Let’s be honest: The cycle of risk and harm for people who inject drugs in Queensland prisons

ACKNOWLEDGEMENT OF COUNTRY

We acknowledge the Traditional Owners and First Nations people's lands of where we work and live, in Meeanjin (Turrbal name for Brisbane CBD), Yugambeh Country (Gold Coast), and Gubbi Gubbi/Kabi Kabi Country (Sunshine Coast). We also acknowledge the First Nations people's lands of our site visitors. We recognise that these have always been places of continued culture, teaching, and learning.

We wish to pay respect to their Elders, past, present and emerging, and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within health services and the harm reduction community, by providing services that are culturally appropriate and safe.

We acknowledge the profound harm and enduring consequences wrought by colonisation on Aboriginal and Torres Strait Islander peoples. We honour their strength, resilience, and ongoing cultural and spiritual connections to Country. In the implementation of our work, we affirm our commitment to fostering inclusivity, unity, and respect among all communities.

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ACKNOWLEDGEMENTS

This work was made possible through the leadership and solidarity of the Queensland Injectors Health Network (QuIHN) and Queensland Injectors Voice for Advocacy and Action (QuIVAA), who funded and guided this project. We honour the resilience and the truthful narratives of the participants, people in our communities who have been criminalised, caged, harmed, and too often forgotten. Their willingness to share stories of overdose, incarceration, and systemic neglect speaks to a powerful act of resistance in the face of stigma and structural violence.

We acknowledge all people who use drugs, both in prison and in the community, those who are surviving, those still enduring harm, and those whose lives have been senselessly lost to preventable causes. This report stands in tribute to the many lives devastated not by drugs, but by punitive systems that deny people dignity, care, and safety. It is also a call to action: to recognise that people who use drugs are our peers, families, and community members, deserving of the same humanity, rights, and compassion as anyone else.

We reject narratives that devalue or dismiss these lives, and instead affirm the strength, wisdom, and leadership that exist within our communities. In solidarity, we commit to continuing this work until health, justice, and dignity are no longer conditional.

EXECUTIVE SUMMARY

This report explores the risk environment for people who inject drugs (PWIDs) in Queensland prisons, where injecting drug use continues despite surveillance, with limited access to harm reduction resources. Drawing on Lived-Living Experience (LLE) interviews with 30 recently incarcerated PWIDs, we document how prison settings amplify the risk of overdose, blood-borne viruses (BBVs), and injection-related bacterial infections (IRBIs).

Most participants reported injecting while incarcerated despite no access to sterile equipment, often with shared equipment, and nearly all had witnessed overdose or IRBI-related harms. Participants described restricted access to the opioid dependence treatment program (ODTP), and medical care, creating physical barriers to safety. Stigma, fear of punishment, and punitive institutional cultures further discouraged help-seeking and fuelled unsafe practices, such as rushed injecting and hidden substance use. Economic and policy constraints, such as limited access to clean equipment, led many to share or purchase reused syringes, heightening BBV and IRBI risks. The prison environment itself was shown to shape and intensify health risks, not simply reflect individual behaviour.

These findings highlight an urgent need for context-specific harm reduction strategies that account for the social, structural, and physical conditions of incarceration. Peer-led, rights-based responses, including prison-based needle and syringe programs, are critical to reducing preventable harm. This report provides clear, evidence-based recommendations to guide policy reform and improve the health and dignity of incarcerated PWIDs in Queensland.

s.37 of the Human Rights Act 2019 (Qld) mandates that prisoners be able to access the same standard of health care as available in the wider community.

BACKGROUND

Research suggests that PWIDs are overrepresented within the prison system worldwide (Austin et al., 2023; Penal Reform International, 2023) and within the Australian context (Bah et al., 2024) due to the criminalisation of illicit drug use (Lafferty et al., 2018a). In Australia specifically, approximately 29% of people who are incarcerated report having injected drugs at some stage in their lives before incarceration (AIHW, 2023). Moreover, Queensland has previously recorded the highest prevalence (52%) of any other state for prison entrants reporting injecting drug use (Merone et al., 2022). Despite the reported reduction in rates between injecting drug use before entering prison and whilst incarcerated, risks such as overdose, blood-borne viruses (BBVs) and injection-related bacterial infections (IRBIs) arise for this cohort at a drastically higher rate than in the general population (Rance et al., 2021).

