

CONSENSUS STATEMENT

Strengthening Injecting-Related Harm Reduction in Prisons

Harm reduction in Prisons Working Group, March 2023

- **People in prison inject illicit drugs, and experience significant harms.**
- **Injecting-related harms in prisons can be prevented.**
- **This consensus statement summarises the evidence about how to prevent those harms.**
- **Endorsed by the 29 members of the Harm Reduction in Prisons Working Group, this statement provides the basis for effective action to eliminate injecting-related harms in prisons.**

This statement was drafted by the Harm Reduction in Prisons Working Group¹ to provide a clear and concise overview of the evidence-based harm reduction interventions needed to reduce injecting-related harms in Australian prisons. Australian government commitments to eliminating hepatitis C by 2030 have increased attention on elimination strategies and prisons have been identified as a key setting for intervention. The harm reduction strategies outlined in this statement are critical in achieving this commitment, but importantly, have application for all people at risk of injecting-related harm, disease and death in prisons. It is hoped that this statement can assist policy makers at all levels of government in all jurisdictions to apply a broader lens to harm reduction and to understand why a comprehensive response is needed.

What is injecting-related harm reduction in prison?

Injecting drug use can result in a number of fatal or serious harms including overdose, blood-borne virus transmission and injecting-related injuries. There is a wealth of evidence that injecting-related prison harm reduction programs can reduce the transmission of blood-borne viruses, reduce risk behaviours, reduce death and can even improve prison safety and reduce rates of reoffending (1-4).

Harm reduction is a practice that supports people to improve their health through non-judgemental support. Harm reduction programs, policies and practices aim to reduce the health harms related to injecting drug use, including blood-borne virus infection, drug overdose and injecting injuries. All three of these harms are preventable with effective harm reduction programs. Harm reduction programs provide interventions that support the person where they are at, and are grounded in principles of justice, human rights and equity. They are an approach that is effective at reaching some of the most marginalised members of society who may not otherwise have access to healthcare.

Why is injecting-related harm reduction in prisons important?

1. People who are imprisoned have a much higher rate of harmful outcomes from injecting drug use than the general population

People in prison have much higher rates of injecting drug use than the general population with almost half of new prison entrants reporting a history of injecting drug use (5, 6). Despite attempts

¹ See the end of this document for details about the Harm Reduction in Prisons Working Group.

to prevent drug use and supply in prison, the use of drugs, including injecting drug use, remains common (5, 7-9). There is also evidence that some people start injecting drugs or reinitiate previous injecting drug use while in prison (8, 10).

Additionally, prisons are high-risk environments for injecting-related harms, such as hepatitis C, due to a lack of access to harm reduction programs, including the provision of new and sterile injecting equipment (11-14). Where people in prisons do not have access to needle and syringe programs, sharing of injecting equipment between people who inject drugs is common (15-17). It can also lead to the creation of homemade injecting equipment using unsterile items found in prison (18).

Due to these factors, people in prison experience much higher rates of blood-borne viruses, including hepatitis C and HIV, than the general population (19, 20). Lack of access to sterile and new injecting equipment also puts people at risk of highly complex injecting-related injuries and disease, such as septicaemia, vascular damage and thrombophlebitis (21).

2. Access to harm reduction in prison decreases the risk of injury and disease from injecting drug use

While medication exists to treat most blood-borne viruses, reinfections will continue to occur while people in prison lack access to new and sterile injecting equipment (22, 23). Evidence on hepatitis C is a good example of this. Australia has a goal of eliminating hepatitis C by 2030. The introduction of direct-acting antiviral medicines has seen a significant reduction in the rates of hepatitis C infections in Australia, however new hepatitis C infections and reinfections are occurring in Australian prisons (24, 25). People in prisons need access to harm reduction programs, in addition to treatment, to eliminate hepatitis C and stop the spread of other blood-borne viruses and injecting-related injury and disease (26, 27).

