. And all the other issues that goes with domestic violence and lack of opportunities." (P10, ACCHS AOD Provider, Alice Springs)*

On the other hand, people using illicit drugs with stable employment, income, housing and higher socio-economic status were considered to be somewhat protected from the harms and consequences of their drug use.

> *"[on why military, police, and fly-in-fly-out workers illicit drug use doesn't come to the attention of the community] Because they're just generally protected. They haven't gone… I mean, they're just not acting out in a public place or becoming violent. But I mean, they can become disturbed, but not to the point where someone is going to call the authorities on them. So, for example, a family member might bring them in [to hospital]. So generally, they're not going to get to that point. And also, as we know, with social determinants of health, people, the higher you are up in your socio-economic status, when you take risk, the consequences are not as great for you." (P4, NTG Clinician, Katherine)*

Co-occurring mental health conditions with illicit drug use

Mental health co-morbidities were one of the most frequent harms that participants associated with illicit drug use. These included the experience of psychological distress, behavioural disturbances and/or other mental health impacts. Several participants strongly linked mental health conditions with cannabis use, for example, one participant said:

> *"So, we see a really large comorbidity between, presentations of marijuana use and depression, anxiety, even bipolar and schizophrenia." (P8, NGO AOD Service Provider, Darwin)*

An underlying mental illness in the context of illicit substance use (including polydrug use) and addiction was described as a ‘bonfire’, meaning that it exacerbated harms to the individual, family and society:

“My experience as a family member as well, particularly where there is a there is a mental illness as well as addiction, and it’s just like a bonfire [of illicit drug-related harms]”. (P20, Lived Experience, Darwin)

Participants also described the clinical complexity in treatment and harm reduction initiatives for people with co-occurring illicit substance use and mental health issues:

“So as a baseline drug issue, it’s [cannabis use] underestimated, because it’s just so prevalent and its association with chronic mental illnesses is huge. So, when you look at the typical patient in an inpatient unit at Royal Darwin Hospital or the Alice Springs Hospital, it’s a young man with chronic cannabis use. Which is just almost taken for granted, that everybody’s using cannabis, plus or minus FASD [Foetal alcohol spectrum disorders], plus or minus acquired brain injury cross schizophrenia and so, it’s that complexity of the whole picture and cannabis use as fundamentally a huge issue.” (P12, NTDOH Executive, Darwin)

“The next biggest category [after alcohol consumption] would be marijuana use, when people have psychosis or alcohol and marijuana together, forming a behavioural disturbance of some sort, which we label usually as a drug induced psychosis. But that that is also a continuum from just being disruptive through to actually having a psychotic episode.” (P4, NTG Clinician, Katherine)

Several participants identified the clear gap of services to support people using illicit substances who are in distress and/or have mental health conditions. However, they highlighted that the workforce in the program/service needs to be adequately trained to support people with mental health co-morbidities:

“I’m going to say that there is a new relatively new service that’s supposed to provide support to people in distress who have mental health and or alcohol or drug issues, no matter what their issue. They don’t have trained staff, don’t have training to do that bit, and I’ve seen that first hand. So, if that is your business model, if that’s your funding model and requirement, then you need to make sure your staff actually have the skills to talk to someone about their use of substances. Because my experience of observing the support person just wasn’t ready for the skill involved.” (P20, Lived Experience, Darwin)

“But there’s also a huge deficit in trauma counselling and people understanding the causative factors, adverse childhood experiences, ongoing adult trauma.” (P17, Lived Experience, Darwin)

Further to this, there was an identified need to better integrate mental health and AOD treatment, and illicit drug use and harm minimisation efforts.

“...We’ve seen some AOD services taking on more high acuity mental health clients. We’ve seen problems with that. With the cases of clients being dropped off without mental health treatment plans to services, without medication regimes in place and having active psychosis kicking very shortly after they dropped off to services. And

also, AOD services not being properly prepared or resourced to manage higher acuity mental health conditions. So, there's a pretty clear understanding that AOD clients have a very high propensity of low acuity mental health issues that are expected to be managed within the AOD treatment model. So, it's like depression, anxiety, those sort of lower acuity but high prevalence things that are entirely standard and within the AOD treatment service model. Once you get into the higher acuity stuff, bipolar, borderline personalities disorders. They usually require a higher level of skill set or therapeutic interventions than what is available in our AOD services. Most of our AOD services don't have ready access to professionally trained mental health clinicians. They might have some in-reach or concurrent treatment available at times, but having to be a residential client in those services is very challenging, creates a lot of problems for the services and we've seen a few situations in the last sort of year or two where that's led to clients having to be returned to emergency departments or pushed back into secure treatment facilities because they weren't able to be managed in the AOD services." (P1, Peak Body, Darwin)

"We tend to see motivational interviewing, CBT type models, very alcohol orientated. The issue is and… psychiatry and mental health is not rocket science. It's like, why do people use substances? They use substances predominantly because there's a void of emptiness, related to mental health issues. And so, we tend to negate, it gets back to the dual diagnosis. We tend to ignore the mental health. And, I agree wholeheartedly what P11 is saying, I would go as far as to say you're stigmatised because of an AOD issue, to the point that you're probably less likely than the general population to actually get a service ironically for your mental health. So, for instance, If you were in the AOD service within the [Mental health service name], you would have a separate record to the mental health record, and it would be separate, and you'd hope that you'd get some mental healthcare there, because probably just the culture is that people would start to deflect or ignore you because the assumption is you're already getting care. You're within the AOD service, you're an AOD patient, why would you need mental health? Why would you need a mental health assessment? Or why would you need therapy? And so, there's a real risk. I agree, with [viewpoints that indicate] AOD patients [are] being ignored, stigmatised and actually marginalised because of a perception of being difficult or complex, or being a difficult person, or having a personality disorder. All those things, bowed against your ability to access. So, it's an equity and an access issue." (P12, NTDOH Executive, Darwin)