Incarceration may result in the discontinuation of drug use as preventative measures like X-ray screening and urinalysis hinder illicit drug procurement (Austin et al., 2023; Dolan & Rodas, 2014). However, prison may also foster the initiation or continuation of drug use as it provides the means to cope with the harsh prison environment (Austin et al., 2023; Merone et al., 2022). Injection is a favoured administration route because it maximises the effect of limited drug supply (Austin et al., 2023), however, it does so alongside substantially increased risk to the individual (Cunningham et al., 2018). These risks predominantly stem from lack of access to sterile injecting equipment and, therefore, injection equipment sharing among people who are incarcerated (Reekie, 2014; Simpson et al., 2023). As a result, PWIDs have an increased risk of contracting BBVs (e.g., Hepatits C Virus [HCV]) and Human Immunodeficiency Virus (HIV; Kirwan et al., 2019) and IRBIs (e.g., cellulitis, Burkholderia Cenocepacia [BC]; Shik Luk et al., 2022), which are associated with increases in morbidity and mortality (Brothers et al., 2023). A poignant example of this is that BBVs like Hepatitis C Virus (HCV) affect up to 60% of incarcerated PWIDs, compared to 36% in the broader community (King et al., 2022a; Merone et al., 2022). Further, Australian prison HIV prevalence may range between 0–0.6% (Simpson et al., 2023), which is greater than the general population (0.14%; King et al., 2022a).

The incidence of hospitalisations for IRBIs is rising in Australia (Colledge-Frisby et al., 2022) and the burden on the acute healthcare system is substantial, with the average cost of a single occurrence being $16,528 (Morgan et al., 2024). Moreover, outbreaks of the antimicrobial medication-resistant bacteria BC are recorded among PWIDs in Australian prisons which have led to serious bone, joint and heart valve infections, and limb-threatening soft tissue injuries (Australian Society for Infectious Diseases, 2024). In fact, between 2018-2023, over 60 episodes of BC infection were recorded within nine Queensland correction centres hosting male long stay prisoners (Holland et al., 2025). Like other medication–resistant bacteria, strains of BC were associated with morbidity, mortality, and economic burden (Holland et al., 2025), underscoring the urgent need for further investigation and intervention.

Most concerning is that people in prison do not have the same level of access to evidence-based harm reduction interventions compared to the community, despite Section 37 of the Human Rights Act 2019 (QLD; Queensland Human Rights Commission, 2019) mandating equal access and standard of health care as the wider community for prisoners. When considering current policy and guiding principles (4.1.7) highlighted by the Corrective Services Administrators' Council (2018), alongside the United Nations (2015) Commission on Crime Prevention and Criminal Justice, and in particular 'Nelson Mandela Rules': Rule 1 and Rule 24 (see below), we are directed to consider the serious issue of healthcare inequity affecting our communities.

RULE 1

All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.

RULE 24

1. The provision of health-care for prisoners is a state responsibility. Prisoners should enjoy the same standards of health-care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

2. Health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

APPROACH

The risk environment framework (Rhodes, 2002) highlights how social and structural factors beyond the individual shape drug-related risks and harms. These environments operate across physical, social, and economic domains at both micro and macro levels, to shape drug-related risks and harms. Micro-level factors include interpersonal negotiations over equipment sharing, group norms around injecting practices, or institutional actions such as police presence at syringe exchange sites that disrupt access (Rhodes, 2002; Rhodes et al., 2005). Macro-level factors include laws, policies, and broader inequalities such as gender and race, which interact with and shape local practices (Rhodes, 2002; Rhodes et al., 2005). This framework shifts the focus from individual responsibility to the social and structural contexts that produce risk, emphasising the need for locally grounded harm reduction strategies and enabling environments that provide material, social, and affective support (Duff, 2010; Piatkowski, Kill, Duff, et al., 2025). Thus, understanding a specific risk environment is pivotal for the development of contextually-sensitive harm reduction interventions.