3. People in prison have the right to access safe and effective harm reduction and healthcare

All people are entitled to the highest level of attainable healthcare, regardless of whether they are in prison or in the community. This is a basic human right. International law through the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), and the Australian Government's Guiding Principles for Corrections in Australia both require healthcare in prisons to be equivalent to that in the community (28).

4. Prison provides an opportunity to support marginalised and vulnerable populations with harm reduction interventions

The health needs of people in prison in Australia can be significant and complex and often long-term and chronic in nature (5). People in prison often represent some of the most vulnerable and disadvantaged community members (2) and prison populations often have high rates of trauma, mental illness, chronic disease and cognitive disability, and are disproportionately affected by the social determinants of health (29). They are also less likely to be connected to healthcare services (30).

Prison settings therefore provide an opportunity to engage with people who have a history of injecting drug use, provide harm reduction interventions and facilitate access to other healthcare services which they may not have accessed in the community (31). Prisons can also provide opportunities to link people after their release with health and community services that provide support and promote wellbeing (32). Providing harm reduction services in prisons therefore not only benefits people who access those services, but also improves prison safety and the health of their communities after release (29, 33).

What interventions are effective at reducing injecting-related harm?

Harm reduction interventions encourage safer behaviours and practice and reduce preventable risk factors. There are also interventions that reduce harms that are standard healthcare - for instance, the testing and treatment for blood-borne viruses is standard healthcare and it also reduces one of the harms from drug use. What is important is providing a full suite of harm reduction interventions. Cherry-picking harm reduction responses seriously limits effectiveness with the best results of many harm reduction interventions working in tandem (e.g. through the synergistic provision of opioid agonist treatment and needle exchange programs, or peer education to prevent blood-borne virus infection/reinfection alongside effective blood-borne virus treatment).

Harm reduction should also be considered along a continuum of complementary approaches and be provided throughout the carceral journey from entry through to release (2). Table 1 below lists interventions for preventing injecting-related harms that have proven effective and are freely available in the community. All the interventions listed should form part of a suite of standard interventions at all adult prison facilities across Australia. All people in prison in Australia should be free to choose which of the following interventions are most suitable for them and whether or not to engage in harm reduction.

Who supports prison harm reduction and how does it fit with our international and national obligations?

The United Nations and the World Health Organization have called for greater harm reduction in prisons, noting the important role of harm reduction interventions in both the response to people who use alcohol and other drugs, and in the prevention of blood-borne viruses. Several reports and guidelines suggest a comprehensive package of interventions to reduce harms for people in and exiting prison, including needle and syringe programs and opioid agonist treatment (2, 12, 34-37).

Australia has five national blood-borne virus and sexually transmitted infection (STI) strategies² that all recognise people in prison as a priority population, prisons as a priority setting for interventions, or both. Greater access to interventions which prevent or reduce the harms from drug use are supported in all the strategies. Increasing availability and distribution of sterile needles and syringes, pharmacotherapy and peer-based education are variously supported by the strategies on hepatitis B, hepatitis C, HIV and the blood-borne virus and STI strategy for Aboriginal and Torres Strait Islanders (38-41).

Harm reduction is also one of three pillars in the National Drug Strategy 2017-2026 alongside demand reduction and supply reduction (42). People in contact with the criminal justice system are identified as a priority population for harm reduction strategies that encourage safer behaviours, such as needle and syringe programs. The National Prisons Hepatitis Network statement on management of hepatitis C in prisons calls for the scale up of harm reduction in order to prevent hepatitis C infections and reinfection (11). This includes the provision of regulated needle and syringe programs, and greater access to the full range of opioid agonist treatment options (11).

