CRISIS-PROOFING COMMUNITIES:

HOW PEOPLE WHO USE/D DRUGS ADAPT TO CLIMATE AND HEALTH EMERGENCIES

2026

AIVL

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Icons: thenounproject.com

Suggested citation: Jess Doumany, Ele Morrison, and Joël Murray. *Crisis-Proofing Communities: How people who use drugs adapt to climate and health emergencies* (Report, AIVL, July 2026).

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Acknowledgement of Country

AIVL acknowledges the Traditional Custodians of the lands on which we live and work. We pay our respect to Elders past and present. We celebrate the stories, culture, wisdom and traditions of Aboriginal and Torres Strait Islander peoples. We thank Aboriginal and Torres Strait Islander peoples who are part of the AIVL Network and communities for the unique and essential contribution they make to the lives of our people, our environments, our communities, and our work. Always was and always will be Aboriginal land.

Recognition of peers

AIVL recognises the legacy of Peers who went before us and those who continue to strive for equity and social justice in the face of criminalisation. We reaffirm our commitment to work alongside our community of people who use drugs, challenging stigma and discrimination in all their manifestations.

Preface

In 2023, the International Network of People who Use Drugs (INPUD) released the community-led research report *Pandemic Preparedness and Response: Voices of People Who Use Drugs*. The report shared global perspective on the experiences of people who use drugs (PWUD) during the Covid-19 pandemic and recommendations to inform the drafting of the Pandemic Treaty, an initiative of the World Health Organization (WHO). To extend this work, INPUD commissioned AIVL to investigate and report on the Australian experiences of Covid-19, which overlap with Australia's frequent climate disasters, such as bushfires and floods – our report draws also from PWUD experiences in communities affected by these extreme weather events.

It is essential that AIVL and AIVL Network prepare PWUD for future pandemics and natural disasters. Part of preparedness is about advising government, particularly the newly created Australian Centre for Disease Control, on critical supply chain issues and the importance of maintaining harm reduction services and programs when disasters occur. This timely report by AIVL is not only relevant to Covid-19 but can also inform how governments and services can better prepare for future health emergencies and disasters so that no one is left behind.

John Gobeil
Chief Executive Officer

About AIVL and AIVL Members

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 Australia. **aivl.org.au**

Australian Capital Territory's (ACT) peer-based drug user and drug treatment consumer organisation. The Connection is CAHMA's Aboriginal program run by and for Aboriginal communities in Canberra. CAHMA and The Connection seek to engage people with the alcohol and other drug sector and related community and social services to improve health and wellbeing of people who use drugs. **cahma.org.au**

Harm Reduction Victoria is powered by the strength of the living-lived experience of their team, members, and board. Founded in 1987 as part of the community response to the HIV epidemic, HRVic aims to bring together our communities to improve the rights and wellbeing of PWUD. **hrvic.org.au**

NTAHC is the key non-government organisation working in blood-borne-viruses (BBVs), education and support in the Northern Territory and deliver a range of programs aimed at preventing communicable diseases transmission in urban and remote communities. The NTAHC team are from within priority populations. **ntahc.org.au**

NUAA is a peer-based drug user organisation that is governed, staffed and led by people with living-lived experience of drug use. NUAA provides education, practical support, information, and advocacy, as well as innovative harm reduction services for people in New South Wales. NUAA works with a broad range of stakeholders and partners to support systems change. **nuaa.org.au**

Peer Based Harm Reduction WA provides non-judgemental peer-based support, information and education, and health and harm reduction services aimed at reducing the transmission of BBVs and sexually transmissible infections, and preventing overdose and other harms associated with drug use in Western Australia. **harmreductionwa.org**

Operating on a peer-based philosophy, QuIVAA encourages and supports current and former people who use drugs to be active and provide input into strategic responses and policy development related to drug use in Queensland. **quivaa.org.au**

QuIHN is an independent not-for-profit providing a range of specialist social and medical services relating to alcohol, other drug use, and mental health. Operating Queensland-wide, QuIHN provides programs across a continuum of care comprising harm reduction programs, therapeutic programs, and primary medical care. **quihn.org**

South Australia Harm Reduction Peer Services is a team of peers who can draw on their living-lived experience to engage with people who inject drugs and provide accurate, relevant harm reduction information and services without stigma and discrimination. **hepatitissa.asn.au**

TUHSL is Tasmania's state-wide peer-based Drug User Organisation advancing the dignity, health and human rights of all Tasmanians who use or inject drugs, platforming out community to actively lead peer-based harm reduction. **instagram.com/tuhsl_tas/**

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List of acronyms

Acronyms	Expansion/Description
ACT	Australian Capital Territory
ACOSS	Australian Council of Social Services
AIDS	Acquired Immunodeficiency Syndrome
AIVL	Australian Injecting and Illicit Drug Users League
AHRC	Australian Human Rights Commission
AOD	alcohol and other drugs
APS	Australian Public Service
A$	Australian dollar
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy – the drug user organisation for the ACT and AIVL member organisation
CARM	culturally and racially marginalised[1]
CDC	(Australian) Centre for Disease Control
Covid-19	coronavirus, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)
DPMC	Australian Department of Prime Minister and Cabinet
DUO	drug user organisation
HIV	Human Immunodeficiency Virus
HRVic	Harm Reduction Victoria – the drug user organisation for Victoria and AIVL member organisation
INPUD	International Network of People who Use Drugs
LAIB	long-acting injectable buprenorphine
NSP	needle syringe program
NSW	New South Wales

[1] Diversity Council of Australia (DCA), 'Words at Work: Should We Use CALD or CARM?', *DCA* (Web Page, 2025) <https://www.dca.org.au/news/blog/words-at-work-should-we-use-cald-or-carm>.

Acronyms	Expansion/Description
NUAA	NUAA – the drug user organisation for NSW and AIVL member organisation
NT	Northern Territory
NTAHC	Northern Territory Hepatitis and AIDS Council – an HIV and Hepatitis Council that includes peer-led harm reduction programs and the Sex Worker Outreach Program (SWOP) in the Northern Territory and AIVL member organisation
ODTP	opioid dependence treatment (ODT) program – long-term medications and the program that provides medications including methadone and buprenorphine people dependent on opioids; Also known as: opioid substitution treatment (OST), opioid treatment program (OTP), opioid agonist treatment (OAT), and opiate agonist maintenance therapy (OAMT)
PM	Prime Minister of Australia
PPE	personal protective equipment
PWID	people who inject/ed drugs
PWUD	people who use/d drugs
QuIHN	Queensland Injectors Health Network – a harm reduction and AOD organisation in Queensland with peer workers and AIVL member organisation
QuIVAA	QuIVAA – a drug user organisation for Queensland and AIVL member organisation
RBA	Reserve Bank of Australia
SA	South Australia
SAhrps	SA Harm Reduction Peer Services – a peer-led program for people who use drugs in South Australia and AIVL member organisation
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2, the virus that causes COVID-19
TUSHL	Tasmanian Users' Health and Support League – the drug user organisation for Tasmania and AIVL member organisation
WHO	World Health Organization

Gratitude to those who contributed to this research

This report was made possible with the financial support of the International Network of People who Use Drugs (INPUD).

A special thank you to the AIVL member organisations who shared their experience and ideas and participated in this project: the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), Harm Reduction Victoria (HRVic), NUAA, the Northern Territory Hepatitis and AIDS Council (NTAHC), Peer Based Harm Reduction WA, QuIVAA, QuIHN, the South Australian Harm Reduction Peer Services (SAhrps), and the Tasmanian Users' Health and Support League (TUSHL).

Special thanks to: David Baxter, Kerry Dare, Geoff Davey, Emily Ebdon, Carol Holly, Emma Kill, Jo Murphy, Nikki Parry, and Peter Sidaway.

AIVL receives funding from the Australian Government through the Australian Centre for Disease Control.

Executive Summary

Covid-19 entered global consciousness in late 2019 and rapidly became a defining global health crisis. By early 2020, Australia had implemented some of the most restrictive public health responses in the world.[2] While these measures were designed to protect public health, they were neither aimed nor felt equally.[3] The Covid-19 pandemic and climate disasters exposed and intensified existing inequities experienced by people who use drugs (PWUD) in Australia. This report documents how public health responses—while effective in controlling viral transmission—had unintended and disproportionate impacts on PWUD, including reduced access to essential services, increased policing and surveillance, heightened mental health challenges, and worsening housing and financial insecurity.

The findings demonstrate that structural factors such as stigma, criminalisation, poverty, and digital exclusion compounded the risks faced by PWUD during the pandemic. Disruptions to harm reduction services, opioid dependence treatment (ODT), and broader health and social supports increased vulnerability to avoidable harms, including reduced engagement with care. At the same time, restrictive public health measures and inconsistent communication created barriers to accessing services and navigating rapidly changing systems.

Importantly, the pandemic also highlighted significant opportunities for reform. Peer-led drug user organisations and harm reduction services played a critical role in maintaining continuity of care, rapidly adapting service delivery models, and responding to emerging needs within communities. Innovations such as flexible ODT arrangements, telehealth, outreach-based service delivery, and expanded access to harm reduction supplies demonstrated clear benefits for accessibility, autonomy, and health outcomes. However, many of these reforms were temporary and have since been rolled back, despite strong evidence of their effectiveness.

The experiences captured in this report emphasise that future pandemic and disaster preparedness must move beyond one-size-fits-all approaches. Preparedness planning must explicitly account for the needs of PWUD as a priority population and recognise the essential role of peer-led responses.

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[2] Ian Macreadie, 'Reflections from Melbourne, the World's Most Locked-down City, through the COVID-19 Pandemic and Beyond' (2022) 43(1) *Microbiology Australia* 3 <https://doi.org/10.1071/MA22002>; Lorraine Finlay et al, *Collateral Damage: What the Untold Stories from the COVID-19 Pandemic Reveal about Human Rights in Australia* (Report, Australian Human Rights Commission (AHRC), March 2025) <https://humanrights.gov.au/resource-hub/by-resource-type/publications/collateral-damage-report-australias-covid-19-pandemic>.

[3] Australian Department of Prime Minister and Cabinet (DPMC), *COVID-19 Response Inquiry Report* (Report, Commonwealth of Australia, 2024) <https://www.pmc.gov.au/resources/covid-19-response-inquiry-report>.

Without deliberate inclusion, PWUD risk again being overlooked in emergency responses, resulting in avoidable harms and inequitable outcomes.

Drawing on these findings, this report makes a series of recommendations to strengthen Australia's preparedness for future pandemics and disaster events. Central to these recommendations is the need to embed a human rights-based approach that ensures no one is left behind.

Recommendations

Involve people who use/d drugs in climate and health disaster planning and preparedness

Recommendation 1: Governments should formally recognise people who use/d drugs (PWUD) as a priority population within national emergency preparedness frameworks, including the National Communicable Disease Plan, and develop population-specific management plans.

Recommendation 2: Governments and public health agencies should ensure the meaningful inclusion of PWUD and drug user organisations in the codesign, implementation, and evaluation of pandemic and disaster responses.

Recommendation 3: Governments should implement equitable, public health–oriented policing approaches during emergencies, including safeguards to prevent disproportionate targeting, surveillance, and penalisation of PWUD and other marginalised populations.

Recommendation 4: Governments should adopt a human rights-based approach to pandemic and disaster responses, ensuring that policies are equitable, proportionate, and inclusive, and that no population is left behind.

Recommendation 5: Governments at all levels and relevant agencies should ground pandemic and disaster preparedness planning in the expectation of increased demand for harm reduction services, opioid dependence treatment (ODT), needle and syringe programs (NSPs), and wrap-around health and social supports.

Recommendation 6: Governments and health systems should ensure secure and continuous supply chains for essential harm reduction commodities, including sterile injecting equipment, naloxone, and pharmacotherapy medications, during emergencies.

Recommendation 7: Governments and emergency response agencies should develop and maintain contingency plans for workforce shortages and service disruption, including surge workforce capacity and decentralised service delivery models.

Recommendation 8: Governments and service providers should integrate pandemic and climate disaster preparedness planning, ensuring continuity of harm reduction, pharmacotherapy, and health services across multiple types of emergencies.

Expand flexible models of care

Recommendation 9: Governments and regulators should maintain and expand flexible models of care introduced during the Covid-19 pandemic, including telehealth, increased ODT take-home doses, home delivery options, and the use of nominated persons to collect medications.

Recommendation 10: Governments should ensure that all telehealth and digitally enabled services are complemented by accessible non-digital service options to prevent exclusion of people without reliable technology access.

Recommendation 11: Governments and regulators should remove barriers to naloxone access and distribution, including enabling supply through NSPs and peer-led services, and ensuring consistent availability across jurisdictions.

Invest in peer-based organisations and services for PWUD

Recommendation 12: Governments should provide sustained, long-term funding for peer-led harm reduction and drug user organisations, including outreach, after-hours services, and service delivery innovations, beyond time-limited emergency funding periods.

Recommendation 13: Governments and services should expand outreach and alternative distribution models for harm reduction supplies, including mobile services, home delivery, and vending machines, particularly in rural, regional, and restricted settings.