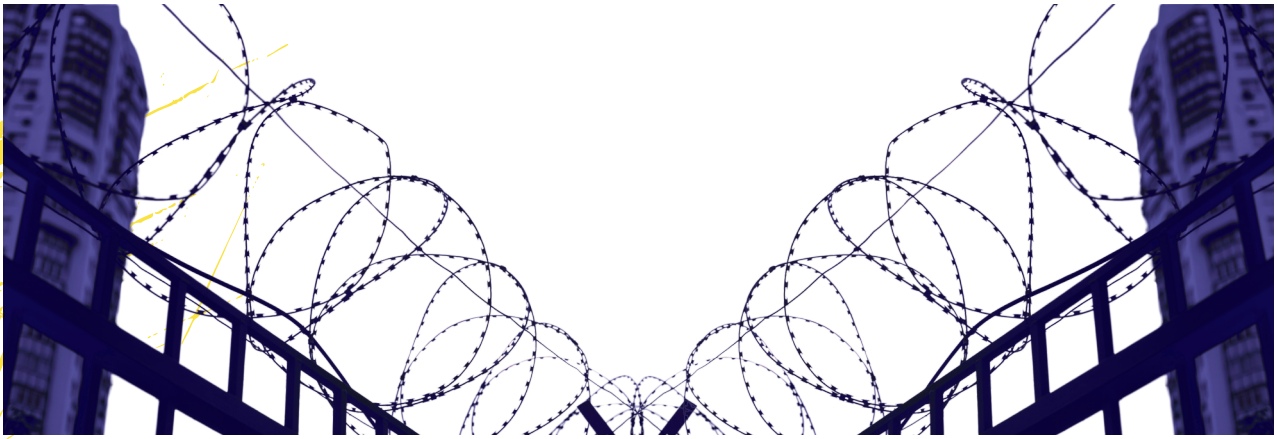
Building on our previous work (Piatkowski, De Andrade et al., 2024; Piatkowski, Kill, et al., 2024, 2025; Piatkowski, Seear et al., 2024), we recognise and advocate for the diverse perspectives of people with Lived-Living Experience (LLE) of injecting drug use and their experience of acute and chronic harms as a result of systemic and structural factors. We continue this work by implementing the risk environment framework (Rhodes, 2002) to explore the experiences of PWIDs in Queensland prisons and how this environment affects acute (e.g., overdose) as well as chronic (e.g., BBV and IRBI) harms.

METHOD

This study received ethics approval from Griffith University (2023/782) and was conducted with community leadership from Queensland Injectors Voice for Advocacy and Action (QuIVAA) and the Queensland Injectors Health Network (QuIHN). Participants were recruited either online via social media or face-to face via professional networks and outreach at QuIHN sites using purposive and snowball sample techniques (Naderifar et al., 2017; Palinkas et al., 2015). Eligible participants fulfilled the following criteria: a) aged 18 years and over, b) had injected drugs in their lifetime, c) had been released from incarceration in Queensland within the last 3 years, and d) had experienced or witnesses an overdose within the last 3 years. Recruitment ceased at thematic sufficiency, where substantive novel insights were beyond the existing framework (Guest et al., 2020; Saunders et al., 2018).

Interviews were conducted either online or face-to-face, and ranged from 20 to 92 minutes (median: 67 minutes). A $40 gift card was offered in recognition of participants' time and expertise. Interviews were transcribed, de-identified, and imported into NVivo (v12) for analysis.

Data were analysed using reflexive thematic analysis (Braun & Clarke, 2019), informed by both inductive and deductive coding approaches (Piatkowski et al., 2024). The analysis was conducted by the lead author with regular input and discussion from the research team, ensuring that findings remained grounded in LLE and participant narratives while offering insights relevant to policy and practice. As guided by the risk environment framework (Rhodes, 2002), themes were identified within the physical, social, and economic risk environments and highlight the contribution of current policy to risk. Within the body of results, quotes are *italicised*, and each participant's pseudonym, age and gender are presented before the quotes.



FINDINGS

Participants

Study participants were 30 PWIDs aged from 29 to 57 years (*M*age = 42.73, *SD* = 6.95), with the majority identifying as men (*n* = 23, 77%). All participants had been released from incarceration in Queensland, Australia within the past three years with almost a quarter (*n* = 7, 23%) reporting to have also served previous sentences in New South Wales. Nearly two-thirds of the participants (*n* = 19, 63%) engaged in injecting drug use whilst incarcerated, with each having to share injecting equipment to facilitate use. All participants had either experienced overdose (*n* = 24, 80%) or witnessed overdose (*n* = 29, 97%) in the past three years. Almost all participants had witnessed injecting equipment sharing amongst other prisoners (*n* = 29, 97%).