Some participants commented about limited therapeutic services specifically tailored for caring for patients impacted by co-occurring mental health conditions and illicit drug use. As one participant commented:

"[There is a] lack of therapeutic services for people with [illicit] drug use. We've got emergency accommodation, we've got some very limited rehabilitation. I just don't think we've got enough therapeutic services for people who are really struggling with mental health and AOD issues and you've got the whole gamut… That's a really big issue, therapeutic capacity, but I wouldn't have said it was unique to the NT, but it's particularly problematic here." (P11, NTDOH Executive, Darwin)

Poly-drug use

Cannabis and alcohol (including non-beverage alcohol, or alcohol from secondary/illicit supply) co-consumption was the most frequently reported poly-drug use described by interview participants. In the 2019 NSDHS, only 6% of respondents in the NT reported using 2 or more illicit drugs, which is at odds with the accounts of key stakeholders involved in this study. Further research about poly-drug use could be beneficial to understand these patterns in greater detail.

> *"That's the main group. Most of that group [25 to 30 year olds] will be cannabis and alcohol. They're polydrug users. Yeah, they're the ones that are, that are usually the most problematic about trying to keep cannabis out of here." (P10, ACCHS AOD Provider, Alice Springs)*

> *"And again, it's that polydrug use as well. A lot of times, especially when you see methamphetamines, there are others using illegal or legal drugs to help with that come down, especially that crash side of things as well. Cannabis is one of those ones that are prevalent as well, especially with methamphetamines use and even with alcohol as well. We see those. I see there's a lot out in communities, especially those two." (P7, NGO AOD Service Provider, Alice Springs)*

Perspectives on currently available illicit drug programs and services

Strengths and benefits

Residential rehabilitation

Participants noted that investment and demand for residential rehabilitation facilities is strong compared to other states and territories. This finding was in agreement with the Demand Study for Alcohol Treatment Services in the NT (19), funded by the NTG. The explicit aims of the Demand Study included: to quantify and describe met and unmet demand for alcohol treatment services in the NT; and to explore challenges, opportunities and potential solutions associated with planning, delivering and evaluating effective and economically viable, and contextually and culturally responsive alcohol treatment services in the NT. One participant said:

> *"The other complexity that we have here is that a lot of people going to treatment, or requiring treatment, also require accommodation. So, we have very high rates of residential rehabilitation beds. It's about 5 to 10 times as high as any other jurisdiction per 100,000 for our residential treatment. So, we've got a lot of investment in residential beds, but we've got a relatively small investment in other modes of treatment that are more heavily invested in other states." (P1, Peak body, Darwin)*

Participants said residential rehabilitation services are generally tailored towards alcohol, rather than illicit substances. When asked about the extent to which illicit substances are the

primary drug of concern among patients in a residential rehabilitation facility, one participant said:

> *"I would say almost none. It would only be in the setting of poly drug use I would say. I don't think we ever have anyone that is purely one drug, but it would be pretty rare." (P4, NTG Clinician, Katherine)*

Participants also noted that residential rehabilitation facilities are often accessed by consumers experiencing challenges with housing and/or other vulnerabilities as an accommodation substitute. This is of concern due to the high cost of residential rehabilitation compared with social housing alternatives. Participants also noted the strength of residential services for after care for people engaged with the criminal justice system, identifying the need to strengthen residential rehabilitation programs. One participant said:

> *"There is an urgent need for more funding for Residential Rehabilitation programs. So, for the venues, the quality of facilities and infrastructure, for capacity and also for quality of program delivery, governance of program delivery, oversight of program delivery, and staffing. It's great to have residential rehabilitation programs, it's even better to have high quality rehabilitation programs that are accessible and available in a timely way. Unfortunately, the reliance on community corrections or corrections diverted participants in residential rehabilitation… Residential rehabilitation programs are reliant on the funding that comes through court diverted patients who have a range of motivations for engaging in treatment programs. The imperative to offer a really robust and a quality service can drop, people are there because they have to be there, with a range of motivations. And so, their demands of the service and their expectations of the service, can sometimes be less than someone who's an illicit substance user who is seeking treatment and wanting the best available treatment." (P14, NTG Clinician, Alice Springs)*

Peer-to-Peer Engagement

Participants noted the strength of existing peer-to-peer services. To increase treatment and harm reduction service accessibility, participants suggested scaling up existing programs and services across the NT that are underpinned by peer-to-peer engagement.

> *"Yeah, that model of peers that [non-government AOD service] has with the methamphetamine outreach program could be replicated and really well utilised across the whole of the NT because… umm, Tennant Creek, Katherine and Darwin don't get that. We don't get that relationship building while people are in prison to come into [services] or any of the other services in Darwin, because the biggest pathway in the NT is police and prisons, so lawyers and the prison system. Corrections doesn't fund any AOD treatment per se. But they do rely heavily on the system for their inmates or ex-inmates as they're transitioning out. So, that's a big gap, and it could be done through nurses. It could be done through AOD workers. It could be done through the model, like [non-government AOD service] has with the methamphetamine outreach project, but it's a massive opportunity to do better in this area. (P6, Peak Body, Darwin)*

The NT Lived experience network was noted as an advocacy body to lead peer-engagement, and participants suggested consulting this network in future service planning and delivery. Several participants also referenced AADANT's Stories project (20) as a valuable tool for peer engagement, reducing stigma through storytelling and prioritising the voices of those with lived experience of the harms of illicit drugs use.

