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Supplementary Submission to the House of Representatives Standing Committee on Health, Disability and Ageing

Inquiry into the health impacts of alcohol and other drugs use in Australia

Australian Injecting and Illicit Drug Users League Ltd

27 November 2025

AIVL member organisations endorse this submission in whole or in-part.

Supplementary submission addressing the issues paper

1. About

1.1 AIVL, the Australian Injecting and Illicit Drug Users League, is the national peer-led peak organisation representing our network of peer-based harm reduction and Drug User Organisations in every state and territory.

2. Introduction

2.1 AIVL welcomes the opportunity for the standing committee to finish the work of the inquiry into the health impacts of alcohol and other drugs (AOD) use in Australia, established in the previous session of parliament.

2.2 This submission is supplementary to AIVL's submission to the original inquiry[1] and addresses the evidence presented in the issues paper, specifically:

- gender-based perspectives and narcofeminism (p.6)
- women who use drugs: stigma, violence and access—not safe and not supported (p.7)
- mothers and pregnant people who use drugs (p.10)
- young women and gender diverse people (p. 12)
- sex workers who use drugs (p.14)
- sexualised drug use (p.19)
- oral health (p. 21)
- impacts of COVID-19 (p.23)

2.3 AIVL welcomes the opportunity to answer the committee's questions about people who use drugs and the issues we have raised in our original submission and this supplementary submission.

[1] Australian Injecting and Illicit Drug Users League, Submission to the House of Representatives Standing Committee on Health, Aged Care and Sport, Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia (Submission No 144, 16 December 2024).

Summary of recommendations

Section 4 – Women who use drugs

4a Address the gendered drivers of violence in policy and funding, rather than focusing primarily on alcohol as a driver of violence.

4b Invest in peer-led harm reduction services for women and increase funding and support for AOD treatment services for women, including those that can accommodate women.

4b Invest in capacity development and training about stigma, harm reduction, and narcofeminist perspectives for people working in SDFV, child protection, and AOD services, and primary health settings.

Section 5 – Mothers and pregnant people who use drugs

5a Ensure AOD treatment programs, including pharmacotherapy, are family-friendly and open to parents, particularly pregnant women, to manage both health and parental responsibilities.

5b Work with Australian states and territories to eliminate policies that penalise mothers who use drugs, such as using drug use history against them in family court proceedings and guarantee the right of pregnant people to access all harm reduction services.

5c Invest in and develop parenting support programs tailored for mothers who use drugs, explicitly recognising and accommodating their distinct socioeconomic and gendered challenges.

Section 6 – Young women and gender diverse people who use drugs

6a Invest in health promotion, harm reduction, consent, and primary prevention of violence campaigns and resources codesigned with young people, particularly young women and gender diverse people.

6b Invest in AOD services and support, including novel services of provision of harm reduction information that are tailored to young women's and gender diverse people's needs.

6c Long-term investment in meaningful research on AOD use among young people, including community-controlled and self-determined research for Aboriginal and Torres Strait Islander young people.

Section 7 – Sex workers who use drugs

7a Ensure that all national AOD strategies explicitly recognise SWWUDs as a priority population requiring tailored, peer-led approaches.

7b Resource SWWUD peer-led research to document experiences and needs to inform policy development, and law reform analysis, and effective service approaches.

7c Resource and implement mandatory stigma-reduction and cultural safety training developed with SWWUDs embedded in sex worker organisations, in collaboration with drug user organisations, for AOD, advocacy, health, legal, housing, and social services.

7d Significantly increase investment in peer-led sex worker organisations to resource outreach and peer education specifically by and for SWWUDs.

7e Include peer-led sex worker organisations in AOD policy forums and advisory bodies at national, state, and territory levels.

7f Ensure equitable access to harm reduction, the full range of pharmacotherapies (not just opiate substitution), BBV and STI prevention and treatment, trauma-informed care, and mental health services for SWWUDs, regardless of sex work laws or migration status, including within detention settings.

7g Adopt policy frameworks that reject the conflation of sex work and drug use with violence and identify criminalisation and stigma as drivers of violence.

7h Reject policy frameworks based on stereotypes that sex workers use drugs 'to cope' or that drug use 'drives' people to sex work

Section 8 – Sexualised drug use

8a Invest in and expand health promotion and peer-led support for sexualised drug use to include cis heterosexual populations, recognising that SDU is not exclusively an LGBTQ+ phenomenon.

8b Invest in peer-led development of inclusive and non-stigmatising public health campaigns that focus on pleasure, consent, and practical harm reduction, tailored to difference substance use patterns across communities who engage in SDU.

8c Invest in peer-led research to better understand the specific substances, contexts and harm reduction needs, as well as the values and preferences of cis heterosexual people who engage in SDU.

Section 9 – Oral health care

9a Oral health care must be person-centred, non-judgemental and trauma-informed, while also being available, accessible, and affordable.

9b Invest in peer-led workforce development and training for oral health professionals and students including the formation of partnerships with relevant institutions that represent and support the oral health care workforce.

9c Explore the financial and economic benefits and disbenefits of including dental health services in Medicare.