Of those who injected, over two-fifths contracted HCV (*n* = 14, 47%) whilst four out of five of participants (*n* = 24, 80%) knew of other prisoners who contracted BBVs from sharing injecting equipment. Whilst only six participants experienced IRBIs (*n* = 6, 20%), most had witnessed other prisoners with IRBIs (*n* = 28, 93%). Participant characteristics are displayed in Table 1 (next page).

Table 1.

Participant Characteristics (N = 30)

Participant	Pseudonym	Age	Gender	Experienced Overdose	Witnessed Overdose	Incarceration Jurisdiction	Injected Drugs (Yes/No)	Shared Equipment (Yes/No)	Witnessed Sharing Equipment (Yes/No)	Contracted BBVs (Yes/No)/Type	Witnessed BBV (Yes/No)/Type	Contracted IRBIs (Yes/No)	Witnessed IRBIs (Yes/No)
1	Jim	38	Male	Yes	No	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
2	Michael	52	Male	Yes	Yes	Qld	No	No	Yes	Yes/HCV*	Yes/ HAV, HBV	No	Yes
3	Stanley	41	Male	No	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
4	Pam	40	Female	No	Yes	Qld	No	No	Yes	No	Yes/Unspecified	No	Yes
5	Toby	46	Male	No	Yes	Qld & NSW	Yes	Yes	Yes	Unknown	Yes/Unspecified	No	Yes
6	Andy	43	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
7	Robert	47	Male	Unknown	Yes	Qld	Yes	Yes	Yes	Yes/HCV*	Yes/HCV	No	Yes
8	Gabe	29	Male	Yes	Yes	Qld	No	No	Yes	No	Yes/HAV, HCV, HIV	No	Yes
9	Todd	42	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	Yes	Yes
10	Darryl	52	Male	Yes	Yes	Qld	Yes	Yes	Yes	No	Unknown	No	No
11	Pete	49	Male	Yes	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HCV, HIV	No	Yes
12	Kelly	51	Female	Yes	Yes	Qld	No	No	Yes	No	Yes/HCV	No	Yes
13	Oscar	43	Male	No	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HIV**	No	Yes
14	Roy	50	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
15	David	49	Male	Yes	Yes	Qld	No	No	No	No	No	No	No

Note. QLD = Queensland; NSW = New South Wales; BBVs = Blood-borne Viruses; IRBIs = Injection-Related Bacterial Infections; HAV = hepatitis A Virus; HBV = hepatitis B Virus; HCV = hepatitis C Virus; HIV = Human Immunodeficiency Virus; * = Blood-borne virus contracted from tattooing; ** = Blood-borne virus contracted from sexual partner, *** = Blood-borne virus contracted (not whilst incarcerated).

Table 1. (continued)

Participant Characteristics (N = 30)

Participant	Pseudonym	Age	Gender	Experienced Overdose	Witnessed Overdose	Incarceration Jurisdiction	Injected Drugs (Yes/No)	Shared Equipment (Yes/No)	Witnessed Sharing (Yes/No)	Contracted BBVs (Yes/No)/Type	Witnessed BBV (Yes/No)/Type	Contracted IRBIs (Yes/No)	Witnessed IRBIs (Yes/No)
16	Danny	32	Male	Yes	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HCV, HIV	No	Yes
17	Charles	34	Male	Yes	Yes	Qld	Yes	Yes	Yes	Unknown	Yes/HCV	No	Yes
18	Meredith	49	Female	Yes	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
19	Nate	29	Male	Yes	Yes	Qld	No	No	Yes	No	Yes/HCV	No	Yes
20	Brian	42	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	Yes	Yes
21	Nick	42	Male	Yes	Yes	Qld	No	No	Yes	No	No	No	Yes
22	Katy	35	Female	Yes	Yes	Qld	No	No	Yes	No	Yes/HCV	No	Yes
23	Zeke	39	Male	Yes	Yes	Qld	No	No	Yes	No	Yes/HCV	Yes	Yes
24	Jordan	41	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV	No	Yes
25	Matt	42	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV***	No	No	Yes
26	Kevin	47	Male	Yes	Yes	Qld & NSW	Yes	Yes	Yes	Yes/HCV	Yes/HCV	Yes	Yes
27	Ryan	57	Male	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HAV, HCV	Yes/HAV***	No	Yes
28	Irene	45	Female	Yes	Yes	Qld	Yes	Yes	Yes	Yes/HCV	Yes/HCV, HIV	Yes	Yes
29	Donna	40	Female	Yes	Yes	Qld	No	No	Yes	Yes/HCV**	Yes/HCV	Yes	Yes
30	Helene	36	Female	No	Yes	Qld	No	No	Yes	No	Yes/HCV	No	Yes

