Northern Territory Harm Reduction Summit

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Abbreviations

AOD Alcohol and other Drugs

BDR Banned Drinker Register

CBD Central Business District

DDHS Danila Dilba Health Service

DFV Domestic and Family Violence

FASD Fetal Alcohol Spectrum Disorder

HEAL – Healthy Engagement and Assistance in the Long-grass

LEAD Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity

MUP Minimum Unit Price

NGO Non-Government Organisation

NTG Northern Territory Government

NAAJA North Australian Aboriginal Justice Agency

SUS Sobering Up Shelter

Introduction

Alcohol in Australia

Alcohol is the most widely used drug in Australia. Its use is embedded in Australian society and cultural norms and its harms are often underestimated (Department of Health, 2019). Its use is linked to a wide range of short and long-term adverse effects, and many people drink at levels which are harmful to their own health and hazardous to society in general. Data from 2015 reported by the Australian Institute for Health Welfare (AIHW) indicated that alcohol use is responsible for 4.5% of the total burden of disease and injury in Australia (AIHW, 2019). It is implicated as a risk factor in more than 200 diseases including cancers and cardiovascular diseases (AIHW, 2018b; WHO, 2018). Alcohol use was the leading risk factor contributing to disease burden for men aged 15 to 44 and in the top five risk factors for men aged 45 to 64 (AIHW, 2018b). While the 2019 National Drug Strategy Household Survey (NDSHS) indicated that more Australians, particularly young Australians, are giving up or reducing their alcohol intake, 25% of people are still drinking at risky levels at least once per month (Australian Institute for Health Welfare (AIHW), 2020) with one in ten recent drinkers likely to meet the criteria for alcohol dependence.

In the Northern Territory

The Northern Territory has the highest rates of alcohol use in Australia. (AIHW, 2022). Commensurately, the NT also has the highest in rates of alcohol related hospitalizations' and alcohol attributable deaths in the country (Skov et al., 2010, Lensvelt et al., 2018), chronic liver disease, alcohol related road traffic injuries, suicide and self-inflicted injuries and total disease burden attributable to alcohol use (AIHW, 2018a). The total social cost of alcohol in the NT has been estimated at $1.4 billion dollars (Smith et al., 2019). The Northern Territory population has the highest proportion of Aboriginal and Torres Strait Islander people (ABS, 2022), and recognising the influence of the ongoing impacts of colonisation, Aboriginal and Torres Strait Islander people are disproportionately affected by alcohol, tobacco, and drug related harm (Department of Health, 2017). While alcohol has consistently been recognized as harmful, investment in strategies to reduce alcohol harms has been sporadic, with rapid changeover in alcohol policies in the past two decades and mixed investment in evidence-based strategies (Clifford et al., 2021).

The Northern Territory Harm Reduction Summit 2022

Overview

Despite harm reduction being recognized as an essential pillar of alcohol and drug harm minimisation, only a small fraction of budgets spent on addressing drug use goes towards harm reduction (i.e. 2.1% of $1.7b in 2009/10), with the majority spent on supply reduction (National Drug and Alcohol Research Centre, 2013).

The major alcohol and drug network, the Australasian Professional Society on Alcohol and Other Drugs (APSAD), held its annual conference for 2022 in Darwin from October 9-12. Conference co-convenors Peter Burnheim (Association of Alcohol and other Drug Agencies NT (AADANT)) and Dr Cassandra Wright (Menzies School of Health Research) sought to harness the focus on AOD and utilize the expertise and knowledge of national and international conference attendees, by organizing a summit with local stakeholders to discuss harm reduction measures to address alcohol and other drug use in the Northern Territory. The event was held at the Darwin Convention Centre from 9:30-3pm on Friday October 14. The event aimed bring together community and government agencies who have frontline engagement with people at risk of harm from their alcohol and other drug use, to identify key priorities in the areas of reducing alcohol harm. The aim of the day was to identify strengths of the current system that could be built upon, as well as new directions to improve harm reduction in the NT.

Photo: https://www.aadant.org.au/

Photo: https://www.menzies.edu.au/

The summit was intended to define shared priorities and co-create pathways to move forward to present a united front on some key directions and support participants' advocacy, policy, and program initiatives. The session was run using a co-design approach involving group discussions, activities, with brief panel reflections. The focus was on prioritising local voices, while tapping into knowledge and reflections of some experts visiting as part of the APSAD conference. The purpose of this report is to capture the output for the day, so that aggregated findings and outcomes can be shared with all participants for use as evidence of local priorities and support for initiatives.