Section 10 – COVID-19 and pandemic preparedness

10a People who use drugs must be explicitly considered in future pandemic preparedness, responses and embedded within government advisory mechanisms, including:

i. integrate expert advice that takes human rights into account and includes specific impacts on PWUD

ii. enhance data and surveillance capabilities to better understand impacts and needs of PWUD

iii. increase pandemic-related workforce capacity among PWUD and in areas of need to be able to quickly respond to future health emergencies in those communities

iv. develop funding mechanisms to allow for rapid implementation and scale-up of localised and specific programs and services for PWUD

v. develop and/or maintaining effective communication structures that ensure involvement of AIVL, peer-led Drug User Organisations and PWUD to ensure pandemic response expertise is not lost, to inform planning, and to ensure rapid response in case of future emergencies

vi. develop a communications strategy with PWUD for use in health emergencies.

Issues

3. Gender-based perspectives and narcofeminism

3.1 Understanding substance use through a gender lens is critical to addressing its health and social impacts. Access to harm reduction, healthcare, and social support services, is profoundly shaped by gender. Cisgender heterosexual men are more likely to access AOD services[2] and needle and syringe programs,[3] and often economically benefit from the criminalisation of drugs. Conversely, punitive and biased systems enables perpetrators of violence to maintain coercion and control over women and gender diverse people who use drugs.

3.2 These gender-based perspectives are necessarily intersectional and complex. In response to exclusionary feminism, the political movement of narcofeminism has emerged, combining "a *feminist and human rights agenda to push for more humane drug policy, harm reduction and decriminalisation"*.[4]

3.3 From a narcofeminist standpoint, the *"waywardness"* of people who use illicit drugs is often reduced to pathology and criminality. This is especially true for Aboriginal and Torres Strait Islander peoples, women, gender diverse people, and sex workers who are already marginalised, with their drug use read as further 'deviance'. Women who use drugs (WWUD) who refuse 'recovery' are seen as accepting of this 'wayward life', thus justifying punishment and surveillance to control and push them back into normative gendered roles. This refusal can itself be viewed as a form of political resistance.[5]

[2] Australian Institute of Health and Welfare;, Alcohol and Other Drug Treatment Services (AIHW, 2025) <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-and-other-drug-treatment-services>.
[3] Sue Heard et al, Needle and Syringe Program National Minimum Data Collection (National Data Report, Kirby Institute, UNSW Sydney, 2024) <https://www.kirby.unsw.edu.au/research/reports/needle-syringe-program-national-minimum-data-collection-2024-national-data-report>.
[4] Judy Chang, 'Narcofeminism: A Feminist Auto-Ethnography on Drugs' (2023) 71(4) The Sociological Review 760 <https://doi.org/10.1177/00380261231176893>; Fay Dennis, Kiran Pienaar and Marsha Rosengarten, 'Narcofeminism and Its Multiples: From Activism to Everyday Minoritarian Worldbuilding' (2023) 71(4) The Sociological Review 723 <https://doi.org/10.1177/00380261231174962>.
[5] Fay Dennis and Kiran Pienaar, 'Refusing Recovery, Living a "Wayward Life": A Feminist Analysis of Women's Drug Use' (2023) 71(4) The Sociological Review 781 <https://doi.org/10.1177/00380261231175729>.

4. Women who use drugs: stigma, violence and access—not safe and not supported

4.1 The term "women who use drugs" (WWUD) is inclusive of all women—Sistergirls, women of cis and trans experiences and gender diverse people. Some issues described impact specific groups of women, while other affect all women.

4.2 Harm reduction and AOD treatment and support for women are rare and where they exist, are underfunded.[6] The use of substances can complicate access to sexual, domestic and family violence (SDFV), AOD treatment, and housing services and support, as WWUD (including sex workers who use drugs (SWWUD)) are refused health and social services and support.[7]

4.3 Due to criminalisation and stigmatisation, WWUD are between two and five times more likely to experience gender-based violence including sexual, domestic and family violence (SDFV), compared to women who don't use drugs.[8] Men who use violence and the systems that enable them, create the conditions for coercive control of WWUD, where a women's substance use is used to discredit, disempower and punish her, while men's substance use is used as an excuse for violence.[9]

4.4 **The mischaracterised role of alcohol in violence.** The issues paper overlooked the gendered drivers of violence as a primary cause, while potentially overplaying the association between alcohol and violence: "*alcohol is a significant contributor to gendered violence in Australia, with alcohol present in 34 per cent of intimate partner violence incidents and over 29 per cent of family violence incidents. Harms to children… are significantly greater in households where a person drinks alcohol at higher risk levels (Submission 87, cited).*[10]

[6] Network of Alcohol and other Drugs Agencies, Working with Women Engaged in Alcohol and Other Drug Treatment (Practice Resource No 3rd ed., Network of Alcohol and other Drugs Agencies, 2021) <https://nada.org.au/wp-content/uploads/2021/06/Working-with-Women-2021_NADA-Resource.pdf>.
[7] Chang (n 4); Dennis, Pienaar and Rosengarten (n 4).
[8] Chang (n 4).
[9] Coercive Control in MH/AOD Special Interest Group - Specialist Family Violence Advisor Program, What Is Substance Use Coercion (Issues Brief, Gippsland Family Violence Alliance, 2023); Ngaire Naffine, Female Crime: The Construction of Women in Criminology (2015); Chang (n 4).
[10] House of Representatives Standing Committee on Health, Aged Care, and Sport, Issues Paper Relating to the Health Impacts of Alcohol and Other Drugs in Australia (Issues Paper, Parliament of Australia, March 2025) 9, 2.10.ue