> *"The Northern Territory AIDS and Hepatitis Council, which perhaps, falls best under the harm reduction, peer support service category. So, in terms of things like needle and syringe programs, and advocacy of people who are continuing to use illicit substances." (P14, NTG Clinician, Alice Springs)*

Culturally appropriate care

Participants noted that Aboriginal and Community Controlled Health Services are leading culturally tailored care across the NT, and that this was a strength of the sector:

> *"…it's being run by [Aboriginal and Community Controlled Health Organisation] and there's a real intention to create more cultural engagement and activities, rather than just sending people to [ACCHS] and then sitting there, isolated and by themselves, detoxing. The Aboriginal health services are doing it better because they're actually able to see people in community." (P5, NTG Clinician, Katherine)*

Culturally appropriate service models led by Aboriginal and Torres Strait Islander health professionals were deemed critically important for addressing illicit drugs use in a culturally responsive manner.

> *"Yeah, we've got a couple of good Aboriginal workers and there's some real strengths in working in with people who have culture… someone who's been through ceremony, who's a very traditional male…because the different way of working and different respect. It's given. It has been really good for us to have that feedback from some experienced workers that have thought that through and used that approach in their practice. For some of the younger ones, it's about teaching them about culture. Yeah, but just different ways of going about it. Like the language, people come from different clans and stuff, there's obviously some complexities in that. Uh, here we have separated the men's and women's area. They never come together on site." (P10, ACCHS AOD Provider, Alice Springs)*

Service gaps and opportunities

Lacking a comprehensive approach to integrated service delivery

Participants described a fragmented system, and experienced challenges in collaborative, coordinated and/or person-centred care. Participants called for a more cohesive and integrated approach by services, including post care support for those exiting treatment services:

> *"People have a bucket load of unmet needs. So, if you're going to an emergency ward, you're probably not going there for your methamphetamine use. You're probably going there for psychosis or an injury that has occurred through a violent episode. So, they're*

dealing with the violent episode. They're probably not dealing with the methamphetamine use. Similarly, in residential rehabilitation, people do as much as they can through case management to support to people with their legal issues, their homeless issues or their housing issues, their financial issues, their family issues, their child protection issues. But… It's endless. The support that people need, and unmet needs are massive. So yes, there's great services doing what they can do in the context of their work. They don't always play well together. Clinical and non-clinical, they don't often talk the same language in terms of harm. They're not prioritising the same issues in the same way. So, ED would prioritise it differently to [NGO AOD Organisation], to a primary health service to an Aboriginal community-controlled service. So, you've got all those other barriers that exist in the system. It's not just about 'can the service deliver the support that person around their drug use'." (P6, Peak Body, Darwin)

"There needs to be a lot of work on articulating, defining, and advertising, the capacity, the role and the pathways for patients to more seamlessly access and integrate across services. Traditionally, drug and alcohol services, in my experience, pathways in referrals, in self-referrals, aren't done with a good understanding of what services are available. Often, it's something goes wrong, I need help, and it's up to the service and the sector to appropriately triage. And so, if those organisations don't have good links and understandings, it can be very hard and fragmented for someone to navigate through that process." (P14, NTG Clinician, Alice Springs)

Continuing, coordinated care was described as challenging to achieve due to long wait lists, which are exacerbated by under-resourced services. This also puts high need or complex patients at greater risk of falling through the cracks of services and not receiving the right care at the right time:

"From what we've seen is that if our wait list extends, so that clients are presenting, two weeks, three weeks after they've made their initial call, the likelihood of their attendance becomes less and less over time. There is an imminent need to get the client in for the first session. If we miss that window, within seven days, then generally we won't see them for that presentation. So that's something that we have to be really mindful of as a service is that, with under resourcing or lack of resources with counsellors at the moment, our current wait list is that we are essentially closing the door to quite a few presentations that are calling us… places like [sexual assault service], where we would send people for trauma treatment. They've got a three to six month waiting list. So, it becomes very, very difficult. You've got people with complex trauma and nowhere to send them. You've got your people in crisis and nowhere to send them. You've got, 6 to 8 year waits in housing and nowhere to send them. It's really complex and there's lots of lots of gaps in the industry up here." (P8, NGO AOD Service Provider, Darwin)

One participant in Central Australia noted that care fragmentation can lead to distrust, poor service utilisation, and perceptions of stigmatisation.

"In Central Australia… not many of the services have the capacity to meet a person's needs across all their spectrum of needs, which then creates the imperative to have better integrated service, [and a greater] diversity of services. So, getting your social and emotional well-being support from an Aboriginal controlled health organisation,

then, the fragmentation of care if you go into a residential rehabilitation program, then the fragmentation of care if you need clinical, medical or nursing support… There's probably also a gap there in terms of working with people who are not contemplating reduction or cessation in substance use. Traditionally, in Central Australia, there's been a barrier between services for harm reduction and supports for harm reduction within the government sector, health sector, and those peer support harm reduction models. They traditionally haven't had a lot of overlap and there is a little bit of mistrust and weariness with clients who access one versus the other. So, is there something for everyone? In some ways there is, but I think what is available needs to be at all points on the spectrum. All services need to be strengthened. All services need more funding, services that are there need better integration." (P14, NTG Clinician, Alice Springs)

The same participants noted that primary health care organisations and commissioning agents can partner with services to help integrate their services, thereby clarifying patient pathways and destigmatising illicit drug treatment and harm minimisation:

"So in terms of thinking about the role of organisations and Primary Health Networks [PHNs], if the AOD sector and services aren't well integrated and articulated in terms of roles and connections, then you can tell PHNs, how we work and how to advertise our pathways, which means then that clients refer and organisations who direct patients towards a service, do it in a much less coordinated and a much less informed way, which often creates either difficulty barriers or traumatic experiences of people trying to access services, people who present to the emergency department, when their needs could be met in an outpatient setting. But [they] have to go through the trauma or going through an emergency department being told no, this is the wrong spot for you, not getting that first, welcoming and inviting point of contact with a service that knows how to confidently manage them. If you go somewhere where you're not wanted, you're often met with frostiness rather than 'hey, you haven't come to the wrong place', or 'you have, but we can confidently direct you to the right place'. A lot of people in Central Australia have trouble accessing services for those reasons." (P14, NTG Clinician, Alice Springs)

Patient awareness of care pathways is also needed to support patient self-referral and access to illicit drug programs and services in Central Australia:

"Another uniqueness to Central Australia is how the Alice Springs Hospital emergency department really is seen as, for a lot of people, it's where they get chronic disease managed. It's where they get acute health care needs met. It's much less of an emergency department as it is an undifferentiated needs department…for a lot of people, it's the first place they'll go to." (P14, NTG Clinician, Alice Springs)

Different models of care and ways of working across programs and services

While it is a strength to offer a variety of services for patients, there is a need to better communicate and work with each other through partnership and collaborative models.

"I agree with that because I've always worked in government and [service name] is my first NGO. I'm trying to understand and wrap my head around what a TC [Therapeutic Community] was. It took a while to understand that concept. Even though I do think I operate under that sort of model, always have, it was just trying to grasp it.

Like community is method. I'm like, 'what does that mean?'" (P7, NGO AOD Service Provider, Alice Springs)

"You have systems and services using different approaches to doing AOD work, some of them, [like] the social and emotional wellbeing [SEWB] model might not call it AOD work, but it's often AOD work at the early intervention/prevention stage. Looking at a better way of those models talking to each other or understanding each other or enabling each other. It's a big piece of work, in terms of barriers to doing better work for the service user through the systems." (P6, Peak Body, Darwin)

Some participants commented that adequate resourcing was essential to ensuring care is delivered at the right time:

"We're under resourced. As far as the wrap around, people are only interested in their own turf, because they have to hang onto their money. It's a dog-eat-dog world, and that's honest. I mean, people won't say it, but that's honest. So, you won't get a lot of these people collaborating because you're going to take their work away, or it's seen to be doing their work, it is very competitive out there. We're up against the big organisations. We're quite small. I mean, we've been around for a long time, but we have a very niche market, we're not able to expand because they don't give the dollars to expand it. It's like [P8] said, we've got waiting times for our clients. We can go bigger. We've talked about case management, the wrap around for our clients that come out of [name of non-government organisation]. That's where you hit the brick walls and the gaps." (P9, NGO AOD Service Provider, Darwin)

Collaboration was a strength of some services in providing wrap around care for clients. However, generally there were significant limitations for collaboration across the sector, which was exacerbated by workforce issues:

"I just think that better collaboration across the stakeholders [is needed]." (P7, NGO AOD Service Provider, Alice Springs)

"But the lack of training opportunities in Central Australia is through the roof. Uh, and plus you've got such a limited workforce. Like other states, I always use the example, Victoria's got 7 rehabilitation services, and we've got 3 in Alice Springs. We've got one that's non-Indigenous, one that's Indigenous, and one that's for youth. We work really well together. I called a meeting of all the local services. We have regular catch-ups now. So, we're not trying to compete for services. We're just trying to say, 'hey we've got three different options here. If you're a young person [you have one], and if you're an adult you have two options, so whatever works for you'. But training, retention, all that stuff. My point about that was… we got [ACCHS] – a really large Aboriginal health service [in the area], so we are competing for all the workers. And then you've got aged care and mental health. And so, it's really difficult to get workers. All of the media of late doesn't help." (P10, ACCHS AOD Provider, Alice Springs)

"It's pretty frustrating to be honest, up here. I'm from Sydney. So, we have a lot more services and places where we can go with clients, but up here it just doesn't really exist and that collaboration to have that wrap around services doesn't really exist. The fact that the population here is quite transient makes it quite difficult. So, if we build a relationship with this specific case manager say for example at [other non-government

organisations] or even a financial counsellor at one of those places, we build a relationship, they're likely to leave within 6 to 12 months. And so, then we start again, and that can be really frustrating. And like I said, a lot, a lot of the services we just, even when we do send a referral, it feels like it lands on deaf ears." (P8, NGO AOD Service Provider, Darwin)

One participant called for further training around knowledge of services and roles, which will support stakeholders to identify when to engage collaborators:

"There is such high expectations in the drug and alcohol sector. There's a strong commitment, there's strong passion and people want to do a really good job because people are really unwell. But there's limitations to what an NGO AOD sector can do around some of the issues that the clients have and, understanding the limitations is really important part and like what is the scope of work that we're doing at [name of NGO AOD service]? Where are limitations? When do we refer to a CATT [Crisis Assessment and Treatment] team? When do we call an ambulance, and the mental health indicators of someone escalating around their mental health. At what point do you need a higher level intervention from paramedics or police or whoever? Some training around that would also be really helpful just to understand the limitations of what's expected or what the AOD and NGO sector can actually do." (P6, Peak Body, Darwin)

Challenges in sustaining a skilled workforce to care for people who use illicit drugs

The most significant workforce challenge discussed was attracting and retaining a skilled illicit drug workforce. Several participants attributed this challenge to cost of living and housing availability. One participant suggested that there needed to be more emphasis on creating opportunities for professional development, upskilling and growth across the sector as a workforce retention strategy.