Recommendation 14: Governments and public health agencies should improve communication strategies during emergencies by investing in and empowering peer-based organisations to codesign accessible, consistent, and peer-informed messaging tailored to PWUD and other marginalised communities.

Address social determinants of health and equitable access to digital services

Recommendation 15: Governments should address digital exclusion by funding access to devices, mobile data, and digital literacy support to ensure equitable access to telehealth and online services for PWUD.

Recommendation 16: Governments should prioritise long-term, stable housing solutions for people experiencing homelessness, including PWUD, and ensure that emergency accommodation responses transition into sustainable housing pathways.

Recommendation 17: Governments and service providers should strengthen mental health support for PWUD, including integrating low-threshold mental health care into harm reduction and drug treatment services.

Build the capacity of the peer workforce and emergency services workforce

Recommendation 18: Governments and service providers should invest in the peer workforce by funding training, upskilling, and pandemic preparedness, and by supporting workforce wellbeing, retention, and sustainable employment pathways.

Recommendation 19: Governments and emergency services should provide training and education for first responders and frontline workers on harm reduction, stigma reduction, and the needs of PWUD during emergencies.

Introduction

Background

Coronavirus or Covid-19 is an infectious respiratory virus caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2).[4] Since the start of the pandemic, nearly 12 million confirmed or probable Covid-19 cases were reported, while 25,236 people have died from or with Covid-19 in Australia (to 30 November 2025).[5] Australia's Covid-19 mortality rate of 35 per million population is some 15 to 20 times lower than observed in countries across different parts of the globe.[6]

Australia is a large and geographically diverse island country and continent with a relatively small population distribution clustered in capital city regions and the coastlines—some two-thirds of Australians live in major cities. A geographically dispersed population raises challenges for models of care, supply, and financing health services that are equitable across states and territories.

As a result of Australia federation and geographically dispersed populations, the experience of Covid-19 and responses to the pandemic differed significantly between jurisdictions, metropolitan cities and regional towns, from the time Covid-19 was declared a human biosecurity emergency on 18 March 2020, to the time this emergency status was lifted on 11 April 2022.[7]

Australia implemented some of the longest lasting and most restrictive responses comparative to different countries, including:

- border closures and international travel bans
- stay-at-home orders and curfews
- limitations on public gatherings and restriction on personal freedom of movement

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[4] World Health Organization (WHO), 'Naming the Coronavirus Disease (COVID-19) and the Virus That Causes It', *World Health Organization* (Web Page, 2025) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it>.

[5] WHO, 'WHO COVID-19 Dashboard - Number of COVID-19 Cases, World', *World Health Organization Data* (Web Page, 30 March 2025) <https://data.who.int/dashboards/covid19/cases?n=o>; World Health Organization, 'WHO COVID-19 Dashboard - Number of COVID-19 Deaths, World', *World Health Organization Data* (Web Page, 30 March 2025) <https://data.who.int/dashboards/covid19/deaths?n=o>.

[6] Fiona Stanaway et al, 'COVID-19: Estimated Number of Deaths If Australia Had Experienced a Similar Outbreak to England and Wales' (2021) 214(2) *Medical Journal of Australia* 95 <https://doi.org/10.5694/mja2.50909>; World Health Organization, *WHO COVID-19 Dashboard - Number of COVID-19 Deaths, World* (n 7).

[7] Finlay et al (n 2); Australian Department of Prime Minister and Cabinet (DPMC) (n 3).

- mandatory mask use, testing, and vaccination requirements
- shifts to remote work and online education.[8]

Some positive responses were also seen, limited to defined areas, populations and circumstances, including:

- provision of safe accommodation for people experiencing different types of homelessness[9]
- doubling of government unemployment benefits[10]
- government provided financial support directly to employers tied to loss of income to retain employees on fewer hours rather than retrenchment[11]
- implementation of specific fixed site and outreach programs for people impacted by the virus that included such services as Covid-19 testing, provision of food, and psychosocial support[12]
- changes to provision of health and social services including the use of telehealth, options reducing the need for in-person contact such as increased outreach models, and changes to the types of services provided to allow more people experiencing disadvantaged to access services and programs[13]

Many of Australia's responses to Covid-19 involved general health and service system strengthening for the public health response.[14]

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[8] Macreadie (n 2); Finlay (n 2); DPMC (n 3).

[9] Hal Pawson et al, *COVID19: Rental Housing and Homelessness Impacts in Australia* (Report No 12, Australian Council of Social Services (ACOSS) and the University of New South Wales (UNSW), 2021) <https://doi.org/10.26190/unsworks/28124>.

[10] Reserve Bank of Australia, 'The COVID-19 Pandemic: 2020 to 2021', *Reserve Bank of Australia (RBA)* (Web Page, 2025) <https://www.rba.gov.au/education/resources/explainers/the-covid-19-pandemic-2020-to-2021.html>.

[11] Ibid.

[12] DPMC (n 3).

[13] Ibid.

[14] Ibid.

Australia's federated governments and structure of the health care system

Understanding Australia's federated system is important to contextualising the challenges of the Covid-19 pandemic. Australia has three levels of government through the Australian Parliament, six state and two territory parliaments, and 537 local councils (shires, municipalities). The federal government is responsible for matters like managing the economy, financing Medicare (Australia's universal health care program), defence, immigration, and foreign policy; state/territory governments responsibility is largely service delivery like public hospitals, schools, public transport, emergency services, and prisons. Whereas local councils are concerned with town planning, sewage, local roads, and rubbish collection. The Australian Health Care System is similarly federated and is classified as a 'supply- and choice-oriented public system'.[15] The features of Australian Health Care System are described in Table 1, and responsibilities are described in Table 2.

Table 1: Australian Health Care System

The Australian Health Care System		
Responsibility	**Supply**	**Financing** (payers)
Delegated and shared responsibility by federal, state and territory, and local governments.	Health care services are supplied by public and private systems.	Governments, private health insurance firms, and individual health consumers (out-of-pocket expenses, insurance premiums, and levies).[16]

[15] Nadine Reibling Ariaans, Mareike, Wendt, Claus, 'Worlds of Healthcare: A Healthcare System Typology of OECD Countries' (2019) 123(7) *Health Policy* 611, 617 <https://doi.org/10.1016/j.healthpol.2019.05.001> ('Worlds of Healthcare').

[16] Australian Government, 'The Australian Health System', *Department of Health, Disability and Ageing* (Web Page, 7 April 2025) <https://www.health.gov.au/about-us/the-australian-health-system>.

Table 2: Delegated and shared responsibilities for health care

Delegated and shared responsibilities for health care	
Australian Government	**States and territories governments**

• coordination, regulation, administration, service and financing for
  ○ Medicare
  ○ Aboriginal and Torres Strait Islander Community Controlled Health Organisations
• subsidies and regulation for private health insurance
• ageing care system
• medicines safety and pricing
• vaccine supply
• primary health services workforce development and distribution, and safety, quality, efficacy, and effectiveness
• funding public hospitals with states and territories
	• delivery of public health responses
	• prevention and health promotion
	• data surveillance
	• running public hospitals and community dental services
	• funding public hospitals with the federal government

Prelude to the pandemic

In December 2019 and January 2020 Australia experienced the 'Black Summer of Bushfires'. They affected large parts of Victoria, NSW, the ACT and Southern Queensland.[17] While state and territory governments were focused on bushfire responses, the then Prime Minister was enjoying a family holiday in Hawaii.[18] Despite the absence of the PM and the experience of the Australian Public Service (APS) in bushfire responses, the unprecedented size of communities impacted by the climate-related disasters meant the APS had to intensify coordination. The Australian Government

[17] Australian Public Service Commission, *State of the Service Report 2019-20* (Report, Australian Public Service Commission, 25 February 2021) 8.

[18] Stephanie Dalzell, 'Scott Morrison Says He Accepts Criticism for Hawaii Holiday during Bushfires, Apologises for Any Upset Caused', *ABC* (Web Page, 22 December 2019) <https://www.abc.net.au/news/2019-12-22/prime-minister-scott-morrison-hawaii-holiday-bushfires/11821682>.

provided some A$223 million in emergency disaster assistance payments directly to those affected.[19] These responses to the climate-related disasters were the first test for the governments of Australia.

The emerging global health crisis on Australian shores

The emerging public health challenges notified by China to the World Health Organization (WHO) did not seem to be a priority for the Australian Government (nor the governments of most of the Global North) who were sceptical of the early disease models produced from real world data. The first Australian public health measures were adopted on 20 January 2020 with the first Australian Covid-19 cases and related death detected just five days later.[20] However, it was not until 18 March 2020 that Covid-19 was declared a human biosecurity emergency in Australia, following the advice of the WHO.

As seen globally, the Covid-19 pandemic compounded existing health, social and financial disadvantage of people living in Australia and signified a new wave of challenges for government services and programs. The impacts of the pandemic were particularly devastating in rural areas, often in areas in the lower quintiles of relative socioeconomic advantage and disadvantage, including at the household level, and intensified the challenges of economic and social recovery, housing support, and health and wellbeing.[21]

Geographical challenges for public health responses

While many regional areas of Australia, as well as entire states, did not experience the same restrictions on travel and social mobility as other areas, these experiences showcase how each local area and region faced their own unique challenges and issues within a variable national pandemic response.[22]

The more serious restrictions were usually focused on cities and were also implemented at different times over the period in which curfews and lockdowns were in place. Melbourne was particularly affected by lockdowns, curfews and other severe restrictions on people's movement. The city

[19] Australian Public Service Commission (n 19) 8.
[20] Ibid 12.
[21] DPMC (n 3); Pawson et al (n 11); Finlay (n 2).
[22] DPMC (n 3).

became known as the most *"locked down city in the world"* with a total of 262 days in which the city's population of 5.5 million people found their movement restricted.[23]

Since the end of the most severe restrictions on the community, the impact of Covid-19 responses for people in the community are increasingly being understood. Some of the impacts experienced by specific populations were immediate, while other impacts had longer term consequences. For example, a survey of 10,000 women in Australia found that women experienced the onset or increased frequency and severity of physical, sexual or coercive violence during times of lockdown,[24] as well as declining mental health and interruptions to preventative health screening.

State and territory governments enabled additional powers to the police and private security workers to stop and search people in public, to move them on, and to issue infringements with financial penalties for breaching public health orders. As with many other discretionary regulations, these powers were not applied evenly across all Australians. Aboriginal and Torres Strait Islander peoples, sex workers, and people who are culturally and racially marginalised (CARM) in Australia were also more likely to experience issues including police harassment and violence and pandemic-related fines. For example, in NSW, 74% of Indigenous people who were stopped by police for pandemic-related reasons were searched compared to only 45% of non-Indigenous people.[25] In Victoria, Indigenous people were 4.5 times more likely to be issued with a fine than non-Indigenous people, and Sudanese and south Sudanese born people were 35.6 times more likely to be issued with a pandemic-related fine.[26]

People who use/d drugs and Covid-19

Vulnerability to infection and illness

People who use/d drugs were vulnerable to a range of pandemic-related adverse health impacts and outcomes, compounded by the ongoing impacts of stigma and criminalisation of drug use. For

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[23] Macreadie (n 2).

[24] Hayley Boxall and Anthony Morgan, *Intimate Partner Violence during the COVID-19 Pandemic: A Survey of Women in Australia* (Special Report No 11, Australia's National Research Organisation for Women's Safety Limited (ANROWS), October 2021) <https://www.aic.gov.au/publications/special/special-11>.

[25] Louise Boon-Kuo et al, 'Policing Biosecurity: Police Enforcement of Special Measures in New South Wales and Victoria during the COVID-19 Pandemic' (2021) 33(1) *Current Issues in Criminal Justice* 76 <https://doi.org/10.1080/10345329.2020.1850144>.

[26] Tamar Hopkins and Gordana Popovic, *Policing COVID-19 in Victoria: Exploring the Impact of Perceived Race in the Issuing of COVID-19 Fines during 2020* (Report, Inner Melbourne Community Legal, 2023) <https://policeaccountability.org.au/commentary/policing-covid-19-in-victoria/>.

PWUD, vulnerability to the virus, health systems access and poorer general health outcomes increased individual risk of serious illness and death from Covid-19, particularly before vaccines were made available. For example, the economic impacts of drug dependence meant some were more likely to be homeless or living in overcrowded and unstable housing situations, making social isolation and physical distancing difficult and leaving people vulnerable to infection.[27] The additional impact of PWUD having barriers to health service access meant some were less likely to have received Covid-19 vaccinations once they became available, and less likely to access health services when they were unwell.[28] Finally, pre-existing conditions more common to PWUD than the general community include cardiovascular disease, respiratory illnesses, blood-borne viruses such as hepatitis C, and pulmonary diseases, all of which result in poorer outcomes if infected with Covid-19.[29]

Interactions with law enforcement

Due to the criminalisation of some drugs, many PWUD or who have a history of using drugs already have more frequent contact with law enforcement than other people in the community.[30] The cost of many illicit drugs in Australia, already high comparative to global prices, increased during the Covid-19 pandemic while the purity and quality of drugs was perceived to be lower.[31] People who use/d drugs may not have the money or networks to source larger amounts of drugs and may have to

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[27] Eilish Scallan et al, 'Finding Stability amidst the COVID-19 Pandemic: The Impact of Emergency Temporary Housing for People Who Use Drugs' (2022) 41(1) *Drug and Alcohol Review 7* <https://doi.org/10.1111/dar.13335>; Karan Varshney, Talia Glodjo and Jenna Adalbert, 'Overcrowded Housing Increases Risk for COVID-19 Mortality: An Ecological Study' (2022) 15(1) *BMC Research Notes* 126 <https://doi.org/10.1186/s13104-022-06015-1>.