² Third National Hepatitis B Strategy 2018-2022; Fifth National Hepatitis C Strategy 2018-2022; Eighth National HIV Strategy 2018-2022; Fourth National STI Strategy 2018-2022; Fifth National Aboriginal and Torres Strait Island Blood Borne Virus and STI Strategy 2018-2022

Table 1: Interventions to reduce injecting-related harms

Interventions	Harms prevented or reduced	Evidence of effectiveness
Needle syringe programs (NSPs): regulated provision of sterile injecting equipment to people who inject drugs	Blood-borne virus transmission Injecting-related injury and disease	<p>A wealth of evidence demonstrates NSPs work in reducing transmission of blood-borne viruses, particularly when implemented in combination with opioid agonist treatment (OAT) (43). The provision of prison NSPs is considered best practice for blood-borne virus and alcohol and other drug-related harm reduction (44).</p> <p>Evidence emerging from the 10 countries that operate at least one prison NSP show that they are feasible and likely to reduce blood-borne viruses in prisons just as they do in the community (45, 46).</p> <p>The lack of regulated access to sterile injecting equipment is associated with new blood-borne virus infections and reinfections among prison populations despite the provision of direct-acting antivirals (22-25, 27). Regulating access to new sterile needles is also an important strategy in preventing injecting-related injuries and disease and thrombophlebitis (21).</p>
Overdose prevention sites	Overdose Blood-borne virus transmission Injecting-related injury and disease	Overdose prevention sites provide a safer place for people to inject drugs under the supervision of health professionals where overdose can be rapidly reversed. These sites also provide opportunities for people who inject drugs to meet and talk with health professionals and be referred to other services. Recorded outcomes from community overdose prevention sites in Australia and internationally demonstrate that they reduce the risk of overdose and improve access to care (47).
Needle cleaning agents	Blood-borne virus transmission Injecting-related injury and disease	Bleach is an effective agent against the hepatitis C virus and HIV when it can be used properly to clean needles and syringes (48). In prison settings, needle cleaning agents have less evidence that they prevent infections because of the prison environment preventing timely cleaning (due to urgency/fear of detection) and/or lack of access to cleaning agents, or where a needle and syringe is shared by multiple people (17, 49). Where people in prisons cannot access clean and sterile injecting equipment, needle cleaning agents should be provided.
Naloxone provision	Overdose	Naloxone is a drug that temporarily reverses opioid overdose or adverse reaction. It can be administered by an intranasal spray or via injection. Take home naloxone programs train participants in recognising overdose and administering naloxone. Evidence shows that these

Interventions	Harms prevented or reduced	Evidence of effectiveness
		programs reduce the risk of opioid overdose and have the potential to reduce overdose deaths both in prison context, and in the high-risk period following release from prison (50-52).
<p>Education and information</p> <p>Peer-led education and programs</p>	<p>Injecting-related injury and disease</p> <p>Overdose</p> <p>Blood-borne virus transmission</p>	<p>Harm reduction education provides information to people about safer drug use practices. There is extensive research that shows education programs in prison are more likely to be effective at reducing risky behaviours where they are developed and delivered by peers, with peer educators a more credible and trusted source of information for people in prison (3, 53).</p> <p>Peer support programs and peer workers can also provide emotional support and practical information, for instance in supporting engagement in testing (54, 55).</p>
Opioid Agonist Treatment (OAT)	<p>Blood-borne virus transmission</p> <p>Injecting-related injury and disease</p> <p>Overdose</p>	OAT is a cost-effective treatment that is associated with reductions in harmful drug use, blood-borne infections and death, both in the community and in prison (56-58). OAT has also been found to improve prison safety and reduced rates of re-offending among people in prison (3). Combined use of OAT with needle syringe programs is more effective at preventing new blood-borne virus infections than just providing OAT alone (43).
Blood-borne virus (BBV) screening	Blood-borne virus transmission	Prison is an independent risk factor for contracting blood-borne viruses; all people in prison should be offered testing (11). The ECDC, EMCDDA and WHO all suggest that testing for BBVs should be offered to everyone on entry to prison and then at regular intervals (yearly), and be voluntary (20). International research suggests that opt-out systems (whereby screening is standard practice for everyone unless they object), rather than opt-in (whereby screening has to be requested or offered individually following the establishment of relevant risk factors) is best for maximum take-up of screening, as long as people are adequately informed of their right to refuse (59, 60).
Hepatitis B virus (HBV) vaccination	Blood-borne virus transmission	HBV immunisation reduces the pool of people infected with HBV thereby reducing the likelihood of transmission, known as treatment as prevention. HBV vaccination of all people in prison is recommended by the Australian government (61).
Hepatitis C virus (HCV) treatment	Blood-borne virus transmission	Direct Acting Antivirals (DAAs) are an approved medication that have special prescribing status so can be accessed by people in prison under Medicare. The provision of unrestricted access to