4.5 Sexual, domestic and family violence (including coercive control) is a gendered phenomenon that is overwhelmingly perpetrated by men against women in heterosexual relationships. Evidence shows that SDFV can and does occur in relationships among LGBTQA+ people at similar rates to non-LGBTQA+ people, however, gender remains a critical explanatory factor.[11]

4.6 A key ANROWS review found that while there is a *"strong and consistent"* relationship, there is little evidence that alcohol is a primary cause of violence against women.[12] The relationship is complex, and alcohol can act as an enabler or an excuse, rather than a direct cause.[13]

4.7 Alcohol acts as an enabler of sexual violence particularly in public social settings, interacting with gendered social expectations to reduce victim resistance and increase perpetrator confidence. The relationship is complex—when both victim and offender consume alcohol, outcomes may differ compared to when only the offender is intoxicated.[14]

4.8 Women may use substances as a trauma-informed coping mechanism following SDFV, or it may be an act of resistance, seeking creativity or spiritual experiences or to relieve pain. Often the characterisation of substance use in the context of coercive control is deficit based for women, that somehow the use of substances negates her right to safety. Men who use violence exploit biases in systems to continue to control WWUD.[15]

4.9 Coercive control in the context of substance use can look like controlling access to harm reduction, to substances or pharmacotherapy, undermining the AOD use goals of women, including blocking access to AOD treatment services and support. There may be sexual aspects of control, where a perpetrator ensures a WWUD is intoxicated to the level of not being able to physically fight back or have no control over sexual partners. There are economic vulnerabilities to

[11] Eloise Layard et al, LGBTQ+ Peoples Experiences and Perceptions of Sexual Violence (Research Summary Report, ACON Health, 2023) <https://sayitoutloud.org.au/learn-more/learn-more/research-and-resources/lgbtq-peoples-experiences-perceptions-sexual-violence-report/>.
[12] Patrick Noonan, Annabel Taylor and Jackie Burke, Links between Alcohol Consumption and Domestic and Family Violence against Women: Key Findings and Future Directions (Report No 8, Australia's National Research Organisation for Women's Safety Limited (ANROWS), November 2017) <https://www.anrows.org.au/publication/links-between-alcohol-consumption-and-domestic-and-sexual-violence-against-women-key-findings-and-future-directions/>.
[13] KE Leonard, 'Alcohol's Role in Domestic Violence: A Contributing Cause or an Excuse?' (2002) 106(s412) Acta Psychiatrica Scandinavica 9 <https://doi.org/10.1034/j.1600-0447.106.s412.3.x>; Noonan, Taylor and Burke (n 12).
[14] Noonan, Taylor and Burke (n 12) 5.
[15] Naffine (n 9).

control—withholding of income or restricting the ability to work, sex work shame or substance use shame. [16]

4.10 There is also risk of misidentification of the perpetrator of violence when WWUD fight back or defend themselves against aggressors. Women who use drugs don't fit the picture of the 'ideal victim', who is never angry and certainly not using substances. Women who fight back are characterised by their perpetrator and police as irrational and dangerous—the rush to pathologise WWUD allows violence and control to continue to occur.[17]

4.11 The outcome of the impacts for WWUD is that they are less likely to report or engage in seek-support seeking behaviours. Women who use drugs are more likely to be socially isolated and disengage from health care and social services because of systems that are not safe and not supportive of WWUD who experience SDFV including coercive control.

Recommendations

4a Address the gendered drivers of violence in policy and funding, rather than focusing primarily on alcohol as a driver of violence.

4b Invest in peer-led harm reduction services for women and increase funding and support for AOD treatment services for women, including those that can accommodate women.

4b Invest in capacity development and training about stigma, harm reduction, and narcofeminist perspectives for people working in SDFV, child protection, and AOD services, and primary health settings.

[16] Coercive Control in MH/AOD Special Interest Group - Specialist Family Violence Advisor Program (n 9).
[17] Erin Deverell, Misidentification of the Predominant Agressor in Tasmania: Practioner Perspectivces from Engender Equality (Research Discussion Paper, Engender Equality, December 2025) <https://engenderequality.org.au/2023-research-discussion-paper-misidentification-of-the-predominant-aggressor-in-tasmania/>.

5 Mothers and pregnant people who use drugs

5.1 Parental substance use presents complex challenges, particularly regarding the intersection of drug treatment access, family-friendly services, and parenting support tailored for drug-using parents. Open access to health services is critical for engaging parents, especially pregnant people who use drugs, as it creates a crucial window of opportunity to initiate a conversation about harm reduction and the women's goals for the pregnancy, including initiating changes to patterns of substance use.[18]

5.2 Yet, policy and research often adopt a gender-neutral framework when addressing parenting use of alcohol and other drugs, despite pregnancy-related issues being profoundly gender-differentiated. This approach tends to obscure the unique structural inequalities and disadvantages faced by WWUD.[19]

5.3 Mothers who use substances experience additional forms of gendered social stigma. The criminalisation of drugs means that (mostly) mother's risk having their children removed or criminalised if they are known to use illicit drugs. As a result, mothers who use illicit drugs face increased risks such as more likely to use alone and then using in a rush, which are both associated with increased risk of overdose and injecting-related infection and injury.[20] Women are less likely than men to access needle and syringe programs,[21] for mothers there are additional barriers to access harm reduction, AOD treatment and support, naloxone, and connection to peers.[22]