[28] Jenny Iversen et al, 'COVID-19 Vaccination among People Who Inject Drugs: Leaving No One Behind' (2021) 40(4) *Drug and Alcohol Review* 517 <https://doi.org/10.1111/dar.13273>.

[29] Aveyard et al (n 5); Birgitte Thylstrup, Thomas Clausen and Morten Hesse, 'Cardiovascular Disease among People with Drug Use Disorders' (2015) 60(6) *International Journal of Public Health* 659 <https://doi.org/10.1007/s00038-015-0698-3>.

[30] Caitlin E Hughes et al, 'Drug-Related Police Encounters across the Globe: How Do They Compare?' (2018) 56 *International Journal of Drug Policy* 197 <https://www.sciencedirect.com/science/article/pii/S0955395918300756>.

[31] Lisa Maher and Thomas Crewe Dixon, 'Collateral Damage and the Criminalisation of Drug Use' (2017) 4(8) *The Lancet HIV* e326 <https://doi.org/10.1016/S2352-3018(17)30071-1>; Harm Reduction International (HRI), *The Global State of Harm Reduction* (Report No 7, HRI, 2020) <https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2020/>; Paul M Dietze and Amy Peacock, 'Illicit Drug Use and Harms in Australia in the Context of COVID-19 and Associated Restrictions: Anticipated Consequences and Initial Responses' (2020) 39(4) *Drug and Alcohol Review* 297 <https://doi.org/10.1111/dar.13079>; Olivia Price et al, 'Changes in Illicit Drug Use and Markets with the COVID-19 Pandemic and Associated Restrictions: Findings from the Ecstasy and Related Drugs Reporting System, 2016–20' (2022) 117(1) *Addiction* 182 <https://doi.org/10.1111/add.15620>; Ali Farhoudian et al, 'A Global Survey on Changes in the Supply, Price, and Use of Illicit Drugs and Alcohol, and Related Complications During the 2020 COVID-19 Pandemic' (2021) Volume 12-2021 *Frontiers in Psychiatry* <https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.646206>.

regularly travel significant distances to areas known for their drug markets all of which increases the likelihood of interactions with police.[32]

Illegality also dictates the nature of the drug market, requiring those at the bottom of the chain, PWUD, to travel and buy them directly from another person rather than through online or more discreet and safer means.[33] These issues mean that PWUD, particularly those with lower-socio economic status, have to source money and travel frequently to areas with higher police presence, all of which were more difficult in places where there were lockdowns, curfews and travel restrictions.[34]

In one Australian study, increased policing to enforce Covid-19 restrictions resulted in PWUD being more commonly searched than other people, being disbelieved even after demonstrating proof of need to travel and being issued with fines at a rate of approximately three times that of the general community. The study found some people received multiple fines, including fines that were the same or close to the maximum fines given in Victoria – A$1,652 for breaching stay-at-home orders and $A10,000 for repeat offences. Most people had not and could not pay these fines as of the time they were interviewed, resulting in court summons and risk of imprisonment. These findings indicated what the people in the study felt, that they were being targeted and harassed by police because of their drug use.[35]

The participants in the study were issued pandemic-related fines after being searched for drugs, and even when they provided evidence of travelling to utilise essential health services including opioid dependence treatment programs (ODTP) and harm reduction services. The researchers estimated PWUD were fined at almost three times the rate of people in the general community. Increased vulnerability of PWUD to harassment and punishment from law enforcement at times of a public health emergency had the potential to increase their vulnerability to blood borne viruses, other injecting related infections and harms, and overdose.[36]

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[32] Hughes et al (n 32).

[33] Natasha M Loi et al, 'Illicit Drug Use in Australia during the COVID-19 Pandemic' (2022) 12 *Journal of Global Health* 03026.

[34] Dietze and Peacock (n 33); Farhoudian et al (n 33).

[35] Shelley Walker et al, 'Disproportionate, Differential and Targeted Treatment: People Who Use Drugs' Experiences of Policing during the COVID-19 Pandemic' (2025) 13(1) *Health & Justice* 6 <https://doi.org/10.1186/s40352-024-00314-4>.

[36] Dietze and Peacock (n 33).

Changed patterns of drug use

Law enforcement and policing was not the only issue for PWUD in Australia. In fact, there is some evidence overall drug use increased across the country due to factors including unemployment, social isolation and a lack or perceived lack of treatment options. The use of methamphetamine, cannabis and sedatives was seen to increase in some studies,[37] while other studies found the increased prices of many drugs and decreased availability reduced their use in parts of the country.[38] The different findings about drugs indicated the changing nature of availability and use of drugs at different times during the pandemic.[39] Despite constantly evolving variables and changes in market supply, there appears consistent evidence that overall drug quality went down and costs went up. This took its toll on our community when PWUD who already have high rates of depression and anxiety, experienced emotional and financial stress from higher drug prices during the pandemic.[40]

For people who have a drug dependence, the Covid-19 pandemic had significant effects and outcomes. Increased price and reduced availability can also have different impacts for a person who experiences withdrawal more easily than someone who is able to go without. However, even drugs associated with social events that are not normally drugs of dependence, drugs such as MDMA/Ecstasy and cocaine, appeared to be used regularly consistently compared to their use outside of pandemic times.[41] The most used drugs at the supervised injecting services in Melbourne and Sydney, on the other hand, changed during this time. People in Sydney were more likely to inject methamphetamine, while those in Melbourne were more likely to be injecting a mix of heroin and diphenhydramine.[42] These changes have their own associated risks, including physical and mental health concerns, and overdose.

Access to harm reduction and alcohol and other drug services

Australia has a long and evidence-back history of providing vital peer-led harm reduction services to PWUD. This experience base likely provided a crucial role in being able to navigate and adapt to the

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[37] Ibid.

[38] Farhoudian (n 33).

[39] Natasha M Loi (n 35).

[40] Price (n 33).

[41] Ibid.

[42] Amanda Roxburgh et al, 'The Impact of COVID-19 Public Health Measures on Attendance and Overdose at Supervised Injecting Facilities in Australia' (2023) 224 *Public Health* 90 <https://www.sciencedirect.com/science/article/pii/S003335062300313X>.

constantly changing pandemic restrictions and lockdown regulations – which mean that services had to be in the constant know and able to quickly and promptly absorb and adapt to emerging changes in restrictions and provider delivery requirements. This was vital given the undeniable impact of lockdowns, curfews and travel restrictions in the early stages of the Covid-19 pandemic, which made access to harm reduction and other health services difficult for PWUD in Australia.[43]

The supervised injecting facilities in Melbourne and Sydney saw less people during the pandemic.[44] Distrust and fear of police during the pandemic, alongside targeted policing of PWUD, likely contributed to fears of accessing these services. Melbourne Supervised Injecting Service and Sydney Medically Supervised Injecting Centre also changed their procedures in response to public health orders, limiting the numbers of people who could use the service at the same time and restricted entry to those with symptoms of Covid-19.[45]

Other studies and surveys also demonstrated how disruptions in service delivery had a major impact on PWUD. As was the case in other countries, people who injected drugs in Australia were more likely to reuse or share injecting equipment due to difficulties accessing needle and syringe programs.[46] People seeking access to drug treatment for illicit drug use were less likely to be able to access it and many did not try to access treatment services. Despite increases in funding for AOD treatment, 78,360 people reported they needed but did not try to access support, or they experienced significant barriers in accessing support during the earliest part of the pandemic.[47] This was particularly true of services provided in groups such as group counselling and support and live-in detoxification and rehabilitation services.[48] The introduction of telehealth services was perceived as useful for some people but was not as useful for others.

While there were significant barriers to harm reduction and AOD service access during the worst of the Covid-19 pandemic, there were also services that adapted to meet the needs of PWUD. Most needle and syringe programs remained open, outreach services used social distancing protocols

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[43] Walker (n 37).

[44] Roxburgh (n 42).

[45] Ibid.

[46] Henrietta Efunnuga et al, 'Health Service Utilisation and Access for People Who Inject Drugs during COVID-19' (2022) 41(6) *Drug and Alcohol Review* 1304 <https://doi.org/10.1111/dar.13456>.

[47] Nicholas Biddle and Matthew Gray, *Service Usage and Services Gaps during the COVID-19 Pandemic* (Paper, Centre for Social Research and Methods, Australian National University, June 2020) <https://polis.cass.anu.edu.au/research/publications/service-usage-and-service-gaps-during-covid-19-pandemic>.

[48] Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia Annual Report* (Web Report No 2020–21, AIHW, Australian Government, 2022) <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/archived-content>.

and personal protective equipment (PPE) to continue to provide services, and harm reduction services, particularly peer-led services, developed resources for people to use drugs with the aim of empowering them to protect themselves from the virus and the impacts of policing and other measures aimed at reducing its spread.[49]

A further example of an adaptation was evidence that some ODT clinics, dosing pharmacies, and harm reduction services such as needle and syringe programs provided a travel pass of sorts to people who used their services. These were often in the form of a card with information about the essential service being accessed by the person who was holding the card. However, some PWUD found law enforcement did not accept these in cases where they were given fines relating to Covid-19.[50]

Access to pharmacotherapy

Opioid dependence treatment (ODTP) programs in Australia are characterised by delegated responsibility between the federal, state and territory governments regulating prescribers, how it can be prescribed, and how it is provided from clinics and the community.[51] There are two medications used, methadone and buprenorphine, with these being provided in different forms that influence how people can access them. Methadone is a liquid that is usually taken daily. Buprenorphine can be provided as a sublingual pill, formulated with naloxone and taken as a sublingual film, or injected under the skin. The pill and the film form of buprenorphine dosing vary between once a day to every three (3) days, while the injection, known as long-acting injectable buprenorphine (LAIB), may be provided as a weekly or monthly dose.[52]

Depending on the state or territory, Australian people who access and use ODT must attend a clinic or pharmacy to receive their medication doses, with each medication having maximum takeaway

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[49] Loren Brener et al, 'Health Worker Perceptions of the Impact of COVID-19 on Harm Reduction Services for People Who Inject Drugs' (2022) 30(6) *Health & Social Care in the Community* 2320 <https://doi.org/10.1111/hsc.13782>; Harm Reduction Victoria, 'COVID-19 and You. Some Things You Should Know: For People Who Use Drugs', *Harm Reduction Victoria* (Web Page, 4 October 2021) <https://www.hrvic.org.au/covid19-you>.

[50] Walker et al (n 37).

[51] Linda Gowing et al, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (Guidelines, Australian Health Ministers' Advisory Council, Commonwealth of Australia, 2014) <https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence?language=en>; AIVL—Australian Injecting and Illicit Drug Users League, 'Information for People on Opioid Treatment: Methadone, Suboxone, Subutex, and Buprenorphine Injections', *AIVL* (Web Resource, 1 March 2024) <https://aivl.org.au/resources/odtp/>.

[52] AIVL—Australian Injecting and Illicit Drug Users League (n 53); Hester HK Wilson and Jillian Kanck, 'Medicines Used in the Treatment of Opioid Dependence' (2025) 48(3) *Australian Prescriber* 98 <https://australianprescriber.tg.org.au/articles/medicines-used-in-the-treatment-of-opioid-dependence.html>.

doses allowed. For example, Tasmanian regulations allow no more than two (2) non-consecutive doses of methadone or sublingual buprenorphine each week,[53] whereas in Victoria, people can receive up to six (6) takeaway doses of methadone per week and 13 doses of sublingual buprenorphine.[54] LAIB must be injected by a registered pharmacist or prescribing clinician.

People who use/d drugs reported positive experiences about adaptations to ODTP during the Covid-19 pandemic, adaptations to ODTP helped mitigate the impact of lockdowns and ensured that people could maintain their treatment routines despite the challenges posed by the pandemic. Changes to supervised dosing benefitted many PWUD.[55] All of Australia's states and territories allowed more take-home doses of the daily medications, in most places up to six (6) take-home doses of methadone per week and 23 doses Suboxone per month. Fears about increased black market availability and diversion of take-home doses, and associated community overdose from these medications were not reported among AIVL networks.