"When you speak of the NT, it's very difficult to get skilled staff. A lot different than Eastern states. So, it's not the place that everyone wants to be. The cost of living is very expensive up here. Housing is an issue even for our staff to get into a house, and that's the staff. So, there's a lot of, setbacks that we see from an employer point of view. We're trying to attract staff, and to get good staff. So, I mean that's Darwin. But then if you think about going to the more remote regions, like Katherine and Tennant Creek, well that's gonna double, in its inability to get good staff. But our exposure to illicit drugs isn't strong enough [Researcher name] because I don't think we've had the resources to go out and really do the hard yards. That's it. I mean, that's the truth that I've seen in it." (P9, NGO AOD Service Provider, Darwin)

"Retaining them is probably our main priority. The turnover of our workforce is pretty horrific and recruitment is also really difficult, especially in an environment, where there is already really low unemployment. There's lots of demand for people in the social services sector all the time. We're competing with other areas that are a little better resourced. So, supporting our workforce to like stay in their work, but also to upskill and continue to grow in their roles could be really big priority for us..." (P1, Peak Body, Darwin)

There are often limited specialist supports available in regional and remote areas of the NT. Specialist input through Addiction Medicine Specialists and/or increasing access to education and training to build capacity and capability of the non-specialist workforce were identified as important. Two participants said:

> *"Additional clinical Addiction Medicine support is critical. Not because every person who uses illicit substances and experiences harm needs to see an addiction medicine specialist. But there is such a need for the clinical support an Addiction Medicine Specialist can provide to doctors, nurses, and other service providers in correction settings, to GPs, nurses and service providers who are working in remote communities…in the Aboriginal-community controlled health sector, to primary health care services. So, the benefit of having more robust and more resources in addiction medicine [is critical]. We build capacity and can maintain people's capacity to access, harm reduction, and good evidence-based support in those other areas. If it's a single service provider, or no one, the capacity for a specialist in isolation to support those other things, gets quickly overwhelmed, and people don't get their needs met in those other services. More Addiction Medicine support could maintain people's ability to stay safe and get treatment needs met in those other settings. Having a strong core supporting outward is a real need." (P14, NTG Clinician, Alice Springs)*

> *"Borderline personality disorders [are] obviously quite prevalent amongst dependent drug users seeking treatment. It's a bit of a specialised area and we don't have a lot of really highly confident drug workers in rehabilitation services that really know that area well, and it is quite a specialised area. We could do with some skills in more specific approaches to treatment that obviously trauma-informed, culturally-informed, best practice, cognitive behavioural therapy, motivational interviewing and, obviously for trauma DBT [dialectical behavioural therapy] is a really great approach, but it's not going to work for everyone. We need some additional specialist skills, but we just need some good robust baseline skills and then people can refer on if there's the need to refer on." (P6, Peak Body, Darwin)*

Participants expressed that generally, the NT AOD workforce is seen to have low levels of formal qualifications, which does not necessarily match the complexity of the context. Of relevance here is the NT AOD Workforce Strategy developed in partnership between NCETA and the Northern Territory Primary Health Network (21). Our participants echoed the key recommendations in this report, including the need to improve recruitment and retention investments, and improve access to quality education and training. Extending on this strategy, our participants called for further support for peer workers and people with lived experience who were delivering in illicit drug use and harm minimisation initiatives. The value of peer-delivered harm minimisation programs and services is stated in wider literature (22). One participant said:

> *"I just wanted to make the distinction between peer workers and lived experience too. I'm not sure if there's there is a line in the sand, but as someone's transitioning from being a support person or a community member with lived experience or in an advisory role, to actually being a worker, a peer worker. It's not always the same thing and in different states there's different levels of engagement for those different roles. People are going to get triggered, people might cause themselves harm, they might relapse,*

and in my experience, I've seen some really terrible things happen to people with lived experience, with great passion and really good intentions. So, making sure that wherever they're working, they're supported." (P6, Peak Body, Darwin)

Limited availability of illicit drugs outreach services

Many participants pointed to the need for a renewed focus on harm reduction and prevention efforts, rather than focusing on the 'pointy end' [treatment services]. Engaging with existing leaders involved in the NT Harm Reduction Advisory Group, NT AIDS and Hepatitis Council, and the NT Lived Experience Network, were considered important for advancing this agenda.

> *"It's so important that the preventative aspects go into that space, not into the pointy end that we see because we're always going to be here to attend. But what we're not seeing is that investment in that part of it in a meaningful way. Anyway, I know there's attempts, but really until you address all of that, the causes of why people go to this drug predominantly, then you're not going to have a huge impact on alcohol related harms." (P4, NTG Clinician, Katherine)*

Participants expressed the need to offer 'choice' for people impacted by illicit substances by seeking care. Participants identified the need to develop new and/or scale-up existing programs and services to provide clients with alternative prevention and harm reduction options, especially in regional and remote areas where there is limited choice/access to such services and programs.

> *"You need to be able to give people choice…. you want to give people options…To me at the end of the day it is what is the client needs, and if we're not the right place, then you need to be able to give them options. And what are they? I mean, if you look at [regional town], for example, they've only got [name of Aboriginal community-controlled health organisation]. So, especially in those sorts of small places like that. There's no option at all, especially if it's not safe and you can't be on that community for whatever reason that is, then they've got to go to either Darwin, Katherine, or even to Alice Springs." (P7, NGO Service Provider, Alice Springs)*

Insufficient monitoring of illicit drug use prevalence, patterns, and impacts

Better coverage of wastewater monitoring was raised by some participants, with suggestions that additional testing sites outside of major urban areas would be beneficial.