Interventions	Harms prevented or reduced	Evidence of effectiveness
		<p>DAAs has cured nearly half of all people living with hepatitis C in Australia (from 2016 to 2020) and has reduced incidence of new hepatitis C infections in Australia (26).</p> <p>However, DAAs are less effective as a treatment as prevention strategy in contexts where there are high rates of risky injecting behaviour and other harm reduction is unavailable. DAA treatment needs to be combined with effective primary preventative measures (such as needle exchange programs) to achieve hepatitis C elimination (24, 26, 27, 39).</p>
HIV prevention and treatment	Blood-borne virus transmission	<p>Pre-Exposure Prophylaxis (PrEP) is a medication that can be taken to prevent HIV acquisition and Post-Exposure Prophylaxis (PEP) is a course of medication that can be taken after potential exposure to HIV to prevent acquisition. Antiretroviral Therapy (ART) is an approved medication to treat HIV. PrEP, PEP and ARTs are approved medications in Australia that are funded on the Pharmaceutical Benefits Scheme.</p>

About the Harm Reduction in Prisons Working Group

During 2019 a group of concerned practitioners, researchers and advocates came together to discuss the current state of harm reduction in prisons in Australia. From that initial meeting, an informal working group was formed with a purpose of advancing and achieving the elimination of hepatitis C and other blood-borne viruses in Australian prisons. Today, the Harm Reduction in Prisons Working Group continues to operate in an informal capacity, but since that first meeting has grown to include individuals and organisations in every state and territory in Australia and also New Zealand.

We see this statement as the beginning of a dialogue, and it presents a telegraphic summary of injecting-related harm reduction in prisons (not delving into the nuanced and detailed perspectives of all the stakeholders involved in its development). The following members of the Harm Reduction in Prisons Working Group were involved in drafting this statement and endorse it:

Professor Alison Ritter AO, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney

Liz Barrett, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney

Geoff Davey, CEO, QuIHN

Adrian Gorringe, Australian Injecting and Illicit Drug Users League (AIVL), ACT

Anshul Kaul, NT

Dr James Blogg, Senior Staff Specialist, NSW

Jenny Grant, Hepatitis SA

Dr Lise Lafferty, Centre for Social Research in Health, UNSW Sydney

Professor Greg Dore, Kirby Institute, UNSW Sydney

Dr Michael Levy AM, Public Health Physician, ACT

John Ryan, CEO, Penington Institute, VIC

Dr Mary Harrod, NSW Users and AIDS Association

Sione Crawford, Harm Reduction Victoria

Stuart Loveday, NSW

The Board of Hepatitis NSW

Colette Mcgrath, Service Director, Population Health, Justice Health and Forensic Mental Health Network, NSW

Tracey Brown, Programs Manager, Population Health, Justice Health and Forensic Mental Health Network, NSW

Tom Wright, Harm Reduction Coordinator, Population Health, Justice Health and Forensic Mental Health Network, NSW

Sujay Kentlyn, NT

Dr Joy Rowland, Director Medical Services, Health Services, Department of Justice, WA