5.4 Pregnancy magnifies the stakes involved, as women face additional scrutiny from a broad spectrum of professionals, including social workers, midwives, and healthcare providers. These professionals monitor attendance and treatment compliance, often interpreting them as proxies for maternal motivation and legitimacy. The stigma attached to mothers who use drugs, combined with fears of child removal, compels women to engage in identity management

[18] Polly Radcliffe, 'Drug Use and Motherhood: Strategies for Managing Identity' (2009) 9(3) Drugs and Alcohol Today 17 <https://doi.org/10.1108/17459265200900026>.
[19] Ibid.
[20] Jade Boyd et al, 'Mothers Who Use Drugs: Closing the Gaps in Harm Reduction Response Amidst the Dual Epidemics of Overdose and Violence in a Canadian Urban Setting' (2022) 112(S2) American Journal of Public Health S191 <https://doi.org/10.2105/AJPH.2022.306776>.
[21] Heard et al (n 3) 13.
[22] Boyd et al (n 20).

strategies—such as under-reporting heroin use to avoid judgement—while trying to demonstrate their fitness for motherhood.[23]

5.5 Mothers who use drugs actively work to present themselves as *"regulated consumers"* worthy of motherhood, involving rigorous engagement with health and social services, compliance with treatment regimens (e.g., pharmacotherapy), and participation in parenting programs. Pharmacotherapy prescribing is not only a medical intervention but also a moralised practice: people on pharmacotherapy face pressure to achieve 'clean' drug tests as markers of moral and parental acceptability. However, women experience shame and discrimination within healthcare settings, complicating their treatment journey.[24]

5.6 Open access for mothers into AOD treatment programs, including pharmacotherapy is vital for enabling them to manage both their health and parental responsibilities. Family-friendly services that accommodate the complexities of parenting while addressing substance use foster better engagement and outcomes.

5.7 Research has demonstrated the significance in tailoring health services and support to mothers who use drugs and pregnant people who use drug. Women were more likely to achieve their AOD-related goals to a greater extent when services explicitly recognised and accommodated their distinct socioeconomic, substance use, and gendered challenges.[25]

Recommendations

5a Ensure AOD treatment programs, including pharmacotherapy, are family-friendly and open to parents, particularly pregnant women, to manage both health and parental responsibilities.

5b Work with Australian states and territories to eliminate policies that penalise mothers who use drugs, such as using drug use history against them in family court proceedings and guarantee the right of pregnant people to access all harm reduction services.

5c Invest in and develop parenting support programs tailored for mothers who use drugs, explicitly recognising and accommodating their distinct socioeconomic and gendered challenges.

[23] Radcliffe (n 18); Boyd et al (n 20).
[24] Radcliffe (n 18).
[25] Boyd et al (n 20).

6. Young women and gender diverse people

6.1 **Lived/living experiences of risk and pleasure.** Research with young women and gender diverse people confirms that men's behaviour—harassment, unwanted attention, and sexual violence—is a primary concern in consumption settings (pubs, clubs, festivals, private parties, etc), profoundly shaping their choices and safety strategies. For example, avoidance of bars and mainstream clubs was common due to past negative encounters with men.[26]

6.2 Despite risks, alcohol and drug use were deeply valued for fostering meaningful social connections. Participants reported that consumption facilitated *"open"* and *"deep"* conversations, enhancing intimacy and trust with friends, romantic partners, and family. Substances like MDMA and cannabis were associated with bonding, affectionate communication, and shared emotional experiences, including care and trauma support. Some participants also highlighted the role of sober companions who enhanced group safety and deepened social affection, illustrating complex forms of supportive relationality inherent in these practices.[27]

6.3 Beyond sociality, young women described consumption as enabling pleasurable embodied experiences and new forms of gender and sexual expression. Accounts ranged from enjoying bodily confidence while dancing under the influence, to engaging in more liberated and queer forms of sexuality in private settings. Consumption provided relief from anxiety and dissociation between self and body, contributing to a more affirmative sense of selfhood and agency.[28]

6.4 Participants actively managed the nexus of risk and pleasure through strategies that did not necessitate abstinence. For instance, some used stimulants to maintain alertness in nightlife settings as a protective tactic, while others established personal *"hard lines"* to negotiate consent and safety without relinquishing pleasures of intoxication and intimacy. Critically, harm reduction was framed as a collective and gender-sensitive issue centred on

[26] Adrian Farrugia, Kiran Pienaar and Fay Dennis, 'Narcofeminist Affects: Gender, Harm and Fun in Young Women and Gender Diverse People's Experiences of Alcohol and Other Drug Consumption' [2025] The Sociological Review 00380261251317318, 7–9 <https://doi.org/10.1177/00380261251317318>.
[27] Ibid 9–11.
[28] Ibid 11–13.

men's behaviours rather than solely individual self-control of women and gender diverse people.[29]

Recommendations

6a Invest in health promotion, harm reduction, consent, and primary prevention of violence campaigns and resources codesigned with young people

6b Invest in AOD services and support, including novel services of provision of harm reduction information that are tailored to young women's and gender diverse people's needs.