The structure of the program was designed to ensure that participants are working to address the same solutions, by firstly allowing the group to define what the 'problem' or priorities are. It then integrated a strengths-focused approach by acknowledging the parts of the system which work well,

which can be built upon or used as a model for solutions. Then, models of proposed or existing programs were used to stimulate discussion and ideas. Finally, participants were asked to generate blue-sky ideas to address the identified problems, with the final part of the program focused on narrowing in more specifically on supported and tangible solutions. A copy of the program is provided at Appendix 4.

Opening & Overview of the Day

> *"Different people need different things at different stages in their lives"*
>
> *NT Harm Reduction Summit Participant*

The summit was opened by Dr Cassandra Wright and Peter Burnheim with an Acknowledgement of Country and recognition of the Larrakia people as the traditional owners of these lands.

Dr Wright provided an overview of the aims of the day and stressed that the particular focus of the summit is harm reduction rather than demand or supply reduction. She asked that participants keep in mind that harm reduction is about reducing the adverse consequences for individuals and their community.

Mr Burnheim provided an overview of the intended guiding principles for the Summit reminding participants that we have a broad range of perspectives represented in the room including those of interstate and international visitors. He asked that participants recognise the humanity of those people who use alcohol and other drugs highlighting that often people who use alcohol and other drugs are "othered" in stigmatizing ways, but that they need to be recognized as part of our community, even when their actions make us want to push them away.

Mr Burnheim also asked participants to give each other unconditional positive regard when engaging in discussions, reminding the group that there are different ideas, positions, and backgrounds in the room today but that we all have a shared goal of reducing the harms caused by alcohol and other drugs. He also recognized that, while we are all aware of the broad underlying causes of the harms from being discussed such as socioeconomic disadvantage and historical trauma, the purpose of the Summit is not to resolve those issues but to focus on pragmatic approaches that could reduce the harms experienced by those using AOD.

Mr Burnheim then highlighted that it is important to recognize that drug use is on a spectrum for a variety of reasons, and that The War on Drugs as an approach has not worked. He highlighted the importance of responding to people where they are at, and that there will be different responses

required for different populations. He also asked that participants be pragmatic and focus on solutions and not blame. Peter also recognised that work already had been undertaken through the Reilly Review, The Parliamentary Select Committee on Addictive Behaviours and the Harm Reduction Advisory Group.

Dr Wright assured participants that confidentiality was guaranteed, and that the day would utilize co-design principles, recognising that the best ideas can come from the people on the ground, and that groups would share after some group discussion activities. The day would be broadly divided into identifying issues, identifying what is working and identifying priority actions.

Program Model Examples

L.E.A.D. Bureau

Photo: https://www.leadbureau.org/

Najja Morris-Frazier and Brendan Cox from the Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) program which was started in Seattle, USA, and now operates internationally, gave an overview of the program. The key components of the program are as follows:

- It seeks to move away from the criminal justice system to fix addiction and poverty and apply a public health approach to public safety.
- Provides a formal pathway for people identified as being at-risk of entering the criminal justice system to be proactively referred to the LEAD program for supportive case management.
- Diverting funds from continually arresting people to implementing a care continuum as a way to respond to people at risk of entering the criminal justice system.
- Works with people where they are, nothing is mandated and all solutions are on the table, even as something as basic as a pair of shoes. It's about building a relationship with a person, and facilitating collaboration between lawyer, mental health workers, social workers etc. to support each person.
- Works through a consortium approach including police, prosecutions, health and social services support systems.
- Was initially established to allow for referral by police at the point of arrest and has now undergone additional iterations to allow for pre-arrest referral by police or any concerned community member.

There was significant interest from the audience in this style of program. Members of the group had questions around confidentiality, funding, and the effectiveness across different settings, e.g., rural v urban. Regarding confidentiality, there is extensive consultation with lawyers to ensure the program

is in-line with local laws, participants are informed and sign disclosure agreements about their information, detailed information about each participant is not required for program to function, and disclosure of an individual's details can be kept to a relatively high level. Regarding funding, the program does not require an extensive investment and ends up being highly cost-effective by reducing the burden on police, the criminal justice system and corrective services. The program works in diverse environments from rural settings across the United States to major urban areas such as Los Angeles. The program offers a flexible framework and can be somewhat tailored for each site.