Holly Beasley, Senior Project Officer (BBV), Health Services, Department of Justice, WA

Jill Mackenzie, Senior Project Officer (BBV), Health Services, Department of Justice, WA

Professor Kate Dolan, Harm Reduction Australia, Sydney

Jason George, Harm Reduction Lead, NZ Needle Exchange Program

Melanie Walker, CEO, Australian Alcohol and Other Drugs Council

Professor Mark Stoové, Head of Public Health, Burnet Institute, VIC

Angela Corry, CEO, Peer Based Harm Reduction WA

Carrie Fowlie, CEO, Hepatitis Australia

John Didlick, Policy Analyst, Hepatitis Australia

References

1. Harm Reduction International. The Harms of Incarceration. London; 2021.
2. WHO. Status Paper on Prisons, Drugs and Harm Reduction. Denmark; 2005.
3. Stöver H, Kastelic A. Drug treatment and harm reduction in prisons In: Enggist S, Møller L, Galea G, Udesen C, editors. Prisons and Health. Copenhagen: World Health Organisation (WHO); 2014.
4. Jin X, Kinner SA, Hopkins R, Stockings E, Courtney RJ, Shakeshaft A, et al. A randomised controlled trial of motivational interview for relapse prevention after release from smoke-free prisons in Australia. *International Journal of Prisoner Health*. 2021;17:462-76.
5. AIHW. The health of Australia's prisoners. Canberra; 2019.
6. Fazel S, Yoon IA, Hayes AJ. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction*. 2017;112(10):1725-39.
7. Dolan K, Teutsch S, Scheuer N, Levy M, Rawlinson W, Kaldor J, et al. Incidence and risk for acute hepatitis C infection during imprisonment in Australia. *Eur J Epidemiol*. 2010;25(2):143-8.
8. Cunningham EB, Hajarizadeh B, Amin J, Bretana N, Dore GJ, Degenhardt L, et al. Longitudinal injecting risk behaviours among people with a history of injecting drug use in an Australian prison setting: The HITS-p study. *International Journal of Drug Policy*. 2018;54:18-25.
9. Kirwan A, Curtis M, Dietze P, Aitken C, Woods E, Walker S, et al. The Prison and Transition Health (PATH) Cohort Study: Study Protocol and Baseline Characteristics of a Cohort of Men with a History of Injecting Drug Use Leaving Prison in Australia. *Journal of Urban Health*. 2019;96(3):400-10.
10. Bouck Z, Jain S, Sun X, Milloy MJ, Werb D, Hayashi K. Recent incarceration and risk of first-time injection initiation assistance: A prospective cohort study of persons who inject drugs. *Drug and Alcohol Dependence*. 2020;212:107983.
11. Winter RJ, Sheehan Y, Macdonald G, Rowland J, Colman A, Stoové M, et al. Consensus Statement on the Management of Hepatitis C in Australia's Prisons. 2022.
12. EMCDDA, ECDC. Public health guidance on prevention and control of blood-borne viruses in prison settings. Stockholm; 2018.
13. Sander G, Shirley-Beavan S, Stone K. The Global State of Harm Reduction in Prisons. *Journal of Correctional Health Care*. 2019;25(2):105-20.
14. Dolan K, Wirtz AL, Moazen B, Ndeffo-Mbah M, Galvani A, Kinner SA, et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*. 2016;388(10049):1089-102.
15. Fetherston J, Carruthers S, Butler T, Wilson D, Sindicich N. Rates of injection in prison in a sample of Australian-injecting drug users. *Journal of Substance Use*. 2013;18(1):65-73.
16. Kinner SA, Jenkinson R, Gouillou M, Milloy MJ. High-risk drug-use practices among a large sample of Australian prisoners. *Drug and Alcohol Dependence*. 2012;126(1):156-60.
17. Lafferty L, Rance J, Treloar C. Who goes first? Understanding hepatitis C risk among injecting networks in the prison setting. *Drug and Alcohol Dependence*. 2018;183:96-101.
18. Walker S, Seear K, Higgs P, Stoové M, Wilson M. "A spray bottle and a lollipop stick": An examination of policy prohibiting sterile injecting equipment in prison and effects on young men with injecting drug use histories. *International Journal of Drug Policy*. 2020;80:102532.
19. Merrall ELC, Kariminia A, Binswanger IA, Hobbs MS, Farrell M, Marsden J, et al. Meta-analysis of drug-related deaths soon after release from prison. *Addiction* 2010;105(9):1545-54.
20. Stöver H, Tarján A, Horváth G, Montanari L. The state of harm reduction in prisons in 30 European countries with a focus on people who inject drugs and infectious diseases. *Harm Reduction Journal*. 2021;18(1):67.
21. Colledge S, Larney S, Bruno R, Gibbs D, Degenhardt L, Yuen WS, et al. Profile and correlates of injecting-related injuries and diseases among people who inject drugs in Australia. *Drug and Alcohol Dependence*. 2020;216:108267.