*Note. QLD = Queensland; NSW = New South Wales; BBVs = Blood-borne Viruses; IRBIs = Injection-Related Bacterial Infections; HAV = hepatitis A Virus; HBV = hepatitis B Virus; HCV = hepatitis C Virus; HIV = Human Immunodeficiency Virus; * = Blood-borne virus contracted from tattooing; ** = Blood-borne virus contracted from sexual partner, *** = Blood-borne virus contracted (not whilst incarcerated)*

Theme 1: Physical Risk

Deprivation of access to healthcare and harm reduction services perpetuated the physical risk environment. Drug use in the context of prison reflects an embedded response to deprivation, shaped by the structural conditions of incarceration and the limited means to assert agency. For some, incarceration fostered the continuity of previously acquired drug-using behaviours. For others, it became the site for initiation into drug use and riskier practices like injecting, often with severe consequences, including overdose and the contraction of BBVs like HCV.

> *Gabe [29, Male]:* ***It's blokes being suicidal and wanting something to keep that at bay. Seeing everyone else using [drugs] and they're happy. They wanna feel like that, instead of feeling like they wanna neck up [suicide] every night. I've seen that for three people...never used a needle in their life, and it wrecked [th]em. They all caught hep[atitis] C, and one of [th]em overdosed.***

The barriers to accessing adequate mental and physical healthcare, was reflected in the inadequate access to harm reduction measures. Participants shared how the unavailability of NSPs heightened their risk of contracting BBVs and increased their likelihood of developing IRBIs. The difficulty in accessing sterile syringes led to a reliance on 'sharing' and repeated use of the same needle. Consequently, experiencing or witnessing injecting-related harms, such as BBVs, IRBIs and overdose were common.

> *Todd [42, Male]:* ***I counted 86 people used one needle in one day, and we had that needle for six months, twelve months. I've had a needle for two years once.***

> *Pete [49, Male]:* ***I was sharing a cell with someone who got an infection on his spine, and they put him into an induced coma {...} they administered IV [intravenous] antibiotics to try and get rid of the infection. He nearly died. And I said, 'what was that from?' And he said, 'I shared a fit [syringe]'.***

> *Gabe [29, Male]:* ***Oh yeah! Like bad [infections], like people losing limbs and, that's [where] a lot of the overdoses were coming from... ...they'd fill it [syringe] up to do two or three people and then accidentally put too much in.***

These experiences highlight how policy restricting NSPs in the prison environment constrained the agency of people who are incarcerated, resulting in the adoption of dangerous sharing practices, which substantially increased BBV and IRBI risks and harms. Despite a shift from abstinence-based to harm-reduction education, the programs received critique, as strategies could not be adequately implemented without access to harm reduction services.

> *Robert [47, Male]:* ***They do courses for hep[atitis] C treatment where you go and learn how to inject safely. But there's no doing it safe unless you've got clean equipment to do it with.***

Alongside absent NSP, limited access to harm reduction measures like the ODTP (e.g. Buprenorphine or Methadone) was also noted. Most participants articulated access challenges ranging from lengthy assessment processes to strict eligibility criteria, limiting the commencement of treatment in prison. These barriers also highlight a discrepancy between current policy supporting state-wide access to, and initiation of, ODTP in Queensland prisons (The State of Queensland, Corrective Services, 2024), versus ODTP in practice, as illustrated by Kelly.