6c Long-term investment in meaningful research on AOD use among young people, including community-controlled and self-determined research for Aboriginal and Torres Strait Islander young people.

[29] Ibid 16.

7. Sex Workers Who Use Drugs

7.1 Sex workers who use drugs (SWWUD) experience intersecting systemic stigma, discrimination, socio-economic maginalisation and structural disadvantage that arises from myths and stereotypes about their engagement in both sex work and drug use. These intersecting stigmas shape how SWWUD are seen by services, police and policymakers, and directly undermine health, safety and rights.

7.2 Across Australia, including jurisdictions with sex work decriminalisation, partial criminalisation or licensing systems, SWWUD continue to face significant barriers to accessing health, harm reduction, and alcohol and other drug (AOD) services.

7.3 These barriers are compounded by broader determinants such as racism, migration status, gender inequality, criminalisation of drug use and sex work, and entrenched stigma and discrimination within health, legal, and social systems.

7.4 SWWUD are not a homogenous group, and include workers who are women, trans women, non-binary people, men, Aboriginal and/or Torres Strait Islander, migrant and culturally and linguistically diverse workers, LGBTQ+ workers, and sex workers living with HIV or hepatitis. These intersecting identities intensify exposure to discrimination, police surveillance and raids, workplace insecurity, exclusion from health, legal and social services. SWWUDs' ability to seek justice is routinely undermined by the risk of criminalisation, the potential loss of income that heightens legal vulnerability, and the fear of disclosing drug use or sex work due to stigma, discrimination, and safety concerns.

7.5 National and international evidence recognises SWWUD as an overlapping priority population in respect to sex workers and people who use drugs, requiring targeted removal of legal and policy barriers to facilitate acess to services via rights-based intervention. Australia's national BBV and STI strategies identify sex workers in who inject or use drugs in overlap as "priority populations".

7.6 The overlap of sex workers who use also drugs , requires specifically tailored and culturally safe, harm reduction frameworks to ensure the inclusivity of the needs of SWWUD are meet. Despite this evidence, SWWUD remain overlooked in mainstream policy and funding responses, often falling between the mandates of AOD services, sexual health programs, and sex worker peer organisations or projects.

7.7 The Global Network of Sex Work Projects (NSWP) and the International Network of People who Use Drugs (INPUD) note that sex workers and people who use drugs are recognised as key populations in the HIV response, but are frequently under-funded, subjected to non–rights-based programming, and poorly understood at their intersections.

7.8 Sex workers who use drugs are often categorised as either 'sex workers' or 'people who use drugs', not both. When services are designed for only one key population, SWWUD routinely find that their needs are not met. SWWUD (particularly those who inject drugs) also experience stigma and discrimination from both within sex worker communities and communities of people who used drugs"[30].

7.9 Peer-based sex worker organisations and projects, alongside peer-based drug user organisations and projects, provide essential pathways for SWWUD to access sterile injecting equipment, naloxone, legal information, trauma-informed support, sexual health care, and occupational health and safety resources. Peer models are internationally recognised as best practice for engaging marginalised groups. Evidence shows that workers with lived experience of both drug use and sex work are uniquely positioned to identify barriers, support risk mitigation, and facilitate access to appropriate services. It is essential that SWWUD are directly funded to provide legal navigation and service delivery that is essential for the needs of their community.

7.10 Peer-led peaks Scarlet Alliance, Australian Sex Workers Association[31] and AIVL supported the Northern Territory AIDS and Hepatitis Council (NTAHC)[32] to set up a SWWUD project within the Sex Worker Outreach Program (SWOP NT)[33]. The project commenced in 2023 as a Primary Health Network-funded pilot and demonstrated clear, unmet need for SWWUD-focused resourcing. The SWWUD project has now been funded over two-years to 2026.

7.11 The SWWUD Project Coordinator works with SWOP NT to a provide service delivery and advocacy to the NT SWWUD community, guided by a SWWUD reference group. Together, they have developed specific SWWUD referral

[30] Sex Workers Who Use Drugs- Community Guide, Network of Sex Worker Projects NSWP, International Network of People Who Use Drugs INPUD, Bridging the Gap – Health and Rights for key Populations, pg1, October 2025
[31] Scarlet Alliance, Australian Sex Workers Association is the national peak body representing sex workers and sex worker organisations and projects in Australia.
[32] Programs of the NTAHC, Northern Territory AIDS and Hepatitis Council (NTAHC)
[33] Project overview of service delivery, Sex Worker Outreach Program, SWOP NT , NTAHC

resources that include sex worker and drug user friendly referrals to health and justice services.