Danila Dilba Health Service (DDHS)

Photo: https://ddhs.org.au/#

DDHS developed a proposal for delivery of the Better Pathways program. This approach involved a consortium of organizations providing services to people experiencing homelessness. This includes access to dignity services such as shower and laundry, as well as food and case managers.

People who may need AOD support or want residential support can be identified and dedicated caseworkers can do referrals, connecting people with Centrelink, NAAJA, etc. It was intended to operate in a drop-in center format. Note that this program was never successfully implemented due to issues with the proposed site for delivery.

There was a question from the group about organisations sharing the caseload, which would happen based on the clients' need.

Larrakia Nation

Photo: https://larrakia.com/

Amongst Larrakia Nation services is the HEAL program which runs programs such as Arts in the Grass, the Anti-Social Behavior app, Larrakia Night Patrol, and distribution of Larrakia Nation Cultural protocols for people visiting from other Aboriginal and Torres Strait Islander nations. They are currently undertaking a project to translate these protocols into other languages.

Group Discussion & Feedback

Session 1 – Identifying Issues

Key Points

- **Deficiencies in capacity and scope of systems and services**
- **Understanding clients' needs**
- **Causes of alcohol related harm and interconnected issues**
- **A need to build trust and connection**
- **A need to build resilience in clients**

There was an initial discussion around ensuring clarity around what is needed in the sector and determining appropriate different measures to respond to the spectrum of alcohol and drug use behaviour. Some groups discussed deficiencies in the NT system and services such as a lack of supports for children and young people and people experiencing homelessness, workforce shortages and lack of diversity within the workforce, silos between service providers, and lack of cohesive shared case management. Participants talked about the positive outcomes that happen when we do collaborate but felt that this was currently a clear gap.

Other participants talked about needing to better understand and address client needs. This included basic and practical needs such as access to water in the CBD and places to charge phones, as well as more complex issues such as safe places to consume alcohol, overcoming language barriers and ensuring two-way knowledge translation. Participants discussed the lack of awareness amongst some clients around policies such as the Banned Drinker Register (BDR).

Other issues were related to better understanding and identification of interconnected issues related to alcohol related harm such as:

- intergenerational addiction and trauma
- impacts of racism and stigma
- overrepresentation of Aboriginal people in the criminal justice system
- FASD
- Domestic and Family Violence and
- the overall burden of disease in the Territory.

Another important theme was the lack of trust and connection to communities and the importance of leadership - especially First Nations leadership. Some discussions reflected the frustrations of frontline workers seeing the same people repeatedly, which to them demonstrated that current responses are inadequate for meeting these people's needs.

Many acknowledged the need for services to build resilience in clients to meet the challenges of 'the real world' in contrast to the more controlled environment of a residential rehabilitation setting. Participants highlighted the need for person-centered, holistic models of care and service provision – including in regional and remote areas. A detailed breakdown of the points raised by group is provided in Appendix 1.

Session 2 – What is Working

Key Points

- **Fewer barriers to access government and policy makers**
- **Strong political will in this area & commitment of sector**
- **Inclusion of people with lived experience**

Participants reported many positive things that are working in the sector in our jurisdiction. The Northern Territory is a small jurisdiction, and participants identified the accessibility of government and policy makers as a benefit. Strong political will and support from government was also identified. The size of the jurisdiction also facilitates relationships amongst workers in the sector. Participants recognized that collaboration was improving.

Several groups recognized the commitment and drive of the AOD sector itself, peak bodies such as AADANT facilitating coordination in the sector and events such as this, bringing stakeholders together.

Several participants highlighted inclusion of people with lived experience in service delivery as a significant strength, and the importance of peer support, recognizing that peers can be the best people to talk to young people about harm reduction.

Many groups also identified specific services and organisations in the NT such as sobering us shelters, the Take a Break Program, the Walk-in Withdrawal clinic, Dancewize, Larrakia Nation and Night Patrol, Danila Dilba Health Service, Amity Community Services, needle and syringe programs and access to rehabilitation beds. These services were identified as important facilitators for delivering harm reduction, which contrasted with a strong focus within the sector on abstinence-based treatment.

Others identified that while not perfect solutions, policies such as the minimum unit price (MUP) and banned drinkers register (BDR) may give the sector the space to work on other things. Similarly, court diversions can provide opportunities to start conversations with people.

Groups also talked about the strengths in non-clinical approaches (i.e. holistic models of care) in the NT with a focus on community and place, the broad acknowledgement of social determinants of health, and the focus on inclusion of the people being impacted when working

out solutions. A detailed breakdown of the points raised by the group is provided in Appendix 2.