A retrospective longitudinal case-control study of people in ODT services in South Eastern Sydney Local Health District, showed that every additional day of attendance required for dosing was associated with a 5% increase in the odds of acquiring Covid-19. People accessing these medications were overall far more likely to acquire the virus than the general population.[56] Aboriginal people accessing ODT medications were even more likely to acquire Covid-19 than non-Indigenous people accessing the program, while people who accessed pharmacies rather than ODT clinics were less likely to acquire Covid-19. Where people were able to access the positive benefits, there was increased retention in treatment, decreased exposure to illicit substances, decreased exposure to workplace related issues including stigma, reduced anxiety and increased sense of autonomy.[57]

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[53] The Alcohol and Drug Service, Statewide and Mental Health Services, Department of Health and Human Services, Tasmania, *Tasmanian Opioid Pharmacotherapy Program: Policy and Clinical Practice Standards* (Clinical Standards, Tasmanian Department of Health and Human Services, October 2025) 94–100 <https://www.health.tas.gov.au/publications/tasmanian-opioid-pharmacotherapy-program-policy-and-clinical-practice-standards>.

[54] Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (Policy, Victorian Department of Health, 30 June 2023) 32–38 <https://www.health.vic.gov.au/publications/policy-for-maintenance-pharmacotherapy-for-opioid-dependence>.

[55] Efunnuga et al (n 48).

[56] Benjamin T Trevitt et al, 'The Impact of Changes in Opioid Dependency Treatment upon COVID-19 Transmission in Sydney, Australia: A Retrospective Longitudinal Observational Study' (2024) 24(1) *BMC Public Health* 349 <https://doi.org/10.1186/s12889-024-17827-0>.

[57] Alison Adams et al, 'The Impact of Relaxing Restrictions on Take-Home Doses during the COVID-19 Pandemic on Program Effectiveness and Client Experiences in Opioid Agonist Treatment: A Mixed Methods Systematic Review' (2023) 18(1) *Substance Abuse Treatment, Prevention, and Policy* 56 <https://doi.org/10.1186/s13011-023-00564-9>.

However, many people accessing opioid dependence treatment medications were still impacted by having to attend pharmacies and clinics regularly for dosing, with the maximum number of takeaway doses of methadone allowed in most states only six (6) per week or 13 per fortnight, and only a small proportion of people being able to get the maximum number. Despite the lack of evidence of increased harm from providing more flexibility, and evidence of increased harm that comes with stronger restrictions, only one Australian jurisdiction, Victoria, has maintained the more flexible allowances of take-home doses allowed during the pandemic.

Case Study 1: Lessons about ODT programs during record breaking floods in the Northern Rivers Region of New South Wales

- February and March 2022: the Northern Rivers region experienced *"an exceptional flooding event*" that *"saw rainfall totals and water levels exceeding historical records by a significant amount"*.[58]
- A study of people prescribed ODT medications in the region found that major flood events in has caused severe disruptions to people prescribed ODT medications. Disruptions included pharmacies being flooded, paper records being destroyed, loss of internet and power, and situations where prescribers and clinicians could not be contacted.
- People prescribed ODT medications found themselves cut off from access roads by flooding, and where their own pharmacies were unavailable, facing long delays to getting scripts, loss of any take-home dose access in the emergency clinics, long waiting times each day to dose and reduced privacy and confidentiality for consumers. [59]
- Emergency clinics did not provide medications if they couldn't access people's prescriptions, and stigma was reported as a major barrier and issue in the clinics, impacting people's ability to find shelter and contribute to the emergency recovery efforts of their own families and neighbourhoods.[60]

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[58] Julien Lerat et al, *Characterisation of the 2022 Floods in the Northern Rivers Region* (Report, CSIRO, 30 November 2022) viii <https://www.nema.gov.au/our-work/resilience/northern-rivers-resilience-initiative>.

[59] Theresa Caruana, 'Medication Safety, Privacy, and Stigma: A Qualitative Study of Pharmacy Opioid Agonist Treatment Disruptions and Adaptations in the 2022 Northern Rivers Floods, Australia' (2024) 101 *International Journal of Disaster Risk Reduction* 104244 <https://www.sciencedirect.com/science/article/pii/S2212420924000062>.

[60] Ibid.

- Where pharmacies were able to maintain operations, demonstrated extraordinary commitment to continuity and enhanced accessibility of services, acting outside administering protocols.
- Pharmacies that stayed open operated without power, allowed advance, discretionary and additional take-home doses for people facing flooding, and allowed people to access doses when their scripts had been lost or were inaccessible. Responsive adaptations reduced the chances of severe withdrawal during times of extreme emotional stress and hardship.
- The study found stigma including structural stigma, significantly increased harm, and recommended future disaster planning should recognise stigma as a barrier to health care access, improve communication channels, and support more flexible and person-centred provision of ODT programs.[61]

Social, physical and mental health

Many countries experienced reductions in access to harm reduction services during the pandemic. These included vital frontline services such as needle and syringe programs, supervised drug consumption facilities, opioid dependence treatment, withdrawal and treatment services, and other clinical services such as addiction medicine specialists. These factors had a cumulative impact on PWUD in terms of compounding health issues and increasing risk of unsafe practices, such as sharing or re-using injecting equipment and using drugs alone.[62]

Housing was one of the issues that saw different and sometimes contradictory outcomes play out for PWUD. In some areas, people who were homeless were accommodated in emergency accommodation that had not previously been available, such as hotels, allowing unhoused people to have their own, safer place to live. For others, this was not the case. This culminated in contrasting experiences, where some people were worse off and subject to increased social isolation and attendant mental health harms, as well as overdose risk from using drugs alone. For

[61] Ibid.

[62] Cayley Russell et al, 'Identifying the Impacts of the COVID-19 Pandemic on Service Access for People Who Use Drugs (PWUD): A National Qualitative Study' (2021) 129 *Journal of Substance Abuse Treatment* 108374 <https://www.sciencedirect.com/science/article/pii/S0740547221001008>.

others, it meant safety and stability.[63] Despite the latter, it is important to preface that resolution of housing need for some didn't mean resolution of *all* disadvantage experienced. In addition, like many other responses mobilised during the pandemic, housing resolution was often short-lived—with major cessation of funding to projects and initiatives mobilised during the pandemic—including across multiple sectors and services with the cessation of lockdowns. This is despite still lingering impacts and multifaceted human tolls still in existence since the pandemic. A large amount of money was spent on short term accommodation with many of the people who had received it having to return to sleeping rough.[64]

People who use/d drugs experienced compounded health, social and financial disadvantage during the pandemic – particularly driven by the increased community need for emergency food and housing alongside a range of other health, social and financial issues.[65] Growing evidence shows PWUD, people who didn't have stable housing, and people who have trouble with their mental health experienced some of the more severe impacts on their physical and mental health as well as their circumstances in Australia and around the world.

Even targeted restrictions in Australia tended to have detrimental impacts on PWUD. The 'Melbourne Tower Lockdowns' saw residents and visitors of high-density public housing apartments given basically no notice before commencing often unknown periods of lockdown - placing PWUD living or visiting the building at significant risk. These Tower Lockdowns were strictly enforced by law enforcement, with services including paramedic and other clinical service providers also given no warning to prepare essential medicines and other supports. Some people who were locked into the area had to manage potentially life-threatening drug withdrawal, along with the other attendant harms caused by being suddenly forced to live without outside resources. As was the case with many of the other measures that involved law enforcement, people from low-socioeconomic backgrounds were targeted by these measures, something that was found by later court cases and human rights reviews. [66]

The criminalisation of drug use undeniably increases stigma towards PWUD, which in turn exacerbates harms such as social isolation and exclusion and poor mental health.[67] This is

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[63] Scallan et al (n 29).
[64] Finlay et al (n 2).
[65] Walker et al (n 37).
[66] Finlay et al (n 2).
[67] Walker et al (n 37).

something that we saw play out heavily in the pandemic – with overt and easy targeting of PWUD on the streets and in public – especially with minimal other people around.

Government inquiries into pandemic

Lessons learned from the Covid-19 pandemic are reflected in revised international reports and treaties, including the World Health Organisation's (WHO) Intergovernmental Negotiating Body's (INB) *International Agreement on Pandemic Prevention, Preparedness and Response*.[68] The Australian Government has also completed a national Covid-19 Response Inquiry and since 1 January 2026, an Australian Centre for Disease Control (CDC) has been operationalised, per the inquiry's recommendations. The new agency has responsibility for surveillance and preventing and responding to communicable diseases.[69] Although Australian 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 PWUD were not included.

Impact of Covid-19 response to human rights

A report by the Australian Human Rights Commission (AHRC) highlighted the human impact of Australia's responses to Covid-19. The report found that, rather than overriding people's human rights to respond to public health emergency situations, it was even more important to consider human rights. The report suggests human rights, even those enshrined in law, were ignored in place of measures intended to protect public safety, with many of the most adverse outcomes occurring for people who are already marginalised.

The AHRC also found that some of the Covid-19 public health measures resulted in significant harms to people such as experiences of isolation and distress from prolonged quarantine measures; compounded social, emotional and health disadvantage; and requirement to respond to unclear and changing regulations and rules leading to preventable clustered outbreaks.[70]

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[68] Australian Department of Health, Disability and Ageing, 'Frequently Asked Questions - International Agreement on Pandemic Prevention, Preparedness and Response' <https://www.health.gov.au/resources/publications/international-instrument-on-pandemic-prevention-preparedness-and-response-frequently-asked-questions?language=en>.

[69] Australian Department of Health, Disability and Ageing, 'About the Interim Australia Centre for Disease Control (CDC)', *Australian Centre for Disease Control* (Web Page, 6 November 2025) <https://www.cdc.gov.au/about/about-interim-australian-centre-disease-control-cdc>; Australian Department of Prime Minister and Cabinet (DPMC) (n 3).

[70] Finlay (n 2).

The report identified four key themes: (1) the importance of balancing the needs of community and individual rights; (2) having a broad approach can lead to ignoring of specific needs, with some people and populations falling through the cracks; (3) key communication gaps need to be considered and addressed; and (4) having a narrow perspective (terms of reference) leads to inflexibility.[71]

[71] Ibid.

Methods

The Pandemic Preparedness Project consisted of three (3) overarching project activity stages.

1. Project planning and preparatory stage	2. Data collection stage	3. Data analysis and reporting stage
♦ Early engagement and information provision to AIVL DUO Members, foreshadowing the project and participation.	♦ Completion and collection of the survey outline for services by AIVL members.	♦ Information and data transfer to thematic analyses frameworks.
♦ Project information and research tool development, including preparation of paper and online versions of a project information sheet, consent form and survey outline.	♦ Engagement of people who use/d drugs (PWUD) by DUO to complete the survey for individuals.	♦ Thematic analyses of service and individual survey responses.
♦ Data collection framework preparation.	♦ Engage with participating DUO services to collect copies of individual consent forms and surveys.	♦ Comparison of research evidence against survey responses.
♦ Confirm AIVL Member participation and project assistance.	♦ Desktop literature review of evidence from international and national research.	♦ Report writing and editing stage and feedback to AIVL members and stakeholders.

During the start out planning and preparation stage, AIVL directly approached and invited all DUO to take part in the project in the following ways:

a) to complete the survey outline for providers based on their Covid-19 experience as a peer-based DUO

b) to actively support engagement and surveying of people who were using drugs during the pandemic, using the provided survey pack provided and prepared by AIVL.

All participating DUO were paid a nominal amount of cash for their participation in completing the surveys, to be able to pay participants, and to compensate for the resourcing provided in supporting participants to complete surveys. Online and paper survey options were made available to both services and individual participants.

Project information sheets for services and individuals outlined data collection, storage, ethics and confidentiality provisions, to enable participants to provide informed consent.

All individual survey responses were deidentified.

A thematic analysis process was applied to elicit outcomes and impacts arising from both the individual and provider surveys.

The literature review was conducted by internet search engine for peer-reviewed journal articles and grey literature including reports from government, civil society non-government organisations, and research institutes. Journal articles mostly comprised research about PWUD in Australia during the Covid-19 pandemic from 2020 to 2022, to a lesser extent the 'Black Summer' bushfires from 2019 to 2020 and floods in the Northern Rivers Region in 2022 and supplemented by international research on PWUD and Covid-19 where it aligned with experiences captured in our research.

Organisations and participants

There were two surveys used in the Pandemic Preparedness Project. One survey was completed by peer-organisations who had provided services to PWUD during the Covid-19 pandemic, and the other survey was completed by individuals who had used drugs and harm reduction services during the Covid-19 pandemic.

AIVL Members, state and territory DUOs and peer-based harm reduction services were invited to participate. Eligibility requirements for the organisational survey was: (a) that they had provided services to PWUD during the Covid-19 pandemic; and (b) were willing to complete the surveys.

Organisations were provided autonomy and choice on their representative to complete the survey. The person or people who completed the information signed a consent form agreeing they were authorised by their organisation to participate in the research.

Individual survey participants recruited by the participating AIVL member organisations using convenience, service-based, and snowballing sampling strategies. Participant eligibility was:

- have used drugs during the time asked about in the survey, and
- required or accessed a harm reduction service during this time.

All participants were provided the Participant Information Sheet and provided voluntary consent to participating in the research. All data was stored securely and was only accessible by the project team.

Qualitative data analysis

Qualitative data were reviewed and coded to organise and classify results, before themes were identified. A thematic analysis framework template was developed for both surveys and was structured and organised to reflect the main survey components and included questions within these separate sections.