7.12 The SWWUD Coordinator has presented at both Scarlet Alliance and at AIVL conferences and peer only network spaces to raise issues and advocate for rights from perspective of sex workers who use drugs, such as those represented in the following quotes (used with permission):

> *I've had so many challenges navigating AOD sectors services, STI and BBV clinical services and general medical services. I've experienced so many judgments and assumptions about my drug use, my sex work and my health status. The associated stigmas, I have learned to live with for over a decade.*

> *I've had my confidentiality breached regularly, I've been prescribed [name of antibiotic] for broad range response to STIs when I had none, and what I needed was a different antibiotic for a UTI and to have my veins checked, as I was worried about one of my regular injecting areas.*
>
> *This is a typical example of health care services for me, …There was no treatment for my STI and the doctor only glanced at my injection site on my arm. I then had to had to two days later access a different clinic to get the antibiotic I needed to relive and clear the UTI and to get a vein check.*
>
> *I was told by that doctor that [name of antibiotic] was never prescribed to treat UTIs and that I needed to stop immediately using the vein and limb area I was concerned about, a topical cream, [name of topical antibiotic] was prescribed to heal my wounds on my arm.*

> *"Wow, the stigma from health providers, and lack of understanding of my sex work and or illicit drug use realities, has at times caused me such anxiety that I haven't been confident to seek support for any pharmacotherapy, I get really anxious about accessing those services, I get my pharmacotherapies on line , but not sure if they are the best ones for me, I've got no way of assessing if the side effects are minimal or not, as I don't have AOD medical oversite for health care.* [34]

> *It's also been challenging when I've been moving around different states and territories to work or to get on, I think about how difficult other workers say transferring state to state is with Australia's Pharmacotherapy framework, I also need to be freed up to travel for work, as need to keep up with navigating differing laws that either legalise or criminalise my drug use and or sex work."* [35]

7.13 Nationally, SWWUD are calling for the removal of all barriers in legislation and or policies that prevent SWWUD from accessing services and rights, they require expansion of peer-led outreach, culturally safe services, improved AOD treatment pathways, multilingual supports, and workforce development across general health and social services. SWWUD lived/living experience demonstrates the need for systemic reform that acknowledges the realities of sex work and drug use, prioritises harm reduction, respects autonomy, and eliminates structural barriers to care.

Recommendations

7a Ensure that all national AOD strategies explicitly recognise SWWUDs as a priority population requiring tailored, peer-led approaches.

[34] NT Sex Worker Who Use Drugs Reference Group, SWWUD Project, SWOP NT, NTAHC
[35] Ibid, n35.

7b Resource SWWUD peer-led research to document experiences and needs to inform policy development, and law reform analysis, and effective service approaches.

7c Resource and implement mandatory stigma-reduction and cultural safety training developed with SWWUDs embedded in sex worker organisations, in collaboration with drug user organisations, for AOD, advocacy, health, legal, housing, and social services.

7d Significantly increase investment in peer-led sex worker organisations to resource outreach and peer education specifically by and for SWWUDs.

7e Include peer-led sex worker organisations in AOD policy forums and advisory bodies at national, state, and territory levels.

7f Ensure equitable access to harm reduction, the full range of pharmacotherapies (not just opiate substitution), BBV and STI prevention and treatment, trauma-informed care, and mental health services for SWWUDs, regardless of sex work laws or migration status, including within detention settings.

7g Adopt policy frameworks that reject the conflation of sex work and drug use with violence and identify criminalisation and stigma as drivers of violence.

7h Reject policy frameworks based on stereotypes that sex workers use drugs 'to cope' or that drug use 'drives' people to sex work

8. Sexualised drug use

8.1 Sexualised drug use (SDU) is a clinical and academic term that describes the social practice of consuming alcohol and other drugs for the purpose of sex, either intentionally or opportunistically, to maximise pleasure, fun and sociality.[36]

8.2 Most of the focus of research, programs and services on SDU has focused on gay and bisexual cismen, and trans and queer people within the subculture known as chemsex, party n play (PnP), and high-fun, due to the association between SDU, HIV and sexually transmissible infections (STI) risks in the context of condomless sex in the absence of PrEP and treatment as prevention for people living with HIV—what some have categorised as *"a rush to risk"*.[37]

8.3 Framing SDU as a purely GBTQ+ phenomenon, overlooks non-LGBTQA+ populations—cis heterosexual people—who are participating in SDU and who may benefit from targeted health promotion and peer support.[38]

8.4 The Australian Drug Trends recently published a bulletin from interviews conducted in 2024 with people who regularly use illicit stimulants (Ecstasy and Related Drugs Reporting System (EDRS)) on the prevalence of SDU, comparing cisgender heterosexual people to LGBTQ+ people. A total of 61.0% of EDRS participants reporting using drugs or alcohol before or during sexual activity with another person in the last four weeks. In addition, the authors found that engagement in and frequency of SDU in the past month, was similar across cis heterosexual and LGBTQ+ participants. [39]

8.5 The types of substances EDRS participants reported they used for SDU were predominately alcohol, cannabis and ecstasy, whereas gay and bisexual cismen have reported methamphetamine and GHB/GBL are predominately

[36] Luke Muschialli et al, 'Sexualized Drug Use and Chemsex: A Bibliometric and Content Analysis of Published Literature' (2025) 57(3) Journal of Psychoactive Drugs 321 <https://doi.org/10.1080/02791072.2024.2367614>.
[37] Ibid; Joanne Bryant et al, 'The Rush to Risk When Interrogating the Relationship between Methamphetamine Use and Sexual Practice among Gay and Bisexual Men' (2018) 55 International Journal of Drug Policy 242 <http://www.sciencedirect.com/science/article/pii/S0955395917303663>; Jack Freestone et al, 'Controlling for Pleasure and Risk: The Experiences of Sexuality and Gender Diverse People Who Use GHB' (2022) 105 International Journal of Drug Policy 103747 <https://www.sciencedirect.com/science/article/pii/S0955395922001669>.
[38] Thomas Norman, 'Sexualised Drug Use among Heterosexual Adults: Commonplace yet Poorly Conceptualised' (Webinar, Australian Centre for Sex, Health and Society, La Trobe University, 13 October 2025) <https://www.youtube.com/watch?v=yXBm5YpoO6E>.
[39] Lilly, Kieren et al, Sexualised Drug Use among Cisgender Heterosexual and LGBTQ+ People Who Regularly Use Illicit Stimulants in Australia (Bulletin, National Drug and Alcohol Research Centre, UNSW Australia, 2025) <http://hdl.handle.net/1959.4/105624>.

used for chemsex.[40] These findings do not suggest that methamphetamine isn't being used by some cis heterosexual people engaging in SDU, but rather, not among the majority of EDRS participants.