Session 3 – Solutions & Priorities

Key Points

- **Consultation & community-led solutions**
- **Developing wraparound services**
- **Community education**
- **Strengthening AOD workforce**
- **Legal support and reform**

Groups first worked together to identify ideas for strategies and programs that may support harm reduction goals in the NT. Following group discussions, groups brought ideas on post-it notes to the front of the room and were asked to organize them into broad themes. While some ideas were quite specific in nature, others identified broad principles that they felt were important to integrate into programs.

Theme one centered on key concepts for harm reduction responses including:

- community led solutions and consultation
- education
- building strength and resilience
- place-based responses
- culturally safe programs and evaluations
- facilitating collaboration and cohesion in the AOD sector.

Theme two centered on implementation of harm reduction program ideas including:

- child and youth substance use services and general child and youth services
- safe spaces with facilities for people experiencing homelessness
- wet camp or managed alcohol programs
- drop-in centers, including those for youth only and men only
- more support services and facilities made available for outer suburbs and Palmerston
- more crisis accommodation and medium-term accommodation
- family focused services (i.e. better supports for children of those in treatment to minimize generational harm)
- outpatient support and care post treatment
- pill-testing and drug checking services for illicit drug use.

Theme 3 centered around community education including:

- early intervention in school

- more effective health messaging
- advocacy groups for people who use drugs.
- peer-led support

Theme 4 focused on the AOD workforce including:

- recruitment and retention
- workforce training and education
- access to interpreters
- ensuring adequate funding

Theme 5 focused on legal issues including:

- decriminalisation of drugs
- redirecting funding to health initiatives and training
- increasing access to diversion programs.

A detailed breakdown of all ideas is in Appendix 3.

Participants Reflections

Representatives from different sectors were asked to provide some reflections on the ideas generated. A representative from an ACCHO said a lot of these ideas are *things we should be doing anyway*. They noted that some require funding and that we need to be more innovative with available resourcing. A representative from policing said there were a lot of *really good ideas* and that ideas only required co-ordination while the more specific programs needed

funding. This representative stressed the importance of including *harm minimization for others* impacted such as the children of impacted people, which was not well-represented among the ideas. A representative with lived experience agreed, saying that their parents had struggled with substance use and the impact that that had had on them. They continued, saying there was a need for *law reform*, and stressed the importance of *peer led education*- peers being a trusted source of service delivery with privileged knowledge about the problems and the solutions. This peer representative expressed pleasant surprise at the significant focus on wraparound and holistic services, contrasting this to the often band aid solutions discussed in other forums. They shared another example of successful cross-sectoral collaboration being the recent integration of *lived experience-led training to NT police recruits*. A representative from the policy sector discussed reflections on strong themes of community-led approaches, lived experience and a locally-contextualized responses. They highlighted the importance of providing *a full range of solutions* which acknowledges that different people need different things at different times in life. They also talked about the need for *more rural and remote services* to prevent a logjam in the tertiary sector. They also talked about *a whole of government approach,* which brings together different government departments who each have complementary roles in reducing alcohol and drug harm (i.e. housing, health, families, emergency services). A representative from the treatment sector reflected on the strength of our shared understandings of the problems and solutions, mentioning that *we are all thinking and saying the same thing*. The treatment representative agreed with the importance of peer-led models. They also highlighted the prominent support for a *wet camp*, an idea which has been raised repeatedly over the past 5 years in the NT. Continuing the support for integrated care, they felt the session reflected the dire need for a one-stop shop for clients. They confirmed a great need for *person-centred approaches*, noting the gaps in *drop-in and outreach options*.

How can we support each other to create change in this space?

Photo: Stock photo

Theme of Networks and Coordination

- We need stronger networking, not just with people working in the AOD sector but across the board – e.g., Territory Families. Police, Legal Services etc.
- Revising expected outcomes from funding agreements could create more of a supportive environment for collaboration
- A pilot of the LEAD program in Darwin
- Continued action from the Harm Reduction Advisory Group
- Cross-service collaboration, focused on client and client needs
- Cross sector workforce training

Theme of Stigma

- Stigma and trauma organisational training

Theme of Training

- Interagency training could leverage off existing expertise across NTG departments and NGOs
    - Free training based on an exchange program of training

Theme of Service Coordination

- Show up and engage
- Consistency in engagement is needed
- Differences in governance between NTG & NGO leads to bureaucratic traffic jams
    - A participant highlighted that the principle of harm reduction was born out of breaking down bureaucracy in the first place.
- A suggestion was made to create a handbook summarizing what everyone offers. Mr Burnheim reminded the group that AADANT already has a service directory online and that paper copies can be hard to keep up to date.
- More flexibility is needed in defining AOD treatment.
    - Sometimes things can be categorized as AOD and this can become a barrier, as some people have no intention of abstinence but still need services

Feedback from the Summit

A brief survey was sent to those who attended the summit to capture their feedback. Questions focused on measuring the value of the summit to the group and understanding individual opinions on different elements of harm reduction policy and practice.