22. Lafferty L, Wild TC, Rance J, Treloar C. A policy analysis exploring hepatitis C risk, prevention, testing, treatment and reinfection within Australia's prisons. *Harm Reduct J.* 2018;15(1):39.
23. Harkness B, Levy M, Evans R, Wenke J. Why is there still hepatitis C transmission in Australian prisons? A case report. *Harm Reduction Journal.* 2017;14(1):75.
24. Hajarizadeh B, Grebely J, Byrne M, Marks P, Amin J, McManus H, et al. Evaluation of hepatitis C treatment-as-prevention within Australian prisons (SToP-C): a prospective cohort study. *Lancet Gastroenterol Hepatol.* 2021;6(7):533-46.
25. Silano JA, Treloar C, Wright T, Brown T, McGrath C, Snoyman P. Commentary on the harm reduction reference group of justice health and forensic mental health network and corrective services NSW, Australia. *International Journal of Prison Health.* 2021;ahead-of-print(ahead-of-print).
26. Burnet Institute, Kirby Institute. Australia's progress towards hepatitis C elimination: annual report 2021. Melbourne; 2021.
27. Bretaña NA, Gray RR, Cunningham EB, Betz-Stablein B, Ribeiro R, Graw F, et al. Combined treatment and prevention strategies for hepatitis C virus elimination in the prisons in New South Wales: a modelling study. *Addiction.* 2020;115(5):901-13.
28. UNODC. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Vienna; 2015.
29. McLeod KE, Butler A, Young JT, Southalan L, Borschmann R, Sturup-Toft S, et al. Global Prison Health Care Governance and Health Equity: A Critical Lack of Evidence. *American Journal of Public Health.* 2020;110(3):303-8.
30. Fazel S, Baillargeon J. The health of prisoners. *Lancet.* 2011;377(9769):956-65.
31. Jenner L, Bartle J, Lee N. What works: Alcohol and other drug treatment in prisons. Melbourne; 2018.
32. Freudenberg N. Jails, prisons, and the health of urban populations: a review of the impact of the correctional system on community health. *J Urban Health.* 2001;78(2):214-35.
33. O'Moore E. The community dividend: why improving prisoner health is essential for public health. UK; 2015.
34. WHO. Prisons and Health. Enggist S, Møller L, Galea G, Udesen C, editors: World Health Organization;; 2014.
35. WHO, UNODC, UNAIDS. WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva; 2009.
36. UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna; 2013.
37. WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Switzerland; 2016.
38. Department of Health. Third National Hepatitis B Strategy. Canberra: Commonwealth of Australia 2018.
39. Department of Health. Fifth National Hepatitis C Strategy. Canberra: Commonwealth of Australia; 2018.
40. Department of Health. Eighth National HIV Strategy. Canberra: Commonwealth of Australia; 2018.
41. Department of Health. Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022. Canberra: Commonwealth of Australia; 2018.
42. Department of Health. National Drug Strategy 2017-2026. Canberra; 2017.
43. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, et al. Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. *Addiction.* 2018;113(3):545-63.