8.6 In the Goanna 2 Study (2013) among Aboriginal and Torres Strait Islander young people, one-third of young men reported being drug or high at last sexual encounter compared to 22% of women aged 16-29.[41] The Goanna 3 study has yet to publish more recent data—whether experiences of SDU have shifted over the past decade in this key population, will be informative to the current needs of Indigenous young people.

8.7 The Australian Drug Trends interviews with people who regularly inject drugs (Illicit Drug Reporting System (IDRS)) reported recent use (past six months) of any form of methamphetamine among 82% of participants in 2025. This was stable from 2024. Reports of recent use of methamphetamine crystal more than doubled between 2009 (37%) and 2021 (78%) and has remained stable since 2021 onward. In 2025, 79% of IDRS participants reported recent use of methamphetamine crystal, stable from 2024.[42]

Recommendations

8a Invest in and expand health promotion and peer-led support for sexualised drug use to include cis heterosexual populations, recognising that SDU is not exclusively an LGBTQ+ phenomenon.

8b Invest in peer-led development of inclusive and non-stigmatising public health campaigns that focus on pleasure, consent, and practical harm reduction, tailored to difference substance use patterns across communities who engage in SDU.

8c Invest in peer-led research to better understand the specific substances, contexts and harm reduction needs, as well as the values and preferences of cis heterosexual people who engage in SDU.

[40] Ibid; Mohamed A Hammoud et al, 'The New MTV Generation: Using Methamphetamine, Truvada™, and Viagra™ to Enhance Sex and Stay Safe' (2018) 55 International Journal of Drug Policy 197 <http://www.sciencedirect.com/science/article/pii/S0955395918300604>; Freestone et al (n 36).
[41] James Ward et al, 'Findings from the Goanna Study' (2013) 11(3) HIV Australia <https://www.healthequitymatters.org.au/resources/findings-goanna-study>.
[42] Rachel Sutherland et al, Australian Drug Trends 2025: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews (Report, National Drug and Alcohol Research Centre, UNSW Australia, 26 September 2025) 35,40 <https://doi.org/10.26190/unsworks/31585> ('IDRS 2025').

9 Oral health care

9.1 The Issues Paper described that people with substance use disorder were *"less likely to receive dental care"*.[43] Barriers to oral health prevention for people who use drugs (PWUD) is less about receiving care, but rather, about access to care. People who use drugs experience individual and structural/systematic barriers to oral health care.

9.2 Structural barriers include: cost of services; poor accessibility and availability of services, general misconceptions in the community about accessibility of services; social determinants of health and life circumstances and responsibilities (housing, family and kin, employment); stigma and discrimination in services; federal, state and territory shared responsibility for financing oral health services for some key populations; and misinformation and disinformation about substance use and oral health.

9.3 Individual barriers include: low self-esteem and quality of life; dentistry phobia; pain management concerns including discrimination and trauma from previous experiences; cognitive impairment; internalised stigma; financial/economic including levels of private health insurance coverage; and prioritising different health issues.[44]

9.4 For PWUD who are living with or have lived with a blood borne virus (BBV) like hepatitis C or HIV, there is an additional risk of stigma and discrimination.[45] For example, an oral hygienist or dentist may take additional protective measures (e.g. double gloving) that are unnecessary as universal health precautions are already standard practice. In addition, stigma and discrimination may be

[43] House of Representatives Standing Committee on Health, Aged Care, and Sport, Issues Paper Relating to the Health Impacts of Alcohol and Other Drugs in Australia (Issues Paper, Parliament of Australia, March 2025) 2.8, 8.
[44] Agnivo Sengupta et al, 'Perceptions of Clinicians on Promoting Oral Health Care in an Alcohol and Other Drug Use Health Care Service: A Qualitative Study' (2025) 44(3) Drug and Alcohol Review 742 <https://doi.org/10.1111/dar.14016>; Natalia Uthurralt et al, 'Providing Better Access to Oral Health Care for People Receiving Substance Use Treatment: A Timely Discussion' (2024) 43(1) Drug and Alcohol Review 257 <https://doi.org/10.1111/dar.13753>; Grace Wong et al, 'Exploring Oral Health Challenges and Integration Strategies in Opioid Treatment Programs: Perspectives from Clinicians and Clients' (2025) 31(1) Australian Journal of Primary Health PY24134 <https://doi.org/10.1071/PY24134>.
[45] Dion Kagan et al, Hepatitis C-Related Stigma and Discrimination in a Post-Cure World: Summary Report of Project Findings and Recommendations (Report, La Trobe University, 2023) <https://doi.org/10.26181/23909613.v1>; T Broady et al, Stigma Snapshot: People Living with Hepatitis C 2021 (2022) <http://handle.unsw.edu.au/1959.4/unsworks_80950>; T Broady et al, Stigma Snapshot: People Living with HIV 2022 (2022) <http://handle.unsw.edu.au/1959.4/unsworks_81484>.