> *"For the waste water monitoring… there's limitations on that data because it's only taken from 2 sites in the NT... So there's an urban one, which is in Darwin and there's one they consider regional, which is Alice Springs. I believe that's only two sites they do. It's a bit of a snapshot, but it doesn't really tell us a lot about anything outside of those centres…Then we've got the EDRS [ecstasy and related drugs reporting system] and the IDRS [illicit drug reporting system], which also capture limited snapshots of information. And then we've got data from AIHW [Australian Institute of Health and*

Welfare] around the AODTS NMDS [Alcohol and Other Drugs Treatment Services National Minimum Dataset]. And then outside of that, it's probably primarily anecdotal reporting. We hear direct feedback from treatment services and from the NSP's [needle and syringe programs]. It's usually one of the better sources of information around what we're seeing, especially for injecting drug users and opiate use." (P1, Peak body, Darwin)

Participants felt that there was need to improve the routine monitoring and evaluation of illicit drug use and harms and increase funding to enable monitoring and evaluation of AOD programs and services. Consideration of qualitative monitoring and evaluation approaches to complement quantitative approaches, such as the collation of stories and narratives, is critical for ensuring an appropriate level of nuance and contexualisation for informing more progressive and culturally responsive illicit drugs program and policy reforms.

"Our points of intersection with people who use substances are treatment services, prisons, police and emergency departments. They're hotspots. And they all have different ways of collecting data. I know that wasn't specifically your question, but they also see the pointy end of the drug using market, if you like, they see the harmful stuff. But that is not always indicative of other types of using behaviour that doesn't end up in an instance of psychosis or doesn't end up being, arrested by the police, or you don't end up in a treatment service. So, we've got some general overview of the more pointy or harmful end, and we don't do that very well in terms of our data, but we've got a whole lot of other drug using populations in the NT that don't get picked up at all." (P6, Peak body, Darwin)

"We also need to have programs evaluated. Sometimes there's not funding for that, and it's so important to do that as well. And whether that's done every three years or five years. That needs to happen across the board." (P7, NGO AOD Service Provider, Alice Springs)

"Funding bodies really expect you to be able to as an NGO to prove that you are having the impact on the service users that you say you are and that you're achieving the outcomes that is that you intend to achieve but it's harder and harder to prove that, you've got systems that are supporting, in [AOD service name] case, a number of different programs, so all the backroom systems in terms of output and outcome measures, you've gotta develop them. You've gotta have systems that talk to each other, case management systems that can give you outputs and outcomes. So, I mean, it's really a complicated space that requires a research brain to be able to work with the service provider to do that work and there's no funding, but there's expectations from the funding body that people justify their funding through outcomes and impacts. So, it's a really, I agree, 100%, [P7]. It's a massive gap. Having worked on 2 evaluations of AOD with NGO's in the Northern Territory. One of the big gaps is A – the funding to do it, B – having staff who can do data collection and data inputs and outputs at a level that's going to give you the data that you need, and umm that's a really big challenge, funding at a range of levels, systems level and getting evaluations in to do the work with you." (P6, Peak Body, Darwin)

Similar issues to those described above were also raised in 2022 during an NT-wide forum about AOD harm minimisation approaches in the NT, which was co-hosted by AADANT and Menzies School of Health Research. Some participants indicated that industry partnerships should be explored to enhance monitoring and evaluation capability, and to build an evidence base that can support quality improvement endeavours.

> *"My interest is too, because I'm also trying to get industry involved here because we've got a 5 acre farm. So, I'm trying to get people saying that part of their rehabilitation experience is #1, there's numeracy, literacy, there's education, white cards, forklift license, possibly some starting qualification around horticulture and things like that. But I would also like a connection with a research organisation to make sure that we have ongoing evaluation of our service and the way that we do it, there's not a lot of around at the moment and even when I looked at, because we're an Aboriginal organisation, I rang around about: who's got a great model? And everyone just went: well, we've got this model, but it it's still comes back to local issues and you look at it that. So, I haven't found one true one-size-fits-all, which is probably good around residential rehabilitation for Aboriginal people. I had quite a bit of contact with… I can't think of it off the top of my head… I did a lot of research around assessing Aboriginal rehabilitations. He works for Indigenous Knowledge Centre anyway. So, but most of it was around rehabilitation, still tend to be the same, but it's the cultural part of that, and how you evaluate that and how you run that aspect of it. Because I mean, in reality rehabilitation is still rehabilitation, you still gotta get up, you still have things you need to do, there's a program to do, but it's really, and I'm still looking for but how do we identify what cultural needs are? How do we identify that then how do we address that so. That's done pretty Hotch Potch all over the place. And I'm not saying that some people aren't doing it well. I'm just saying, I don't think we're doing it well." (P10, ACCHS AOD Provider, Alice Springs)*

> *"It's about contextualising this and saying that, we have to be really clear that we have this major, 30% of our population being Aboriginal, [experiencing] enormous disadvantage, colonisation, the racism and the ongoing disadvantage is so huge. So that's just a given and that's what we say about life in the NT. But we have to recognize that in that then there are people with ongoing mental health and AOD issues. So, we have to still try and tease out where the needs are for people who have illicit drug problems and where are the gaps because we're not necessarily addressing that. So, that goes back to your point about trying to get a bit more qualitative and quantitative data and definitely quantitative. And so, then you can start talking about where the gaps are and what might be some commensurate balanced responses." (P11, NTDOH Executive, Darwin)*

Study limitations

This was a relatively small qualitative study undertaken in a short timeframe. While the research team engaged with a broad cross-section of stakeholders, across multiple NT urban and remote locations, it only provides a preliminary snapshot of the contextual factors that need to be considered when addressing the use of illicit drugs and harms in the NT. Key limitations included:

- The study only engaged four people that identified as having a lived experience of illicit drug use in the NT. A more comprehensive study is warranted to privilege the narratives of people from high-risk cohorts, particularly those from marginalised or vulnerable backgrounds. This is important from a health equity perspective.
- Limited engagement with Aboriginal and Torres Strait Islander participants and organisations. A more detailed exploration is required, underpinned by principles associated with Indigenous leadership and governance, Indigenous Data Sovereignty, and self-determination.
- This exploration of illicit drug use and harms engaged ten participants who work in treatment contexts, such as service providers in AOD treatment facilities, and clinicians from the disciplines of Emergency Medicine and Addiction Medicine. This may have led to a more explicit emphasis on interview data related to illicit drug use and harm treatment rather than prevention. However, this potential sampling bias was mitigated by the inclusion of three NTDOH executives, four representatives from peak bodies and four participants with lived experience of substance use and harms.
- The study timeframe for data collection and analysis was less than two months once ethics approval has been received.
- The restricted budget limited face-to-face engagement in remote sites.