44. UNODC. A handbook for starting and managing needle and syringe programmes in prisons and other closed settings. Vienna; 2014.
45. Dolan K, Rutter S, Wodak AD. Prison-based syringe exchange programmes: a review of international research and development. *Addiction*. 2003;98(2):153-8.
46. Lazarus JV, Safreed-Harmon K, Hetherington KL, Bromberg DJ, Ocampo D, Graf N, et al. Health Outcomes for Clients of Needle and Syringe Programs in Prisons. *Epidemiol Rev*. 2018;40(1):96-104.
47. Levenson TW, Yoon GH, Davoust MJ, Ogden SN, Marshall BDL, Cahill SR, et al. Supervised Injection Facilities as Harm Reduction: A Systematic Review. *American Journal of Preventive Medicine*. 2021;61(5):738-49.
48. Binka M, Paintsil E, Patel A, Lindenbach BD, Heimer R. Disinfection of syringes contaminated with hepatitis C virus by rinsing with household products. *Open Forum Infect Dis*. 2015;2(1):ofv017-ofv.
49. Hepatitis NSW. Use of Fincol in NSW prisons: preventing hep c transmission. Sydney; 2019.
50. Clark AK, Wilder CM, Winstanley EL. A Systematic Review of Community Opioid Overdose Prevention and Naloxone Distribution Programs. *Journal of Addiction Medicine*. 2014;8(3).
51. Curtis M, Dietze P, Aitken C, Kirwan A, Kinner SA, Butler T, et al. Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use. *Harm Reduction Journal*. 2018;15(1):48.
52. Parmar MKB, Strang J, Choo L, Meade AM, Bird SM. Randomized controlled pilot trial of naloxone-on-release to prevent post-prison opioid overdose deaths. *Addiction*. 2017;112(3):502-15.
53. Bagnall A-M, South J, Hulme C, Woodall J, Vinnall-Collier K, Raine G, et al. A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. *BMC Public Health*. 2015;15(1):290.
54. Crowley D, Murtagh R, Cullen W, Keevans M, Laird E, McHugh T, et al. Evaluating peer-supported screening as a hepatitis C case-finding model in prisoners. *Harm Reduction Journal*. 2019;16(1):42.
55. Treloar C, Hopwood M, Cama E, Saunders V, Jackson LC, Walker M, et al. Evaluation of the Deadly Liver Mob program: insights for roll-out and scale-up of a pilot program to engage Aboriginal Australians in hepatitis C and sexual health education, screening, and care. *Harm Reduction Journal*. 2018;15(1):5.
56. Larney S, Gisev N, Farrell M, Dobbins T, Burns L, Gibson A, et al. Opioid substitution therapy as a strategy to reduce deaths in prison: retrospective cohort study. *BMJ Open*. 2014;4(4):e004666.
57. Gisev N, Shanahan M, Weatherburn DJ, Mattick RP, Larney S, Burns L, et al. A cost-effectiveness analysis of opioid substitution therapy upon prison release in reducing mortality among people with a history of opioid dependence. *Addiction*. 2015;110(12):1975-84.
58. Hedrich D, Alves P, Farrell M, Stöver H, Møller L, Mayet S. The effectiveness of opioid maintenance treatment in prison settings: a systematic review. *Addiction*. 2012;107(3):501-17.
59. Rumble C, Pevalin DJ, O'Moore É. Routine testing for blood-borne viruses in prisons: a systematic review. *European Journal of Public Health*. 2015;25(6):1078-88.
60. AASLD, IDSA. HCV testing and treatment in correctional settings. United States; 2019.
61. Department of Health. Vaccination for other groups. Canberra; 2022.