enacted based drug injecting history (current or in the past).[46] A lack of knowledge on BBV, as well as socially and culturally informed misconceptions about PWUD, leads to enacted stigma and discrimination toward PWUD in oral health services settings. [47]

9.5 Where states and territories have financed oral health care for PWUD, such as in New South Wales (Oral Health Fee for Service Scheme) and Victoria or in custodial and other closed settings, oral health services utilisation by PWUD has been high and in some areas, supply has not been able to meet the demand. However, often subsidised oral health services for PWUD have had limited duration and barriers to access are still present. [48]

9.6 Levels of private health insurance coverage for the majority of PWUD is assumed to consistent with the person's relative socioeconomic advantage and disadvantage, as the actual level of insurance coverage among PWUD is unknown.

9.7 Given the benefit of improving oral health for PWUD and the impact on their general preventative health and wellbeing, securing access to dental services through inclusion in Medicare may be cost-effective.[49]

Recommendations

9a Oral health care must be person-centred, non-judgemental and trauma-informed, while also being available, accessible, and affordable.

9b Invest in peer-led workforce development and training for oral health professionals and students including the formation of partnerships with relevant institutions that represent and support the oral health care workforce.

9c Explore the financial and economic benefits and disbenefits of including dental health services in Medicare.

[46] T Broady et al, Stigma Snapshot: People Who Inject Drugs 2021 (2022) <http://handle.unsw.edu.au/1959.4/unsworks_80543>.
[47] Rachel Sutherland et al, 'Stigma, and Factors Associated with Experiencing Stigma, While Visiting Health-Care Services among Samples of People Who Use Illegal Drugs in Australia' (2024) 43(5) Drug and Alcohol Review 1264 <https://doi.org/10.1111/dar.13846>.
[48] Uthurralt et al (n 43).
[49] Parliamentary Budget Office, Bringing Dental Care into Medicare (Policy Costing No PR-2024-1539, Parliamentary Budget Office, 27 August 2024) <https://www.pbo.gov.au/publications-and-data/publications/costings/putting-dental-care-medicare>.

10 COVID-19

10.1 The International Network of People who Use Drugs (INPUD) commissioned AIVL to conduct research as part of a global initiative to ensure the voices and experiences of people who use drugs (PWUD) are included in pandemic preparedness.

10.2 By early 2020, Australia had implemented some of the most restrictive public health responses in the world. While these measures were designed to protect public health, they were neither aimed nor felt equally. The pandemic and the corresponding public health response disproportionately affected marginalised groups, including PWUD.

10.3 Many of the major systemic and practical changes in Australia were in place between January 2020 and mid-2023. During this time, people who use drugs experienced heightened vulnerability to infection, worsening mental health, increased policing, and reduced access to critical services, including harm reduction and drug treatment programs. These impacts were further compounded by pre-existing structural inequities, including stigma, criminalisation, poverty, housing insecurity, and barriers to health care.

10.4 The pandemic also demonstrated opportunities for reform. Rapid and pragmatic adaptations, such as increased flexibility in the Opioid Dependence Treatment Program (ODTP), use of telehealth, and community-led service delivery, highlighted new pathways for improving health outcomes and equity for people who use drugs. Many peer-led and other harm reduction services adapted their services to meet the needs of people who use drugs and fill gaps left by the closure of other frontline health and social services.

10.5 Although many of the systemic changes made during the height of the pandemic have ended, the impacts of COVID-19 continue to be felt. Many of the positive changes that occurred are no longer available to people who use drugs. While the impacts of other crises such as natural disasters have since had similar disproportionate impacts on people who use drugs demonstrating a lack of learning.

10.6 International reports and treaties, including the World Health Organisation's Intergovernmental Negotiating Body's International Agreement on Pandemic Prevention, Preparedness and Response, use lessons learned from the COVID-19 pandemic. Australia national COVID-19 Response Inquiry and establishment of the Interim Australian Centre for Disease Control to be responsible for

preventing and responding to infectious diseases and future health events like COVID-19 are key steps to learning from the COVID-19 response.

10.7 Although these reports and initiatives identify some of the issues faced by people marginalised by their health, economic and social status, the specific impacts and concerns for people who use drugs were not included.

Recommendations

10a People who use drugs must be explicitly considered in future pandemic preparedness, responses and embedded within government advisory mechanisms, including:

vii. integrate expert advice that takes human rights into account and includes specific impacts on PWUD

viii. enhance data and surveillance capabilities to better understand impacts and needs of PWUD

ix. increase pandemic-related workforce capacity among PWUD and in areas of need to be able to quickly respond to future health emergencies in those communities

x. develop funding mechanisms to allow for rapid implementation and scale-up of localised and specific programs and services for PWUD

xi. develop and/or maintaining effective communication structures that ensure involvement of AIVL, peer-led Drug User Organisations and PWUD to ensure pandemic response expertise is not lost, to inform planning, and to ensure rapid response in case of future emergencies

xii. develop a communications strategy with PWUD for use in health emergencies.

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