Key Findings

Key Finding 1: There are diverse patterns of illicit drugs use and harms across the NT.

There is a wide variety of patterns of illicit drug use geographically across the NT impacted by issues of access, availability, cost, and local contextual considerations. Cannabis was the most widely cited illicit drug available and used throughout the NT. It often surfaced as a health and social concern when people accessed the emergency department or when they were presenting for treatment services (and not always as the primary drug of concern). Key stakeholders noted the significant harms arising from cannabis (exacerbated by alcohol co-consumption) particularly among those with co-occurring mental illness.

Key Finding 2: There are priority populations impacted by illicit substance use.

, and the following priority populations identified by participants in this study, namely:

- Young people
- Socio-economically disadvantaged
- Transient and/or homeless ("long-grassers" and "river people")
- Those engaged with the justice system
- Those living in rural and remote areas

There is clear need to increase harm reduction and prevention efforts associated with cannabis use, especially for Aboriginal and Torres Strait Islander people and communities.

Key Finding 3: Current routine data collection, monitoring, evaluation and research strategies provide an incomplete understanding of the patterns of illicit drug use and harms in the NT.

There is limited quantitative and qualitative evidence to inform health planning related to managing illicit drugs harms in the NT. This impacts the ability to adopt strategic and innovative approaches to illicit drugs harm minimisation. Increased investment in quality data collection through local and national surveys, and greater compliance with National Minimum Data Set collection would be beneficial. This could include oversampling of priority populations during surveys, and more active monitoring of NMDS data collection by commissioning agencies. Expanding wastewater monitoring to include selected regional and remote communities would provide deeper insights into illicit drug use in regional and remote settings.

Investing in further qualitative research, particularly that relating to understanding the lived experiences of priority populations using illicit drugs, is warranted, particularly among youth.

Key Finding 4: Harms from illicit drugs are wide-ranging and far-reaching. Yet. treatment services are currently prioritised over broader harm minimisation and prevention efforts.

Participants emphasised the importance of investing in appropriately tailored outreach services focused on amplifying harm reduction efforts at a scale consistent with need. Such outreach investments need to cater for both urban and remote populations. It was also acknowledged that existing AOD services are typically skewed towards reducing alcohol harms rather than illicit drugs harms. While there was consensus among participants that the health and social harms of alcohol use is a key driver of AOD treatment services in the NT, it was also highlighted that more could be done to address harms associated with illicit drugs use, including concurrent use with alcohol. Interview data indicated that targeted funding, and appropriately scaled services, specific to addressing illicit drugs use, are required. Suggestions offered by participants included: increasing operational and staffing resources within AOD services, primary health care services, and schools to explicitly address illicit drugs use in the NT. This will also require increased investment in professional development of key stakeholders within these sectors to address illicit drugs harms (in addition to those currently offered in relation to alcohol outreach and treatment services).

Key Finding 5:
While there are examples of collaboration between services, it is claimed that there is insufficient resourcing and workforce capacity to provide high quality co-ordinated and integrated care to address the harms of illicit drugs use in the NT.

Participants spoke about the importance of service co-ordination between different types of health, AOD and social services to best meet consumer, family and carer needs. Similarly, partnership development and collaboration were also considered to be critical, and an enabler in offering more sustainable service delivery. In some (generally smaller) regions service co-ordination was perceived to be functioning well, whereas in other (larger) regions further effort is required to address the harms of illicit drugs in a co-ordinated way. Some participants spoke about competition (particularly between NGOs) in accessing the very limited pool of funding that is available for illicit drugs harm reduction in the NT. It was suggested that commissioning agencies should be encouraging and prioritising partnerships and consortia arrangements where there is potential for siloed service delivery or

duplication in program offerings. Changes of this nature were perceived by participants to better enable service co-ordination between agencies but would also provide greater scope for integrated service delivery that is more consumer-centred than current program and service delivery options. Finally, there is a priority need for integrated service delivery between AOD and mental health sectors to address illicit drugs needs in the NT, akin to recent research and evaluation findings focused on the alcohol treatment system, social and emotional wellbeing programs, and peer-led mental health workforce initiatives.

Key Finding 6:

Growing a skilled and competent AOD and mental health workforce to address illicit drugs harms in the NT is important. Current challenges are wide-ranging and relate to workforce attraction and retention issues, an expansive geographical footprint, and limited professional development opportunities in the NT.

Participants highlighted an urgent need to attract and retain a skilled AOD and mental health workforce in the NT. High quality training opportunities, that are contextually and culturally responsive were also perceived as important. Options for contemporary training about effective strategies for engaging people who use illicit drugs; addressing co-morbidities associated with illicit drugs use, alcohol use and mental illness; information and knowledge sharing about emerging patterns of illicit drugs use in the NT; targeted strategies for engaging high-risk populations; and more general training about the adoption of trauma-informed, and consumer-centred care, were all identified by participants as potential areas for investment. Similarly, more significant investment in the peer/lived experience workforce was considered important by many participants, including their role in developing promising practice guidelines and further opportunities for training. Expanding the addiction medicine specialist workforce was also raised as important by participants, consistent with findings from the demand study for alcohol treatment services in the NT. Som eparticipants indicated that consideration should also be given to adopting strategies to expand workforce utility by linking in with non-health and social service workers that engage with priority populations, such as those employed as educators, sports coaches and youth workers.