Summary

Survey feedback reported high levels of relevance to the work of participants (50% rated 5/5, 28.75% rated 4/5,) and a very high level of perceived value of the summit (78.57% rated 5/5, 14.29% rated 4/5).

Respondents identified a number of further groups who would be beneficial to engage in future summits including some who were invited but not able to send a representative. These include:

- More lived experience participants (including youth)
- Emergency department staff
- Liquor licencing
- More staff from Aboriginal Controlled Community Organisations (policy and frontline workers)
- Territory Families
- Housing/Homelessness services
- Training organisations
- Justice sector – Attorney generals, North Australian Aboriginal Justice Agency (NAAJA)

With regard to broad harm reduction policy, respondents were asked to rate their level of agreement in three areas on a scale from “Strongly Disagree” through to “Strongly Agree”. Of the respondents:

- 87.5% either strongly agree (62.5%) or agree (25%) that more investment is needed in harm reduction approaches.
- Over 90% of respondents either strongly agree (72.73%) or agree (18.18%) that **new** harm reduction options should be trialled or introduced to meet the needs of the NT population.
- Over 90% of respondents either strongly agree (63.64%) or agree (27.27%) that harm reduction approaches would improve the outcomes related to alcohol management in the NT.

Specific Harm Reduction Strategies

Respondents were asked to provide their position on the following harm reduction policies and activities that had been identified at the summit:

- Managed alcohol program
- Wet areas/wet accommodation (supported alcohol consumption sites)
- Law Enforcement Assisted Diversion (LEAD) Program
- Better Pathways Centres (Drop-in dignity centres for people living rough)
- Drug diversion programs
- Decriminalisation for drug possession

- Pill testing (drug checking) services
- Needle and syringe programs in prisons
- Opioid pharmacotherapy programs in prisons
- Safe consumption sites (e.g. Medically Supervised Injecting Facilities)
- Outreach programs (incl. day/night patrols)
- Sobering up shelters
- Peer support services (e.g. DanceWize, formalised Peer Worker roles)
- Youth-focused services

For each selection, respondents were asked to choose from the following assessment of the option:

#1 Doesn't/won't work – service should not be trialled/should be removed
#2 Currently over-invested – service should be reduced
#3 Current level of investment/service delivery is about right
#4 More investment/introduction/expansion of service is needed
#5 Urgently need considerable investment/introduction/expansion of service

Results

- There was **100%** support for investment, introduction or expansion for the following measures (in order of highest rated priority):
    - **Better Pathways Centres** (76.92% assessed as #5, 23.08% assessed as #4)
    - **Law Enforcement Assisted Diversion** (63.64% assessed as #5, 36.36% assessed as #4)
    - **Drug diversion programs** (57.14% assessed as #5, 42.86% assessed as #4)
    - **Youth-focused services** (53.85% assessed as #5, 46.15% assessed as #4)
    - **Peer support services** (50% each assessed as #4 and #5)
    - **Pill testing/drug checking service** (45.45% assessed as #5, 54.55% assessed as #4)
    - **Wet areas/wet accommodation** (41.67% assessed as #5, 58.33% assessed as #4)

- **92.86%** supported increasing/expanding **outreach programs** (**64.29%** assessed as #5, 28.57% assessed as #4)

- Over **90%** of respondents supported introducing **decriminalisation for drug possession** and the use of **needle and syringe programs** and **opioid pharmacotherapy programs in prisons**.

- Over **75%** supported increasing investment in **sobering up shelters** (21.43% assessed as #3) and introducing **safe consumption sites** (16.67% assessed as #3, 8.33% assessed as #1)

- **63.63%** of respondents supported the introduction of a **managed alcohol program** (18.18% assessed as both #2 and #3).