The project's findings and this report's results, discussion and recommendations have also been supplemented, informed and validated by conversations between AIVL peer workers, and additional discussions with peer workers from AIVL Member Organisations. All results and information contained in this report is deidentified and does not name any individual the project team have spoken to or interviewed. The interview process did not record any names or individuals and similarly during the data collection, storage and analysis stages, no names were used or recorded.

Descriptive and summary statistical analyses were performed for the demographic data using Microsoft Excel for Mac. The open text responses about participants' gender, transformed to the 2020 ABS Standard[72], from 'female' to 'women', and 'male' to 'man'. Based on preferences for language among trans and gender diverse Australian adults,[73] we have reasonably assumed that all participants had a cis gender experience, noting the involvement of trans peers in reviewing this report.

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[72] Australian Bureau of Statistics (ABS), 'Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables', *ABS* (Web Page, 2020) <https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release> ('*2020 Standard*').

[73] Sav Zwickl et al, 'Language and Terminology to Describe Transgender Communities; Perspectives from People with Lived Experience' [2024] *International Journal of Transgender Health* 1 <https://doi.org/10.1080/26895269.2024.2415684>.

Results

Pandemic Preparedness Project

Demographic profile and characteristics of participants

Self-identified gender and state or territory of residence during Covid-19

There were fourteen (14) individual respondents to the AIVL pandemic preparedness Survey, including nine (9) women and five (5) men. No participants reported their gender as non-binary/gender diverse.

Overall, most participants were women (64.3%) compared to men (35.7%) and in Northern Territory and Tasmania, all participants were women. The proportions of women and men for each state and territory are presented in Table 3). Nearly two-thirds of participants (36%) came from South Australia, just over one-quarter of participants were each from Northern Territory (29%) and Queensland (29%) and 7% were from Tasmania.

Table 3: Participants' gender, by state/territory and nationally, proportion (%)

	Women N (%)	**Men** N (%)
Queensland (Qld)	2 (22)	2 (40)
Northern Territory (NT)	4 (44)	-
South Australia (SA)	2 (22)	3 (60)
Tasmania (Tas)	1 (11.1)	-
Nationally (Aust)	9 (64.3)	5 (35.7)

Type of location

Most participants (85.7%) lived in major cities compared to those residing in regional town locations (14.3%) during the Covid-19 Pandemic. Attempts were made to reach more people in regional areas by providing the survey online and actively promoting the survey to this demographic.

The greater proportion of participants who resided in city locations is not surprising—all participating services were based in capital city locations and most participants heard about the survey from those services. As noted earlier in the report, access and availability of services and the challenges these bring for PWUD living in regional, rural, remote and very remote locations compared to PWUD living in major cities. The experiences of PWUD living in non-urban areas may not be fully captured in our research.

Age range and Indigenous status

The median age for all individual survey respondents was 40.5 years, with a range of 25 to 66 years old. Median refers to the 'middle' age of all participants, meaning 50% of participants were younger than 40.5 years and 50% were older than 40.5 years.

One participant identified as Aboriginal and Torres Strait Islander. All other participants reported their cultural background as non-Indigenous Australian.

Service providers

Profile and characteristics of participating services

A total of five (5) completed provider responses were received from:

- three (3) Drug User Organisations (DUOs) who provided services and/or advocacy during the Covid-19 pandemic
- one (1) harm reduction and AOD service provider organisation who provided services during the Covid-19 pandemic
- one (1) DUO that did not provide services during the Covid-19 pandemic but had reflections and important insights to contribute to the findings.

The survey responses from organisations were provided by:

- QuIHN – Queensland Injectors Health Network
- QuIVAA – the Queensland peer-led drug user organisation
- NTAHC – Northern Territory AIDS and Hepatitis Council
- SAhrps – South Australia Harm Reduction Peer Service
- TUHSL – Tasmanian Users' Health and Support League

The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) participated in a telephone interview.

Types of services

Each participating agency has harm reduction as part of its core business. The oldest contributing agency was from the Northern Territory (est. 1986), followed by QuIVAA (1988), QuIHN (2004); South Australia (2013); and TUHSL (2023).

The Northern Territory and Queensland services reported delivering peer-based harm reduction services to PWUD across *all* geographic levels (i.e., including urban, regional and remote locations). The participating agency from South Australia reported servicing primarily urban populations of PWUD.

Contributions to the report

The DUOs that completed the provider survey are the same organisations that supported and assisted in recruiting local people from their respective state/territory jurisdiction to complete the AIVL Pandemic Preparedness survey for individuals who used drugs during the Covid-19 pandemic. Participating jurisdictions were asked to set a target of ten (10) individual surveys with PWUD. Each participating service site was provided a $500 cash contribution to assist toward their project contributions (as well as the contributions paid to individual participants).

What people told us about their COVID experiences

The survey results highlight a range of experiences faced by PWUD during the Covid-19 pandemic. Several key themes and trends emerged from the responses - reflecting the impact of the pandemic on drug use, health, social and emotional wellbeing, financial stress and service access.

Challenges in drug access and pricing

Participants reported poor quality, limited availability and increased prices for all drugs during the pandemic, corroborating the anecdotal evidence from peer workers and services and published research. The significant spike in cost of *all* drugs during the pandemic for substances that are already artificially inflated was particularly difficult for people with a drug dependence. The poor quality and limited availability of drugs led to changes in the types of drugs people were able to access and use, and the way they used them.

People who use/d drugs experienced direct impacts such as decreased access to harm reduction and drug treatment services, experienced drug withdrawals, and financial insecurity. These issues also had the potential to increase harms such as use of more harmful drugs, injury and/or overdose due to adulteration in supply.

Drugs changed. The quality was affected for a short while too.
Woman, 40-49 years old, Queensland (city)

People are cutting drugs for profit but accessing
a nasal spray is harder than getting the drugs.
Woman, 20-29 years old, South Australia (regional)

Quality went way down. Everything costs more.
Man, 30-39 years old, South Australia (city)

It was hard to find and expensive, hard to get equipment…
I could get weed so easy, but it was a mad mission to get meth.
Woman, 30-39 years old, Northern Territory (regional)

Mental health and wellbeing

The impact of changing conditions, travel restrictions, lockdowns and reduced family connections and social interactions significantly impacted participants mental health during the Covid-19 pandemic. Several participants reported isolation as being a major contributing factor to mental ill health and reduced wellbeing.

Isolation hurt me badly.
Staying home (was) not good for (my) mental health.

Man, 50-59 years old, South Australia (city)

I have experienced long terms impacts with mental health, stress and using, and feel like the world is more fucked up now since Covid-19
Women, 40-49 years old, Queensland (city)

Some participants reported finding the changing policies related to lockdowns and the additional conditions and targeting they felt during the pandemic impacted their mental health. Different regions and locations experienced different conditions, while these also changed frequently over time, leading to more uncertainty. Some participants reported they felt people who were most vulnerable or marginalised experienced the worst impacts from these changing policies and practices.

Being isolated for a couple years definitely brings on anxiety and takes away some social skills.
Women, 20-29 years old, Northern Territory (city)

Some friends have ongoing issues with their mental health – don't go out as much. Still feel vulnerable and isolate at home, don't like crowds.
Woman, 60-69 years old, North Territory (city)

Lockdown measures left some people feeling trapped, with those who were particularly vulnerable or restricted by circumstance, such as older participants and people with older family members and networks, noticing significant isolation during times of travel restrictions. Some participants were housed in institutions and other places that implemented stricter measures. These were reported to contribute to feelings of increased isolation and vulnerability.

> *The uncertainty about when and how long lockdowns would occur during COVID has resulted in a greater appreciation of the freedom to travel and to enjoy the company of others.*
>
> **Women, 60-69 years old, Northern Territory (city)**

Some participants identified isolation having ongoing impacts on their mental health and wellbeing, confidence, social skills and social and emotional wellbeing. They reported people from their communities having similar struggles, contributing to feelings of mass uncertainty. In contrast, some participants reported new appreciation for their family and social relationships and the ability to travel freely once the restrictions and lockdowns were lifted.

Criminalisation and policing

Some participants reported feeling more visible to law enforcement as PWUD during the Covid-19 pandemic. Some participants needed to travel to areas known for having high numbers of PWUD and high police presence to access ODTP or to buy drugs. This put them in a position of vulnerability to police interactions and Covid-19 related travel fines. The survey did not ask questions about infringement notices and court appearances related to increased policing. Having fewer people around meant some people felt particularly noticeable while they were in public, as one participant reflected:

> *Lockdowns were hard. With no one around – no one on public transport, no one on roads, I felt exposed and like I was more of a target for cops.*
>
> **Woman, 40-49 years old, Queensland (city)**

Cops were out enforcing lockdowns, making it hard to support my habit.

Woman, 40-49 years old, Queensland (city)

Access to harm reduction, AOD, health and social services

Participants reported varied experiences access to harm reduction, AOD, health and social services. There were several reports of inconsistent and varying operational rules within and between different states and territories and that these were inconsistently rolled out and communicated. While different participants reported continued or enhanced access to needle and syringe programs. Some participants reported services to be more siloed during the lockdown, leading to reductions in the range of services they had previously been able to access. This seemed particularly challenging for some participants who had trouble finding a safe needle and syringe disposal method they could access during times of restricted travel. The changeable nature of services and poor communication of changes reported by some participants contributed to stress and distrust in public health systems and health information messaging.

Services all freaked out and closed but user groups were tight and stayed open providing maximum equipment and sterile water. Also ended up able to get tournies [tourniquets] and water at no cost.

Woman, 20-29 years, South Australia (city and regional)

Closure of services was commonly reported alongside significantly reduced access to AOD, health and social services. Some people reported feeling they were left out of services where there was increased demand, such as those that provided material aid to unemployed people. Some participants felt their identity as PWUD kept them from having the same access to services as others. These findings corroborate the research and anecdotal reporting of peer workers and PWUD.

We count as much as anyone else. Health services are essential.

Women, 20-29 years old, South Australia (city)

I noticed some needle and syringe program providers, got proper PPE for the non-NSP workers, and the NSP workers shielded their counter with cardboard, where are receptionist desks at the same organisation had Perspex screens… the NSP workers… could only see our faces and reach to give us our equipment over the barrier. I could tell that the orgs that did this, didn't really care about us, or the NSP or the NSP workers by not providing them with appropriate PPE.

Women, 40-49 years old, Tasmania (city)

Some participants also noted broader restrictions such as Covid-19 border controls had an impact on access to essential supplies. For one participant, the pandemic had a positive effect, with this person attributing the new availability of free wheel filters and sterile water in their state's needle and syringe programs as coming from increased resourcing for PWUD. Another participant thought the pandemic had a negative effect on access to resources. The life-saving opioid overdose response medication, naloxone, was limited in availability due to regulatory barriers in some jurisdictions.

I needed naloxone nasal spray, but the chemists kept saying they didn't have any and NSP are not able to hand it out which is ridiculous.

Woman, 20-29 years old, South Australia (city)

Changes to the way some AOD and support services were provided received mixed reports. Some participants reported the availability of telehealth for opioid dependence treatment and other medical appointments, and phone and online counselling and support services had benefits for their access to these services. Some of these participants also identified that having these options and therefore more accessibility to services reduced their feelings of stress and anxiety.

Other participants reported difficulty accessing medical, counselling and support services during the pandemic because they didn't have access to a personal phone, computer or the data to maintain

online services. These findings support research and reports that suggest having a range of options is necessary to ensure

Peer-led drug user organisations and peer support

Many survey participants reported their appreciation for peer workers and peer-led drug user organisations. Survey participants were recruited mainly through peer-led drug user organisations, and this may have led to biased results as the participants already had a good opinion of peer-led services. However, several participants noted the drug user organisation they accessed during the Covid-19 pandemic went out of their way to be flexible and adaptive in comparison to other services. S

Some participants accessed needles and syringes from peer outreach workers who operated during the pandemic, some accessed peer-led and operated services at extended times including weekends, and some were able to access other services through peer workers such as food parcels that were no longer being provided by other services.

The flexibility and adaptability of peer workers was a feature of several surveys, However, there were also noticeable differences between jurisdictions and in different areas. Where the drug user organisation or harm reduction service was able to be flexible and had resourcing to offer a greater range of services, participants could access new injecting equipment and services in a range of ways such as through outreach.

A peer NSP worker, discreetly sent an uber with fresh equipment to my quarantine hotel… I really appreciated that.

Women, 40-49 years old, Tasmania (city)

Where resourcing was not as available, PWUD found other ways to adapt and support their peers. One respondent reported that dealers were providing new injecting equipment to their customers, which they identified as *"exceptional harm reduction"*. These findings align with evidence from research in which some PWUD and who may not also be people who deal drugs also play a leadership role in their local communities by providing injecting equipment to people who need it. These people may also play roles in educating their peers about safer injecting and blood borne virus prevention and support.

Opioid dependence treatment adaptations

Opioid dependence treatment is often thought to be inflexible and difficult to access. During the Covid-19 pandemic, most jurisdictions provided more flexibility in the program, with many people being provided telehealth options for prescriber appointments, more take-home doses and the option to have a nominated authorised contact to deliver doses to people who were ill or in quarantine.