Key Finding 7:

Policy and legislation can be better utilised to reduce illicit drugs harms in the NT.

Some participants had experience of working in AOD policy and legislation contexts. They frequently reinforced the importance of progressive policy legislation development and reforms for reducing illicit drugs harms and use. Some participants spoke about the importance of using legislative mechanisms to

decriminalise illicit drugs use, especially around issues such as possession of substance administration equipment, and referred back to a former Parliamentary Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours. Mobilising existing advocacy efforts through the engagement of peak bodies and local working groups, such as the Association for Alcohol and Other Drugs Agencies NT, the NT Mental Health Coalition, the NT Harm Reduction Advocacy Group, and NT Lived Experience Network, was perceived to be critical for advancing illicit drugs policy and legislation in the NT. It was consistently acknowledged that these entities need more resourcing to do this work well.

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Appendix

Appendix A – Interview Guide

This interview guide was used flexibly and adapted for use in a dyadic or one-on-one interview.

Acknowledgement of Country[1]

I acknowledge the [Clan affiliation] people as the Traditional Owners of the [city/town] region where I live and work. I recognise the [Clan affiliation] Peoples' cultural, spiritual, physical and emotional connection with their land. I honour and pay my respects to [Clan affiliation] Elders, both past and present, and all generations of [Clan affiliation] people now and into the future.

Introduction and Interview Briefing

Welcome. Today, we are going to talk about your views and experiences regarding the harms associated with illicit drug use, and priority areas for strategic intervention. To clarify, we are not specifically discussing alcohol consumption, unless it is consumed alongside illicit drugs. We are focusing on illicit drug use, which includes cannabis, cocaine, ecstasy/MDMA, meth/amphetamine, non-prescribed use of pharmaceuticals e.g. opioids, and other substances. Please do not use the real names of any clients or people who you may know use illicit drugs in today's discussion.

We are keen to identify useful strategies to improve services and reach those who may be impacted by illicit drug use the most. Anything you say is important to us, so please don't be afraid of speaking your mind. You don't need to agree with others, but you must listen respectfully as others share their views. There are no right or wrong answers – just ideas and opinions, which are all valuable to us. We will audio-record the discussion today. While we will use first names today, what you say today will be anonymised. To protect each other's identity and maintain privacy, please don't share what is said today and the identity of members outside this setting.

Ice Breaker

To start us off, it will be useful to introduce ourselves to each other, say something about who you are, where you are from, and what work you are doing to support those who may be impacted by illicit drug use. I will start….

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[1]This Acknowledgement of Country will be adapted for with the setting/lands on which the interview is being held.

Question Logic	Main Interview Questions	Potential Probing Topics and Prompts	Duration
Gain a better understanding of the harms associated with illicit drug use in the NT	1. What is your understanding of the current state of illicit drug use across the NT? 2. What do you perceive to be the harms associated with illicit drug use in the NT? 3. In which groups/areas do you see these harms? 4. What are the reasons why these harms might be seen more in these particular areas and/or populations?	• Probe to ensure specific substance use is discussed: cannabis (most common in the NT), cocaine, ecstasy/MDMA, meth/amphetamine, non-prescribed use of pharmaceuticals e.g. opioids; other illicit substances; and any new or emerging drugs of concern • Probe around the concept of 'Harms'. It should be discussed in harms to the individual who is using the drug and harms to other aspects e.g., family, social, and community. • Probe for which primary drug of concern is linked to harms discussed. • Probe as to whether there are any different patterns of needs in different towns/regions of the NT. • Probe re: impact of/on social and cultural determinants of health.	~15-20 mins
Explore views of areas of priority need to reduce harms associated with illicit drug use	5. What support is currently in place for those impacted by harms of Illicit drug use? 6. What are the strengths and weaknesses of these supports/services? 7. Are the current services servicing the client groups most at need? 8. What are the needs to support the monitoring and evaluation of these services and programs? 9. What would be the best investments or critical priorities for future illicit drug harm reduction? 10. What are the health workforce needs to address illicit drug harms in the NT?	• Probe for services/programs/policies focused on harm reduction, demand reduction or supply reduction. • Probe for priorities across specific use of substances. • Probe for treatment of comorbidities and adequacy of services supporting socio-cultural determinants of illicit drug use. • Probe for services and investments targeting types of use: non-harmful use/recreational use vs. dependent use.	~15-20 mins
Explore and plan for specific areas of need for future programs supporting Aboriginal and Torres Strait Islander people and other priority populations	11. The NT has a large Aboriginal and Torres Strait Islander population, who are disproportionately impacted by illicit substance use. How might future services best support their needs? 12. What key considerations are needed to ensure future illicit drug harm minimisation programs/services engage Aboriginal and Torres Strait Islander people and communities successfully? 13. Are there other priority populations that require targeted health services for illicit drug use?	• Probe to ensure specific substance use is discussed. • Improving/integrating cultural safety, trauma informed care and follow-up support mechanisms • Probe for other high-risk client populations e.g. people in contact with the criminal justice system; LGBTIQA+; young men; people living remotely	~10-15 mins
Provide an opportunity for participants to raise anything not yet said	14. Thank you all for your time. Is there is anything you would like to say that we did not get a chance to discuss today?		~5 mins