Conclusion

There is clearly strong support from across a wide variety of sectors for investment in policies and activities that take a harm reduction approach to addressing the harms from alcohol and other drugs. This was identified as a considerable gap compared to the current investment in supply reduction strategies. The strongest theme that was repeatedly returned to by representatives of different sectors was a need for greater service coordination and wraparound services that provide

holistic, person-centred care. This was seen as a way to meet the diverse needs of clients with commensurate and appropriate care, when they needed it. This aligns with participants' expressed understanding of the social determinants of health which underlie alcohol and drug harms. There are a number of existing models and programs that should be trialled with most respondents considering this a matter of urgency. Despite the immense challenges in addressing alcohol and drug harms in the Northern Territory, our summit brought together from across sectors and on different sides of politics and ideology who were largely united in voice and willing to support each other to achieve improved outcomes for the populations they serve.

Next Steps

The outcomes of the forum will be shared directly to relevant sectors and made available publicly to increase understanding of harm reduction priorities for the NT. The outcomes will be used to inform the Harm Reduction Advisory Group for the development of a position paper to outline the priority areas for further development of harm reduction activities in the NT.

The findings of this forum will also be used to inform AADANT's position on key priorities in harm reduction when lobbying for support at multiple levels of government.

Similarly, Menzies School of Health Research will use these findings to inform research priorities and commits to seeking funding for research and activities that support these ideas.

While many of these broader findings may not be unexpected for those working in the AOD sector, seldom have harm reduction needs been documented in the Northern Territory, and very rarely have all of these different sectors been brought together to identify future directions. This report provides a unique resource which can be used as evidence of shared priorities when seeking support.

AADANT and Menzies will plan a more targeted follow-up forum in 2023, to further expand on specific ideas which were strongly supported.

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Appendix 1 – Discussion 1 Key Priorities Feedback

Group 1

- Do we even understand the need of our clients?
- Establishing prevalence
- Definitions of addictive behaviors, recognizing that all people exhibit some degree of these behaviors.
- Workforce shortages and diversity
- Knowledge translation – both ways.
- Lack of trust and connections to communities
- Language barriers including use of plain language

Group 2

- Repeat clients
- Homelessness and availability of emergency crisis accommodation
- Lack of supports for young people
- Secondary supply
- Understanding why some people cannot return to community
- Access to water in the CBD
- Wet camps and safe places to drink

Group 3

- Clients are getting younger and younger, even as young as 7
- Lack of support for people under 12 and from 12—18
- Lack of diversional activities
- Disengagement with school
- Racism and stigmatizing language
- VSA act targets Indigenous populations
- Silos between NTG and NGO
- Lack of shared case management
- Normalization of alcohol in the NT
- Associated DFV
- Promotion of gambling

Group 4

- Leadership including Indigenous leadership
- Cultural impact
- What is harm
- Influence of the past
- Vicarious trauma
- Generational addiction
- Real world v artificial environment – ensuring people have the tools and skills to manage in the real world
- Some changes in behaviors can be dangerous. E.g., Turning to non-beverage alcohol
- Regional and remote context, making sure programs are accessible to everyone
- Prisons are full, therefore something is not working

Group 5

- Need to be person centered and holistic
- There is currently a focus on Western models rather than strengths based self-determining models
- Where do we want to be in 20 years?
- Exposure in the community v residential care
- Intergenerational substance abuse

Group 6

- Trauma
- Transient movement of people
- Repeat clients but seen for short periods
- Easy access to harmful products
- Changing trends e.g., vaping
- Overlap of environment, mental health issues, AOD issues, housing etc.
- The old ways are not effective

Group 7

- Overall burden of disease across the NT
- Culture of drinking is linked to identity – i.e., acceptable for non-Indigenous people, but not acceptable for Indigenous people.
- Stereotypes
- Other drugs such as methamphetamine, cannabis, tobacco
- Spectrum of drug use

Group 8

- Limitations in services
- Lack of service cohesion
- Large unserved population
- Stigma
- Homelessness, mental health
- Insufficient case management services
- Overloaded services
- FASD, DFV, traumatic brain injury
- Need for trauma informed responses to crime to reduce exacerbating existing trauma
- High consumption
- Services for communities and families
- Peer and family pressure

Group 9

- High representation of Aboriginal people
- Overcriminalization of Aboriginal people
- Lack of accommodation options for people
- Risk for children
- Social and cultural determinants

- Reaching young people, peers can be the best people to talk to young people about harm reduction
- Money going on alcohol and not food