> *Kelly [51, Female]:* ***You've got to be very lucky to get put on the program [ODTP] {...} they don't give it to you when you're on the inside [prison]. You've got to come in on it.***

The delays in access to health services were reflected throughout all medical treatments. Participants noted that the barriers to accessing HCV testing and treatment programs. The delayed treatment initiation and sharing practices sustained ongoing transmission risk. This cyclical pattern of treatment and reinfection compromised prisoner health outcomes while also placing a significant financial burden on the healthcare system through repeated resource utilisation. This ensuing cycle of infection-reinfection has significant economic impacts, with treatment costing approximately $15,700 per course (Kwon et al., 2021). Nate sheds light on the cyclic nature of treatment:

> *Nate [29, Male]:* ***They're curing hep[atitis] C in there [prison] but then it gets re-introduced because people are sharing needles. So, it's like a never-ending cycle.***

In addition, barriers to access were present for other healthcare issues, particularly IRBIs. Participants noted how procedural requirements, a lack of access to medical expertise, and fear of repercussions hindered the provision of timely and appropriate care.

> *Irene [45, Female]:* ***You can't discuss it [IRBIs] even if you're lucky to have a decent nurse on, the screws [corrections officers] will be present so you are just telling on yourself. We would sometimes tell people who had serious health issues and were on the waitlist for the doctor so they could tell the doctor to call us but that had numerous problems as you wouldn't know when they would be called to see the doctor, and you would then be relying on the doctor to give a shit and advocate against screws who – you know what they're like – tell nurses 'tell her to put in a form'. Everything in prison is in forms. You can't be honest in the form as it goes through screws to get to nurses. Even if you're able to hand the form to a nurse without a screw around, they now have it in writing that you're using and that is like signing a breach or cancelling your own parole.***

This finding corroborates existing evidence highlighting healthcare access challenges in Australian prisons, like prolonged wait times inadequate complaint mechanisms, and healthcare professional shortages (AIHW, 2023). Consequently, the inefficient procedures and insufficient medical expertise present in an environment perpetuating fear, too often led to hospitalisation, permanent disability, and near loss of life. Here, Toby describes the long-term effects suffered by his close friend.

> *Toby [46, Male]:* ***Another mate of mine is in hospital now. He can't even walk. He's got this spinal infection {...} and he's wheelchair bound probably for the rest of his life. If he had been treated, this could have been avoided.***

Participants spoke of how correction officers' actions impacted infection and disease transmission. Active surveillance and the fear of punishment meant that injecting was often hurried, and hygienic practices forgone, to successfully inject drugs without detection.

> *Kevin [47, Male]:* ***The minute you get it you want to use it so people start smashing it. Or you might need to use really quickly like you're all in the bathroom using 1 lady [syringe] – it's going to draw attention if you're taking too long. There's no time to be too cautious.***

The need for secrecy created conditions where syringes were repeatedly hidden in unsanitary locations, amplifying risk. Michael also described how potential punitive consequences deterred individuals from utilising harm reduction strategies like available cleaning agents.

> *Michael [52, Male]:* ***At one jail [QLD] a couple of years back, they had a cleaning system for your syringes, but to do that, you had to go to medical and put your name down. That gives them the red light of you doing something illegal, so a lot of people wouldn't do it.***

When coupled with a harsh prison environment, these conditions can produce healthcare-induced trauma. Pam describes how surveillance and punishment hindered access to adequate healthcare for IRBIs, with some forgoing treatment altogether, choosing instead to persevere with the infection and injury.

> *Pam [40, Female]:* ***You'd see girls with welts on their arms from missing [their vein] and they were getting elephant arms because they had swelled up so much. Most girls wouldn't seek medical treatment because they'd be caught for using...and, so they would suffer through it.***

Rather than accessing medical care, participants often endured worsening conditions to avoid detection, highlighting the profound harms of punitive prison policies that prioritise control over healthcare. Procedural requirements, lack of medical expertise to facilitate accurate diagnosis, and absent standardised treatment protocols, adversely impacted people with IRBIs. These experiences highlight how policy and law within the prison environment adds further nuance to pre-existing physical barriers to healthcare access. Social stigma further complicates efforts to render appropriate treatment as people who are incarcerated may be reluctant to seek help, thus perpetuating harms arising from BBVs and IRBIs.

Theme 2: Social Risk

The coalescing presence of social stigma further hindered healthcare experiences, with some participants sharing how healthcare seeking was often perceived as drug-seeking behaviour. Consequently, treatment was further delayed as healthcare providers were reluctant to believe requests for help. Here, Donna talks about how stigma hindered her ability to obtain appropriate and timely treatment.