> *The Chemist trusted me to pick up a week's worth of sub for my friend, who was quarantining at home. The chemist knew I was on the program, and they let me take a week's worth of s8 [schedule 8 medicines]. I never thought that would ever happen*
>
> **Woman, 40-49 years old, Tasmania (city)**

> *Got extra TAs [take aways] from chemist but hard to talk to doc on phone.*
>
> **Man, 30-39 years old, South Australia (city)**

Participants reported positively about the flexibility, including that they found it easier to follow advice about quarantining when unwell and avoiding travel. We heard that people were less likely to risk Covid-19 exposure for themselves and others, and less likely to have negative interactions with law enforcement. Having more flexibility in ODTP and the subsequent lowering of risks was reported to decrease stress and anxiety for these participants. Adaptions to ODT programs, benefits, and immediate outcomes are summarised in Table 4.

Conversely, some participants reported issues with access to their opioid dependence treatment. The main issues were service closures and reduced hours, most likely resulting from worker illness and inability to find staff. In addition, issues such as service closures and closures due to unavailability of staff may be of particular concern in regional areas where natural and environmental disasters are likely, and where there are few if any other options available when a service or worker is unavailable. Challenges for adapted ODT programs are summarised in Table 5.

Table 4: Adaptations to opiate dependence treatment programs during Covid-19 pandemic

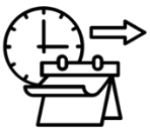
Adaptations to ODT programs	
Topic or theme	**Benefits**
Telehealth services 	Increased access to: • health consultations • therapy sessions • prescription management
Relaxed regulations 	Longer prescriptions Increased take-home doses of methadone and buprenorphine
Home delivery 	Harm reduction supplies like naloxone and urine drug screening kits
Long-acting medications 	Expanded use of long-acting opioid medications Less frequent dosing
Immediate outcomes	
 Reduced impact of lockdowns	 Access and receive health care remotely
 People maintained their treatment routines	 Access to harm reduction supplies
 Reduced frequency of pharmacy and clinic visits	 Connected to peers and peer organisations

Table 5: Challenges with opiate dependence treatment programs during Covid-19 pandemic

Challenges with adaptations to ODT programs	
Topic or theme	**Impact**
Logistical issues 	Coordinating deliveries Greatest impact in remote communities
Health and medical privacy 	Harm reduction and AOD programs and services sometimes delivered take-home doses Increased concerns about confidentiality and privacy
Security concerns 	Safe and secure delivery of medications increased for people receiving OST, medicinal cannabis, ADHD meds
Risk of diversion 	perceived increased risk of medication diversion by police and authorities reduced trust between people receiving ODT and providers

Economic and housing stress

The issue of financial stress and housing was reported by several participants. Access to housing on the private rental market, people in public housing, and people who were experiencing primary, secondary and tertiary forms of homelessness was noted to be different across different jurisdictions.

In some locations, additional accommodation options were made available for people who were unhoused. Some participants in these locations reported they continued to feel anxious about their housing options even while they were accommodated. They noted the ongoing stress of knowing their accommodation was not stable. Other participants positively noted there were accommodation options that remained long after the Covid-19 pandemic restrictions ended.

Personally, it affected my housing as landlord wanted to increase rent.
Man, 30-39 years old, Queensland (city)

I'm fortunate to have stable housing and employment.
Woman, 60-69 years old, Northern Territory (city)

Several participants mentioned worsening financial strain because of the Covid-19 pandemic, some of which was related to rising rental costs. While different participants reported financial stress contributed to concerns about housing affordability.

Several participants reported the significantly higher prices of the drugs used contributed to their worse financial situations. Conversely, some participants shared that they had reduced their drug use during this time and felt this had been a positive outcome. Some participants reported accessing cash, a necessary part of buying drugs, was very difficult. The closure of automatic teller machines contributed to some participants having to travel further distances than they felt comfortable travelling and made it harder to access the substances they were trying to buy.

Banks are all closing and the ATMs are even gone. Shops shut. Everyone is running but we have nowhere to go.
Man, 30-39 years old, South Australia (city)

Managed to cut down which I wanted to do anyway. I had more savings.
Women, 40-49 years old, South Australia (city)

Covid affected people no longer using cash. It's harder to find an ATM these days, and have to travel further and inconveniently to do so, no one uses cash anymore, so this makes it hard and suspicious.

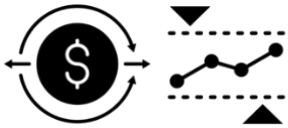
Women, 40-49 years old, Queensland (city)

These findings speak to some of the complexities PWUD faced during the pandemic. Mental health concerns, particularly anxiety and stress, contribute to and are caused by many other real concerns including experience of criminalisation, stigma and discrimination.

Summary of individual results

The individual survey results illustrate the complex interplay of challenges and adaptations faced by PWUD during the Covid-19 pandemic, as described in Table 6. While many experienced heightened risks to their mental health and difficulties in accessing drugs and services, innovations in service delivery and the commitment of peer workers provided some positive outcomes. The findings underscore the need for tailored responses that account for regional disparities and the involvement of PWUD in responses to meet the unique needs of this population during public health crises.

Table 6: Reported personal impacts of the Covid-19 pandemic

Topic or theme	Personal impacts
Flexibility in treatment 	Greater flexibility for ODTP provision Return to pre-pandemic service delivery models
Time-capped services and programs 	Funded pandemic response services and programs addressed unmet needs Non-ongoing funding, services ceased leading to return of unmet needs
Changes in drugs markets 	Changes to availability, quality, and prices influenced patterns of use Increased risk of overdose and harms
Increased surveillance 	Felt more visible and more likely targeted by authorities Impacted decisions to access services like NSPs
Mental health 	Provision of mental health support through telehealth Social isolation, changes in patterns of drug use, affordability and accessibility of mental health care

What services told us about their Covid-19 experience

Experiences of people who use/d drugs accessing, using, and receiving peer-led harm reduction services

Peer-led harm reduction services participating in this project reported experiencing significant challenges and necessary adaptations relating to regulations, policies, environmental issues, staffing and needs of PWUD. Several key themes were reported based on interactions and conversations with people using peer-based harm reduction services during Covid-19.

Aboriginal and Torres Strait Islander peoples

We heard that Aboriginal and Torres Strait Islander peoples who accessed peer-led harm reduction services had additional challenges during the Covid-19 pandemic. These reports mirror the findings of published research, having specific challenges with increased law enforcement interactions, social issues, complex health concerns, and vulnerability to Covid-19.

Access to internet, smart phones limited

Accessing information about changing regulations and service options due to limited availability of devices and technology. Some PWUD, such as people who were living in unstable or assisted accommodation, did not have smartphones or computers, while others did not have access to the internet. Inconsistent or no internet access made it harder for people to contact the services and to know when there were changes related to Covid-19.

Adaptable flexible services provision was positive for PWUD

Flexible and adapted service provision was beneficial for many PWUD. For example, the growth of outreach models providing injecting equipment, more flexible ODT delivery for people in quarantine, and telehealth and phone options for people accessing ODT prescriptions, counselling and support. More flexible and accessible brokerage options to pay for medications and technology also significantly contributed to service users being able to access opioid dependence treatment, outreach and support. These kinds of resources had previously not been accessible in programs for PWUD in most locations and services.

Conversely, service providers reported lockdowns and travel restrictions impacted the ability of PWUD to access their services, as well as other important health and social services at a time.

Services reported issues for PWUD in accessing some specific harm reduction resources including the life-saving medication naloxone and some specific injecting equipment supplies that were previously available. Some of these challenges were specific to jurisdictions and even services, while others appeared to be Australia-wide.

AOD treatment services, mental health challenges, housing, and harm reduction to prisons

We heard restriction in available AOD treatment services were reported as a significant barrier for PWUD during the Covid-19 pandemic. Residential facilities were particularly limited during this time, which was also a time of increased need for people who were faced with higher prices and less availability of all drugs. People with a dependence were the most affected by the sudden loss of AOD treatment access. The closure and inaccessibility of other services was reported to result in more complexity and need in the community of PWUD peer-led harm reduction services did see.

Service providers reported the PWUD they worked with had similar mental health challenges including stress and anxiety as reported by individual survey responders. Service providers reported additional issues with accessing mental health supports relating to people's access to the technology required after face-to-face services were closed or changed to telehealth and phone-based models.

People who were homeless and transient were reported as having different accommodation challenges across different jurisdictions. Many of the challenges experienced by this community increased over the course of the pandemic. Most accommodation options were short term, and many expired at the time of or soon after the Covid-19 lockdown restrictions ended. As a result, many of the people who had been accommodated during parts of the pandemic fell back into homelessness when their accommodation was taken away.

Delivery of services to people in prisons was more of a challenge during the pandemic. These challenges tended to impact people in prisons across the country. However, in some jurisdictions, service providers believed there were efforts to reduce the numbers of people being imprisoned.

Experiences of peer-led harm reduction services

Adaptation and flexibility

Every one of the organisations that provided services during the Covid-19 pandemic reported they were under extreme pressure to learn new skills and be constantly flexible and adaptable.

Organisations reported constantly changing regulations relating to how services were delivered. Social distancing rules, regulations relating to hygiene, and other protocols required services to quickly install physical barriers and procure safety equipment for systems and staff, measures that came with unplanned financial costs. Maintaining compliance with these evolving occupational health and safety standards required constant vigilance and response from multiple people in the workforce. New regulations and requirements including announcements of restrictions at any time and implemented with very little time to prepare. Most of the organisations found their limited resources were stretched by the challenges of meeting these requirements in the little time given to adapt to them.

Significant stress was placed on organisations having to manage procurement and stock supply for the people and their households accessing, using and receiving harm reduction services. Some services were constrained by storage issues. Accessing personal protective equipment was extremely difficult for many organisations during this time, taking a lot of time, human resources capacity, and sometimes coming at high financial cost, especially when demand in the community exceeded supply.

Resourcing to meet needs of staff and service users

Extra government funding was provided to some of the drug user organisations and harm reduction services participants, during and after the Covid-19 pandemic. These additional financial resources assisted with service adaptations including funds for increased human resources, and physical and structural changes to the services. However, most continued to find leadership and workers were under constant pressure to understand and adapt to the changing regulations in the workplace.

Most services that remained open found they were filling gaps in service provision as different health and social services changed, reduced their operations, or closed altogether. Many of the peer-led and harm reduction services had to upskill workers in understanding and using new technology as well as bring on new workers, many of whom were casual. Significant resourcing was required to employ the casual workforce, provide skills training to workers, and support these larger mixed workforces of new and existing casual, part time and permanent workers in new programs and changeable policy and service environments. Most workers understood their positions would not be sustainable beyond the period of additional government funding. Nevertheless, peer workers developed skills and resilience needed to manage work and life balance was especially necessary in these challenging times. Many workers took on extra hours, supported people in their local communities and experienced significant stress relating to the public health measures and rapidly changing situation.

Case Study 2: Canberra Alliance for Harm Minimisation and Advocacy brokerage service

The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) was able to use A$10,000 of funding to provide an individual brokerage program that allowed people using the service to receive vital necessities including prepaid smart phones and mobile data packs. The devices could perform necessary functions and could be used to access information and contact services. These peers would have been detrimentally left behind if the brokerage service hadn't of been available.

CAHMA was also successful in securing monies to enable an active outreach program that provided necessities like groceries and medications to peers in lockdown or quarantine at home. Government recognised the vital role that peers workers with lived-living experience provided during the pandemic in reaching PWUD.

Staff health and wellbeing and retention

Some of the services that participated in surveys reported maintaining staff and supporting staff during the pandemic was a significant challenge. The challenges were mainly about the employment of PWUD who have complex health needs, such as older PWUD, and the ongoing challenge all essential services during the Covid-19 pandemic, with regulations at some points in time requiring people who may have been exposed to the virus to quarantine for 15 days. These challenges hit the services who were small and more resource limited, such as most drug user organisations, particularly hard. Significant resources went into finding and paying for casual staff time, and upskilling new casual workers to participate in the expanding range of services some provided, including outreach programs and material aid distribution

Direct organisational and peer-led harm reduction services impacts

- **Restricted movement and services access and use:** general movement restrictions severely impacted people's access to and use and receipt of services. Navigating the evolving policy and lockdown changes in each jurisdiction and its local areas, to retain and responsive and accessible services to PWUD required consistent creativity, adaptation, and flexibility.

- **Workplaces were redesigned**: workplaces had to redesign physical elements to ensure physical distancing protocols were maintained and compliance with evolving workplace health and safety standards during the pandemic.

- **New technology was rapidly adoption**: both workers and people using the services had to rapidly adapt to new technologies as part of access to, use and receipt of / provision of services. Individual survey responses and discussions with peers and peer workers corroborated that the pressure on PWUD to keep up with latest technology demands and have access to appropriate devices to be able to scan things like QR codes.

- **Internal meetings increased in frequency**: there was a notable rise in internal meetings and demands at all levels of service delivery. This was seen as vital enabler and strength factor in ensuring compliant operations and workplace health and safety procedures – with every worker deeply aware of their role, operating requirements, and how that contributed to/and supported the rest of the team in maintaining the full breadth of services and supports in place.