Appendix 2 – Discussion 2 What's working Feedback

Group 1

- The NT is a small jurisdiction
- Access to ministers via formal and informal channels
- Inclusion of young people and people with lived experience in services

Group 2

- Take a Break program at the withdrawal unit
- Community Link
- Walk in withdrawal clinic
- Priority clients
- Peer support and lived experience support
- Collaboration is improving
- Smart recovery
- Needle exchange program
- Overdose prevention, people come from interstate to access NT services
- NT has more rehab beds per capita
- Dance wise

Group 3

- SUS is a great harm reduction space
- Changing stigma

Group 4

- Need to rely on more early interventions including police and Territory Families to reach the entire family unit
- Adult spaces such as SUS, Amity, rehab
- Events like this
- Larrakia Nation
- DDHS

Group 5

- Level of recognition of use
- Level of investment and support
- Deeper level of engagement of peak bodies
- Moderately strict laws can provide some benefits
- Strong government will
- Policies becoming more evidence based
- Greater awareness of underlying issues

Group 6

- The stakeholders present at this meeting
- Good intent
- Small jurisdiction means people know each other
- Community

- Use of non-clinical approaches in the NT

Group 7

- Community initiatives such as Night Patrol and employment programs
- Broader controls such as the MUP give us the opportunity to work on other things
- Community and place-based approaches
- Getting people who are being impacted involved in the solution

Group 8

- NSB is not stigmatizing
- AOD sector committed (even if they are a bit burnt-out)
- SUS
- Night and Day Patrol
- AADANT

Group 9

- Best access to rehab in Australia
- MUP is one component of harm reduction
- Strongest supply reduction in Australia
- Role of consultation
- Community targeted approaches
- Needle and syringe programs
- Utilizing people with lived experience
- Pub lockouts
- Larrakia Nation can facilitate culturally safe approaches

Appendix 3 – Discussion 3 Solutions & Priorities Feedback

Theme 1

- What do our clients want
- Community campaigns addressing stigma against people who use drugs
- Community consultation
- Collaboration
- Health in all government
- Gain consensus from communities around what will help them to be 'stronger' to support interventions for individuals returning after 'rehab services'
- Person-lead therapeutic approach to AOD rather than criminal
- Aboriginal people are facilitated to buy their own homes on their own land
- Culturally appropriate ways of capturing experience of programs/services to improve quality
- Localized responses and continuity of staff
- Two worlds
    - Co-design
    - Localized
- Population models, involve community
- Community lead responses
- Systemic change
- 20-year investment cycle
- Place based responses
- More culturally inclusive initiatives to obtain meaningful participant feedback to validate initiatives and measure outcomes
- More consultative consultations with providers
- Harm reduction health promotion campaigns
- Culturally safe, secure, and empowering programs
- Strengthen the approach to focus on building capacity as opposed to suppressing dignity to risk
- Self-determined local decision making and solutions that engage and empower cultural authority
- Structural reform to better support frontline people
- Breaking down silos, better cohesion between systems
- Broader interagency collaboration
- Collaboration or joining of funding
- Strengthen the disparity between multiple funding streams to services and quality indicator outcomes.

Theme 2

- AOD one stop shop
- Primary healthcare services in the home (health to the people not people to the hospital)
- Housing first model (no expectation to reduce AOD use)
- Storage for long grass
- New AOD facility to incorporate youth, elderly, LGBTQI+
- More public toilets
- Soup kitchens
- More work land councils
- Approach CBD business about supplying water
- NSP equipment and pill testing
- Day centers
- Drop in centers
- Assertive outreach
- Coordination of targeted expenditure
- Respite facilitate that allow people safe time out from their struggles
- Suburban ADU
- Crisis accommodation
- Pop up support, advocacy, link, referral, assist programs
- Trial other proven models such as LEAD, Planet Youth, Wet camps
- Medium term accommodation
- Wet Camps
- Wet spaces (e.g., managed alcohol programs)
- Safe houses for children who are on the streets
- Men's safe houses, somewhere they can go for a time out
- Service like Oznam House in Northern Suburbs and Palmerston
- Safe space for homeless (wet space)
- Youth SUS
- Government funded anti-craving meds for alcohol and nicotine
- Duress alarms for women at risk of DV (with police response)
- Intensive preventative in home programs
- Safe sleep area for the homeless with toilet and shower
- More after-hours youth programs
- Youth and child focused substance use services
- Halfway sober houses
- Outreach detox and rehab
- Alternatives to western health (counselling) & case management models to site specific Indigenous program