- **Managed financial and human resource constraints**: difficulty in accessing necessary personal protective equipment (PPE) led to increased workloads related to budget management and stock monitoring. The situation of managing exponential levels of compounded personal and community need, with finite monies and resources, and in a climate where the cost of living was ever rising.

- **Planned and consulted PWUD**: significant planning, workforce consultation, and workplace health and safety management were required to navigate the crisis. The input of peers and peer workers was also of absolute necessity – as it was their lived-living experiences. Direct personal familiarity with navigating the range of constantly evolving challenges informed and supported peer-led harm reduction services to plan and implement genuinely response, accessible and appropriate service responses for PWUD.

- **Decentralised business continuity**: business continuity responses varied across different services and geographic areas vastly. This necessitated decentralised services responses, governed and directed by local needs and evolving policies.

- **Quality and breadth of services thinned and diminished**: drug user organisations and peer-based harm reduction services were forthcoming in reporting that the pandemic overtly impacted the completeness of their services, as well as other frontline providers delivering integral services and supports to PWUD. Reports from services and individuals showed that

while peoples' needs grew and compounded, services and supports often thinned and diminished, and certainly became a lot more complicated to navigate and access.

- **Equipment provision**: essential equipment was delivered with social distancing measures, though limited supplies were a challenge. Maintenance of core needle and syringe program (NSP) services by meeting and applying continuously evolving Covid-19 directives and service standards was the main enabling factor behind DUOs and peer-based harm reduction services to keep NSP services operational. Participants noted the continual delivery of NSP services to be a standout achievement by the organisation and workforce.

Worker health and wellbeing and retention

The health and wellbeing of workers and challenges in retaining workforce consistently hindered and challenged service availability. There was a requirement from government funders that harm reduction services implement mandatory vaccination requirements for frontline workers. Peer workers in these services felt that this was not the case for a lot of other sectors and providers. We heard that mandatory vaccine requirements contributed to people leaving their employment.

Workers' health and wellbeing was impacted directly such as the acute phase and recovery from Covid-19 infection, the level of vaccination among their household and networks, and level of compliance with public health orders and social practices to prevent Covid-19. Workers' health and wellbeing was indirectly impacted by the personal management of chronic health conditions, including mental health, disability, vicarious trauma at work and in the community, access to medications including pharmacotherapy, and constant and rapid changes to their workplace.

Challenges and achievements

- **Compromised services in prison settings**: lockdowns in prisons affected the delivery of comprehensive services to incarcerated individuals. Contributing providers cited the negative impact of the pandemic on incarcerated persons, whose access to supports was majorly affected in these settings. Despite these generally negative impacts on incarcerated persons during the pandemic, informal conversations with peers and peer workers did elicit that in some locations during the pandemic, there was a tendency to try and avoid imprisoning people if they could avoid it, opting more so for community correction orders where this was an appropriate punishment, to avoid compounding recognised issues and challenges in the prisons systems.

- **AOD residential facilities**: public health orders restricting freedom of movement created barriers to access and challenges in delivering services within Alcohol and Other Drugs (AOD) residential facilities.

- **Naloxone access**: access to take-home naloxone through national clinical trials was interrupted in some jurisdictions that necessitated expedited regulatory approvals to mitigate supply issues. Services reported slowed distribution and access to the life-saving drug.

- **Decentralised consultation with peer workforce led to innovation**: extensive consultations with peer workforce led to innovative solutions in service continuity and management of workplace health and safety. Peers are well placed to understand need, innovate, plan, and deliver services to their communities.

- **New programs were responsive to need**: services rapidly developed and implemented needs-based programs, including telehealth psychiatry access, outreach teams for homelessness, and seasonal vaccination clinics. Interviews with peer workers highlighted the rapid development of needs-based and individualised services by peer-based harm reduction services during the pandemic. Most organisations, even with additional funding, relied on the goodwill and motivation of their workers to stretch their resources as far as possible and fill as many gaps in services as they could for their local community members.

- **Resilient service delivery**: despite the noted challenges, services reported incredible resilience and innovation. Examples include successful maintenance of NSP services by meeting and observing all regulatory actions and requirements. NTAHC sighted the distinct lower number of lockdowns in their jurisdiction as being evidence of the efficacy of the territory's quarantine facility and approach in reducing impact of Covid-19 infection.

Impact on groups of people who/d use drugs

- **Aboriginal and Torres Strait Islander communities**: access to services was particularly challenging for Aboriginal and Torres Strait Islander communities due to movement restrictions and localised outbreaks, low trust of government information about health, and increased surveillance and biased policing.

- **People experiencing homelessness**: coordination of health, housing, and other supports for people experiencing all forms of homelessness,[74] particularly for those in need of supported accommodation, became increasingly difficult. As noted, there were stark differences in the quality and type of housing responses provided jurisdiction to jurisdiction, let alone region to region. Housing responses providing during the pandemic were typically short-term and generally expired when the lockdowns were formally lifted – with many people falling back into homelessness.

- **People with low digital literacy or lacking access to technology**: transitioning to online services posed challenges for many, particularly for those lacking technology or with low digital literacy, leaving some feeling left behind. Interviews with peer workers corroborated the need and demand among peers for technological upgrades to smart phones, to be able to follow new regulations, such as stay up to date with things like check-in requirements when going out, and to give them some sense of mobility and capacity to be out and about.

- **People living outside of non-major capital cities:** pandemic responses varied greatly within states and territories and comparatively. Beyond the overt impacts on service accessibility and availability, we heard about the negative social and emotional impacts created by public health orders contributed to feelings of isolation while also fuelling resentment between different locations about the unequal response across the nation. People who use/d drugs recognised the importance of being able to access sterile equipment through delivery and outreach type services. There were distinct differences between states and territories in the extent to which NSP remained active.

The survey results reveal a complex interplay of interpersonal, workforce, and service delivery responsive to the changing circumstances of Covid-19. AIVL Member insights underscore the need and benefits of peer-led initiatives and the importance of adapting health services to meet changing needs and embodying flexible delivery models and approaches that include active outreach and home visit options.

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[74] The Australian Bureau of Statistics categorises six different types of homelessness: 1. Persons living in impoverished dwellings, tents or sleeping out; 2. Persons in supported accommodation; 3. Persons staying temporarily with other households; 4. Persons living in boarding houses; 5. Persons in other temporary lodgings; 6. Persons living in severely crowded dwellings. Australian Bureau of Statistics, 'Estimating Homelessness: Census 2021', *ABS* (Web Page, 22 March 2023) <https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#homeless-operational-groups>.

Discussion

Experiences and impacts arising from the Covid-19 pandemic

The qualitative research conducted for this project, along with published literature, elicited clear and distinct themes of personal, service, and system level challenges encountered during the Covid-19 pandemic. People who use/d drugs told us that that any person using drugs of any kind during the pandemic were adversely affected by common sets of factors and experiences. While we are a non-homogenous community with unique identities and experiences; PWUD did face common challenges that were directly linked to the pandemic. Overarching common challenges PWUD experienced, included:

- significantly reduced drug quality and supply, coupled with elevated cost and expenditure – influencing and altering many peoples' usage
- restricted movement and isolation, precipitating significant rises in mental health and feelings of anxiety and vulnerability when moving about due to reduced traffic/people presence, and easy targeting by authorities
- deleterious social and emotional and mental health experiences arising – and often compounded by issues of loneliness and isolation due to lockdowns and movement restrictions, and uncertainty
- strained harm reduction equipment supply and access
- compounding complex issues of homelessness and housing insecurity
- delivery of complete and wrap around services to people in the criminal justice system
- access and entry to residential AOD services.

Key populations within PWUD had especially distinct and complex needs that were compounded and worsened by the pandemic such as Aboriginal and Torres Strait Islander people, who are already face significant gaps in health outcomes when compared to non-Indigenous Australians.

Responses from DUO services corroborated a surge in demand for NSP and harm reduction services Australia wide. Services also reported significant elevations in workloads and the increased internal meeting requirements. Significant planning and reorganisation of workforce was also a

requirement, to be able to meet evolving operating procedures, and respond to prominent levels of staff turnover on account of sickness.

Flexibility, adaptivity and innovation appeared as critical enablers for effective service continuation. While services did cite gaps and concerns about maintaining a complete range of wrap-around services and supports, there was a clear commitment and dedication at management and operational levels to adapt with continually evolving policies and lockdown requirements. People who use/d drugs also cited flexibility and adaptivity as enablers for effective ODTP maintenance and delivery during the pandemic. Increased takeaway doses and options to have a nominated authorised contact collect doses was an unprecedented benefit to people on OSTP.

Feedback from services and PWUD elicited common experiences across the jurisdictions of having innovative pandemic responses abruptly finish and funding cease – despite what has been a continuation and on-flow of continued wrap-around health and social needs. The Northern Territory cited the quarantine facility in their jurisdiction as implicit to their jurisdiction avoiding lockdowns and recommended this should be a future consideration in any future responses to pandemic/disaster events.

Despite the rollback of many pandemic projects and responses, there was consensus that harm reduction was better understood and applied at government and policy levels. The demonstrated experience of AIVL Member services during the pandemic highlights the benefits and value of peer-led approaches to pandemics and climate disasters – supplementing the growing evidence base and state and national government recognition of the need, use and importance of the meaningful involvement of PWUD. AIVL Members reported a general rise in population health literacy and awareness as an outcome of national and state level health promotion and prevention information and education.

What PWUD and DUOs recommend for future pandemic preparedness

The project elicited clear themes and trends in terms of what PWUD and DUOs recommend for future pandemic preparedness. Headline feedback points emphasised the need for and importance of maintenance and where possible, expansion of core and wrap-around services like OST and NSPs. Both DUOs and PWUD cited the need to expect and prepare for elevated service support and equipment needs in the event of a future pandemic or climate-emergency-related disaster event.

Table 7: Lessons for future pandemics and climate disaster responses relating to opiate dependence treatment programs

Lessons for future pandemics and climate disaster responses			
	Incorporate the values and preferences of person receiving ODT		Include ODT programs in plans for rural and remote communities
	Medications delivered by trusted person		Training and education for first responders

Our research found it is important to maintain the full range of support and assistance services, by innovating and adapting to ensure legislative compliance whilst responding to individual needs. Taking a human rights approach where 'no one gets left behind' was also identified as an overt underlying enabler and protocol that should be observed. Many respondents reiterated the need for services to stay true to their human rights and social justice values – especially in times such as the pandemic – so that services and programs are planned and delivered with inclusivity and wrap-around needs at the forefront of services' minds. A human rights-based approach is consistent with the Australian Human Rights Commission review into Australia's pandemic response.

AIVL members also reported the need for and importance of heightened internal planning and discussions that involves PWUD, and meetings with workforce to implement whole-of-team responses where everyone understood their role and adjusted operating requirements. The importance of supporting peer workers to be pandemic confident and ready by providing specific training and upskilling that ensures workers are ready for any number of disaster scenarios is recommended.

Equipment delivery and outreach options, coupled with increased availability of free vending machines, were cited as crucial responses for future pandemic preparedness. Drop-in centres and creation of safe spaces for PWUD were identified as enablers for future preparedness, alongside strengthened housing and homelessness responses.

There was consensus that future pandemic response requires bolstered housing responses that are genuinely capable of achieving real and sustainable housing and accommodation outcomes. Mental health was also flagged as critical priority for future pandemic preparedness. PWUD and the general population experienced compounded health, social and emotional challenges during the pandemic that saw significant rises in mental health and feelings of isolation.

The need for PWUD to be included and represented within the codesign and implementation of public health campaigns and heath promotion community was largely excluded from the public facing response on the part of government and media.

The Australian Government Inquiry Response Report recommends that under the National Communicable Diseases Plan, management plans are developed for priority populations that includes Aboriginal and Torres Strait Islander peoples, people with disability and disabled people, older people, culturally and racially marginalised (CARM) communities, children and young people, and people living in rural, regional and remote communities.[75] While PWUD fit the report's definition of priority population, and our lived-living experiences intersect with priority populations named, there is strong evidence that PWUD need population-specific management plans in the National Communicable Disease Plan that recognise the different health experiences of people with lived-living experience of drug use.[76]

[75] Ibid 19.

[76] The National Mental Health Commission, *The COVID-19 Pandemic through the Experiential Lens of Priority Population Groups* (Report, National Mental Health Commission, 2023) <https://www.mentalhealthcommission.gov.au/publications/covid-19-pandemic-through-experiential-lens-priority-populations>.

Bibliography

A. Articles/Books/Reports

Adams, Alison et al, 'The Impact of Relaxing Restrictions on Take-Home Doses during the COVID-19 Pandemic on Program Effectiveness and Client Experiences in Opioid Agonist Treatment: A Mixed Methods Systematic Review' (2023) 18(1) *Substance Abuse Treatment, Prevention, and Policy* 56 <https://doi.org/10.1186/s13011-023-00564-9>

Aponte-Melendez, Yesenia et al, 'The Impact of COVID-19 on People Who Inject Drugs in New York City: Increased Risk and Decreased Access to Services' (2021) 18(1) *Harm Reduction Journal* 118 <https://doi.org/10.1186/s12954-021-00568-3>

Australian Department of Prime Minister and Cabinet (DPMC), *COVID-19 Response Inquiry Report* (Report, Commonwealth of Australia, 2024) <https://www.pmc.gov.au/resources/covid-19-response-inquiry-report>

Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia Annual Report* (Web Report No 2020–21, AIHW, Australian Government, 2022) <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/archived-content>

Australian Public Service Commission, *State of the Service Report 2019-20* (Report, Australian Public Service Commission, 25 February 2021)

Aveyard, Paul et al, 'Association between Pre-Existing Respiratory Disease and Its Treatment, and Severe COVID-19: A Population Cohort Study' (2021) 9(8) *The Lancet Respiratory Medicine* 909 <https://doi.org/10.1016/S2213-2600(21)00095-3>

Biddle, Nicholas and Matthew Gray, *Service Usage and Services Gaps during the COVID-19 Pandemic* (Paper, Centre for Social Research and Methods, Australian National University, June 2020) <https://polis.cass.anu.edu.au/research/publications/service-usage-and-service-gaps-during-covid-19-pandemic>

Boon-Kuo, Louise et al, 'Policing Biosecurity: Police Enforcement of Special Measures in New South Wales and Victoria during the COVID-19 Pandemic' (2021) 33(1) *Current Issues in Criminal Justice* 76 <https://doi.org/10.1080/10345329.2020.1850144>

Boxall, Hayley and Anthony Morgan, *Intimate Partner Violence during the COVID-19 Pandemic: A Survey of Women in Australia* (Special Report No 11, Australia's National Research Organisation for Women's Safety Limited (ANROWS), October 2021) <https://www.aic.gov.au/publications/special/special-11>

Brener, Loren et al, 'Health Worker Perceptions of the Impact of COVID-19 on Harm Reduction Services for People Who Inject Drugs' (2022) 30(6) *Health & Social Care in the Community* 2320 <https://doi.org/10.1111/hsc.13782>

Caruana, Theresa, 'Medication Safety, Privacy, and Stigma: A Qualitative Study of Pharmacy Opioid Agonist Treatment Disruptions and Adaptations in the 2022 Northern Rivers Floods, Australia' (2024) 101 *International Journal of Disaster Risk Reduction* 104244 <https://www.sciencedirect.com/science/article/pii/S2212420924000062>

Dietze, Paul M and Amy Peacock, 'Illicit Drug Use and Harms in Australia in the Context of COVID-19 and Associated Restrictions: Anticipated Consequences and Initial Responses' (2020) 39(4) *Drug and Alcohol Review* 297 <https://doi.org/10.1111/dar.13079>

Efunnuga, Henrietta et al, 'Health Service Utilisation and Access for People Who Inject Drugs during COVID-19' (2022) 41(6) *Drug and Alcohol Review* 1304 <https://doi.org/10.1111/dar.13456>

Farhoudian, Ali et al, 'A Global Survey on Changes in the Supply, Price, and Use of Illicit Drugs and Alcohol, and Related Complications During the 2020 COVID-19 Pandemic' (2021) Volume 12-2021 *Frontiers in Psychiatry* <https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.646206>

Finlay, Lorraine et al, *Collateral Damage: What the Untold Stories from the COVID-19 Pandemic Reveal about Human Rights in Australia* (Report, Australian Human Rights Commission (AHRC), March 2025) <https://humanrights.gov.au/resource-hub/by-resource-type/publications/collateral-damage-report-australias-covid-19-pandemic>

Gowing, Linda et al, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (Guidelines, Australian Health Ministers' Advisory Council, Commonwealth of Australia, 2014) <https://www.health.gov.au/resources/publications/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence?language=en>

Harm Reduction International (HRI), *The Global State of Harm Reduction* (Report No 7, HRI, 2020) <https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2020/>

Hopkins, Tamar and Gordana Popovic, *Policing COVID-19 in Victoria: Exploring the Impact of Perceived Race in the Issuing of COVID-19 Fines during 2020* (Report, Inner Melbourne Community Legal, 2023) <https://policeaccountability.org.au/commentary/policing-covid-19-in-victoria/>

Hughes, Caitlin E et al, 'Drug-Related Police Encounters across the Globe: How Do They Compare?' (2018) 56 *International Journal of Drug Policy* 197 <https://www.sciencedirect.com/science/article/pii/S0955395918300756>

Iversen, Jenny et al, 'COVID-19 Vaccination among People Who Inject Drugs: Leaving No One Behind' (2021) 40(4) *Drug and Alcohol Review* 517 <https://doi.org/10.1111/dar.13273>

Kesten, Joanna M et al, 'Living Under Coronavirus and Injecting Drugs in Bristol (LUCID-B): A Qualitative Study of Experiences of COVID-19 among People Who Inject Drugs' (2021) 98 *International Journal of Drug Policy* 103391 <https://www.sciencedirect.com/science/article/pii/S0955395921002966>

Lerat, Julien et al, *Characterisation of the 2022 Floods in the Northern Rivers Region* (Report, CSIRO, 30 November 2022) <https://www.nema.gov.au/our-work/resilience/northern-rivers-resilience-initiative>

Loi, Natasha M et al, 'Illicit Drug Use in Australia during the COVID-19 Pandemic' (2022) 12 *Journal of Global Health* 03026

Macreadie, Ian, 'Reflections from Melbourne, the World's Most Locked-down City, through the COVID-19 Pandemic and Beyond' (2022) 43(1) *Microbiology Australia* 3 <https://doi.org/10.1071/MA22002>

Maher, Lisa and Thomas Crewe Dixon, ‘Collateral Damage and the Criminalisation of Drug Use’ (2017) 4(8) *The Lancet HIV* e326 <https://doi.org/10.1016/S2352-3018(17)30071-1>

Pawson, Hal et al, *COVID19: Rental Housing and Homelessness Impacts in Australia* (Report No 12, Australian Council of Social Services (ACOSS) and the University of New South Wales (UNSW), 2021) <https://doi.org/10.26190/unsworks/28124>

Price, Olivia et al, ‘Changes in Illicit Drug Use and Markets with the COVID-19 Pandemic and Associated Restrictions: Findings from the Ecstasy and Related Drugs Reporting System, 2016–20’ (2022) 117(1) *Addiction* 182 <https://doi.org/10.1111/add.15620>

Reibling, Nadine, Mareike Ariaans and Claus Wendt, ‘Worlds of Healthcare: A Healthcare System Typology of OECD Countries’ (2019) 123(7) *Health Policy* 611 <https://doi.org/10.1016/j.healthpol.2019.05.001>

Roxburgh, Amanda et al, ‘The Impact of COVID-19 Public Health Measures on Attendance and Overdose at Supervised Injecting Facilities in Australia’ (2023) 224 *Public Health* 90 <https://www.sciencedirect.com/science/article/pii/S003335062300313X>

Russell, Cayley et al, ‘Identifying the Impacts of the COVID-19 Pandemic on Service Access for People Who Use Drugs (PWUD): A National Qualitative Study’ (2021) 129 *Journal of Substance Abuse Treatment* 108374 <https://www.sciencedirect.com/science/article/pii/S0740547221001008>

Scallan, Eilish et al, ‘Finding Stability amidst the COVID-19 Pandemic: The Impact of Emergency Temporary Housing for People Who Use Drugs’ (2022) 41(1) *Drug and Alcohol Review* 7 <https://doi.org/10.1111/dar.13335>

Stanaway, Fiona et al, ‘COVID-19: Estimated Number of Deaths If Australia Had Experienced a Similar Outbreak to England and Wales’ (2021) 214(2) *Medical Journal of Australia* 95 <https://doi.org/10.5694/mja2.50909>

The Alcohol and Drug Service, Statewide and Mental Health Services, Department of Health and Human Services, Tasmania, *Tasmanian Opioid Pharmacotherapy Program: Policy and Clinical Practice Standards* (Clinical Standards, Tasmanian Department of Health and Human Services, October 2025) <https://www.health.tas.gov.au/publications/tasmanian-opioid-pharmacotherapy-program-policy-and-clinical-practice-standards>

The National Mental Health Commission, *The COVID-19 Pandemic through the Experiential Lens of Priority Population Groups* (Report, National Mental Health Commission, 2023) <https://www.mentalhealthcommission.gov.au/publications/covid-19-pandemic-through-experiential-lens-priority-populations>

Thylstrup, Birgitte, Thomas Clausen and Morten Hesse, ‘Cardiovascular Disease among People with Drug Use Disorders’ (2015) 60(6) *International Journal of Public Health* 659 <https://doi.org/10.1007/s00038-015-0698-3>

Trevitt, Benjamin T et al, ‘The Impact of Changes in Opioid Dependency Treatment upon COVID-19 Transmission in Sydney, Australia: A Retrospective Longitudinal Observational Study’ (2024) 24(1) *BMC Public Health* 349 <https://doi.org/10.1186/s12889-024-17827-0>

Varshney, Karan, Talia Glodjo and Jenna Adalbert, ‘Overcrowded Housing Increases Risk for COVID-19 Mortality: An Ecological Study’ (2022) 15(1) *BMC Research Notes* 126 <https://doi.org/10.1186/s13104-022-06015-1>

Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (Policy, Victorian Department of Health, 30 June 2023) <https://www.health.vic.gov.au/publications/policy-for-maintenance-pharmacotherapy-for-opioid-dependence>

Walker, Shelley et al, 'Disproportionate, Differential and Targeted Treatment: People Who Use Drugs' Experiences of Policing during the COVID-19 Pandemic' (2025) 13(1) *Health & Justice* 6 <https://doi.org/10.1186/s40352-024-00314-4>

Wilson, Hester HK and Jillian Kanck, 'Medicines Used in the Treatment of Opioid Dependence' (2025) 48(3) *Australian Prescriber* 98 <https://australianprescriber.tg.org.au/articles/medicines-used-in-the-treatment-of-opioid-dependence.html>

Zwickl, Sav et al, 'Language and Terminology to Describe Transgender Communities; Perspectives from People with Lived Experience' [2024] *International Journal of Transgender Health* 1 <https://doi.org/10.1080/26895269.2024.2415684>

B. Webpages

AIVL—Australian Injecting and Illicit Drug Users League, 'Information for People on Opioid Treatment: Methadone, Suboxone, Subutex, and Buprenorphine Injections', *AIVL* (Web Resource, 1 March 2024) <https://aivl.org.au/resources/odtp/>

Australian Bureau of Statistics, 'Estimating Homelessness: Census 2021', *ABS* (Web Page, 22 March 2023) <https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#homeless-operational-groups>

Australian Bureau of Statistics (ABS), 'Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables', *ABS* (Web Page, 2020) <https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release>

Australian Department of Health, Disability and Ageing, 'About the Interim Australia Centre for Disease Control (CDC)', *Australian Centre for Disease Control* (Web Page, 6 November 2025) <https://www.cdc.gov.au/about/about-interim-australian-centre-disease-control-cdc>

Australian Department of Health, Disability and Ageing, 'Frequently Asked Questions - International Agreement on Pandemic Prevention, Preparedness and Response' <https://www.health.gov.au/resources/publications/international-instrument-on-pandemic-prevention-preparedness-and-response-frequently-asked-questions?language=en>

Australian Government, 'The Australian Health System', *Department of Health, Disability and Ageing* (Web Page, 7 April 2025) <https://www.health.gov.au/about-us/the-australian-health-system>

Dalzell, Stephanie, 'Scott Morrison Says He Accepts Criticism for Hawaii Holiday during Bushfires, Apologises for Any Upset Caused', *ABC* (Web Page, 22 December 2019) <https://www.abc.net.au/news/2019-12-22/prime-minister-scott-morrison-hawaii-holiday-bushfires/11821682>

Diversity Council of Australia (DCA), ‘Words at Work: Should We Use CALD or CARM?’, *DCA* (Web Page, 2025) <https://www.dca.org.au/news/blog/words-at-work-should-we-use-cald-or-carm>

Harm Reduction Victoria, ‘COVID-19 and You. Some Things You Should Know: For People Who Use Drugs’, *Harm Reduction Victoria* (Web Page, 4 October 2021) <https://www.hrvic.org.au/covid19-you>

Reserve Bank of Australia, ‘The COVID-19 Pandemic: 2020 to 2021’, *Reserve Bank of Australia (RBA)* (Web Page, 2025) <https://www.rba.gov.au/education/resources/explainers/the-covid-19-pandemic-2020-to-2021.html>

World Health Organization, ‘WHO COVID-19 Dashboard - Number of COVID-19 Cases, World’, *World Health Organization Data* (Web Page, 30 March 2025) <https://data.who.int/dashboards/covid19/cases?n=o>

World Health Organization, ‘WHO COVID-19 Dashboard - Number of COVID-19 Deaths, World’, *World Health Organization Data* (Web Page, 30 March 2025) <https://data.who.int/dashboards/covid19/deaths?n=o>

World Health Organization (WHO), ‘Naming the Coronavirus Disease (COVID-19) and the Virus That Causes It’, *World Health Organization* (Web Page, 2025) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it>