Theme 3

- Training for teachers and educators to empower them to deliver harm reduction as part of AOD units
- School education harm reductions strategies not just abstinence
- Expansion of VET and other training programs outside of city centers
- More alcohol harm campaigns like the “Quit Campaign’
- Peer/Sector non-stigma-based approach to look at culture of change around drinking
- Early intervention and education in schools
- Peer led harm reduction programs more than just NSPS
- Peer led harm reduction education and outreach for children and young people early in their drug use career
- Health messaging that is tailored for groups/language/community

Theme 4

- Mental health services that are culturally appropriate
- More funding for alternative care rather than outdated mandated attendance.
- Strengthen the pro-active root cause therapy approach through referral pathways as opposed to reactive referral responses
- Government to lead secure integration of initiatives through funding contract reforms, quality indicators to include provider integration
- Language services/interpreter
- Peak bodies to better understand where they are referring individual’s education and social norms
- Bridge the gap between clinical and therapeutic Incentives and training to bring people into the AOD workforce
- Stigma training and induction
- Shared induction to address workforce turnover
- Cross sector work force development
- Staff training and retention
- Trauma informed trained workforce
- Long term funding for harm reduction and AOD sector
- Increase peer worker/lived experience consultation
- Training and better investment in outreach

Theme 5

- Decriminalization and justice reinvestment (focus on AOD across sectors).
- Pill testing and drug checking
- Decriminalization all drugs
- Decriminalization and legalization – funding directed back into funding treatment
- Strengthen diversion engagement in a more holistic approach
- More power to the programs (peak body capability to provide on the ground advice)
- Law reform
- No drug dogs at major events
- Defund police and redirect to health services
- Decriminalize /align drug driving laws for opiates amphetamines
- Court diversions to health including mental health and AOD
- Scrapping the VSAP Act and promoting USU prevention and treatment within all AOD sectors
- Case conferences (end silos)
- Case management prioritized over court

Miscellaneous

- Increased remote service capacity and delivery
- Transitional supports after treatment
- Remote communities' access to alcohol
- Topsy Harry type facility-controlled access to alcohol
- Demand reduction investment
- Volumetric taxation on alcohol
- Getting locals and TOs involved in services and programs
- Make a TV program like Addicted Australia in the NT
- Dual diagnosis, integrated case management
- Evidence based models of care across AOD services
- Harm minimization to children of affected people to minimize generational harms
- Care coordinator model in the ED to link with services for frequent attenders
- Pain management clinics that offer more options than fentanyl and at doses that work
- No urine test during OST so that people don't get kicked off
- People who use drugs advocacy and activism groups
- Increased accountability of pharmacy that discriminate against drug users

Appendix 4 – Summit Program

Friday 14th October, 10am-3pm, Darwin Convention Centre

9:30am (5 mins) **Acknowledgement of Country**	
9:35am (5 mins) **Setting agenda for the day**	Cass – Overview of Harm Reduction Pete – Guiding principles for the Summit Cass - Outline planned activities, invite other agenda items
9:40am (30 mins) **What are our key priorities?**	What do you see? What do you hear? What are you most worried about? Facilitated activity to get on the same page about what we see the main issues as being.
10:10am (30 mins) **What is working well?**	Facilitated group discussions to identify the strongest parts of our approach to alcohol and related issues and how we can build on these strengths
10:40am (30 mins) **Feedback and sharing**	Group feedback to bring together different discussions from across the room and reflect on what they have been hearing
11:10am (20 mins) **Morning tea break**	
11:30am (40 mins) **Program Model Examples**	11:30-11:40 LEAD Bureau – Najja Morris-Frazier/Brendan Cox 11:40-11:50 Better Pathways program - Danila Dilba Health Service 11:50-12:00 HEAL program – Larrakia Nation 12:00-12:10 Q&A
12:10am (20 mins) **Ideation**	Facilitated activities to generate ideas and initiatives. This may include reinvigorating old ideas or generating new approaches. We will move through a process of blue-sky thinking towards implementable initiatives
12:30pm (45 mins) **Lunch and networking**	
1:15pm (45 mins) **Drilling down our ideas into key action initiatives**	Facilitated activity to bring together ideas and identify priority actions from these ideas
2pm (20 mins) **Feedback and sharing**	Group feedback to bring together different discussions from across the room and reflect on what they have been hearing
2:20pm (30 mins)	How can we support each other to create change in this space?
2:50pm (10 mins)	Wrap up and what's next
End	