> ***Donna [40, Female]:*** ***I just think nobody listens to you, you know [...] I think that they guards have this attitude and the nurses have this attitude that we're just trying to get fucking drugs or we're just trying to get it out of ourselves or something.[...] I was like, you need to listen to me, man. I'm fucking sick. I'm diabetic...***

People who are incarcerated with IRBIs were further stigmatised by fellow prisoners. A common perception existed that people who are incarcerated with IRBIs were unclean and violated the hygienic standards valued by the prison cohort. This led to targeting and physical punishment. However, one participant noted that IRBIs were not from poor hygiene but rather from the use of makeshift syringes.

> ***Gabe [29, Male]:*** ***The blokes who get abscesses, they'll get flogged [physically assaulted] just from people freaking out that they've got blood on [th]em {...}. They were just stuck in that rut where they haven't got access to any clean, you know [syringes], they need to make shit [injecting equipment].***

These experiences highlight how social stigma adds further nuance to pre-existing physical barriers to healthcare access. This further complicates efforts to render appropriate treatment as people who are incarcerated may be reluctant to seek help, thus perpetuating harms arising from BBVs and IRBIs. Stigma and social trust influenced injecting behaviours, to mitigate risk of BBVs and IRBIs in the absence of NSPs and presence of sharing needles and syringes; thus, shaping social risks.

> ***Pete [49, Male]:*** ***I was trying to get a syringe and I come back to him [drug supplier] and I said, 'I can't get one' and he goes, 'you better not have any diseases' cause if I get anything', you're in the shit'. Well, it's ironic, I got hep[atitis] C from him. There are lots of people who carry HIV [human immunodeficiency virus] and other diseases in there, and they're not about to say, 'I want to step out and miss my hit because I've got HIV'.***

The absence of sterile syringes meant that people relied on the trustworthiness of sharing partners, to mitigate risk. Many participants also described strategies to reduce BBV transmission, like limiting the number of people sharing injecting equipment.

> ***Pete [49, Male]:*** ***Rather than having a communal utensil for forty men, narrow it down to half a dozen. The less you've got, the safer you are {...} If you've got a small circle, you can account for everyone.***

Participants navigated the scarcity of clean equipment and the lack of HR services by creating more controlled, trusted environments. Many participants also described rules and boundaries when it came to sharing injecting equipment, reflecting both an awareness of the risks of BBV transmission and a sense of personal responsibility.

> ***Michael [52, Male]:*** ***Unless I've got my own fit [syringe] and I've brought it in with me, I won't use [drugs] in jail. I won't share my equipment with anybody. I won't use other people's equipment, so when I'm in jail, I'll still use [drugs], but I won't inject.***

The development of practices to try and mitigate BBV and IRBI risk and harms was also evident, with many participants sharing knowledge that they adopted to keep themselves perceptibly safer. These practices included informal hygiene strategies for syringes and taking steps to ensure that equipment was shared responsibly. For example, some participants emphasised the importance of 'rinsing' syringes multiple times before reuse to reduce the risk of contracting BBVs and IRBIs.

> *Brian [42, Male]:* ***It's three rinses, that's the rule {...} they'll have a cup of water sitting there.***

These strategies reflect a form of peer-led harm reduction; however, evidence shows that such strategies are ineffective at eliminating BBV transmission (Nathani et al., 2010), meaning infection risk remains. Participant narratives revealed the complex interplay between physical and social risk, which was further compounded by economic risk. Without access to harm reductions resources, the high demand for syringes perpetuated further risk.

Theme 3: Economic Risk

The prison economy played a key role in shaping participants' BBV and IRBI risk. In the absence of harm reduction measures like NSP, syringes were obtained via illicit means, including theft from medical offices and smuggling attempts into the prison. Smuggling often required syringes to be 'cut down' and modified for concealment in bodily cavities.

> *Kelly [51, Female]:* ***The syringe is usually that big [indicates larger size], and they cut it down to that big [indicates smaller size]. They cut the plunger down too, so they can fit it inside them [vagina or rectum], to smuggle it into jail.***

This finding is consistent with work from Treloar et al. (2016), who identified similar risk points in their research on the effects of informal prison economies on BBV risk in NSW prisons. The risks associated with the acquisition and provision of syringes via the prison economy meant that such resources were rare and costly.

> *Michael [52, Male]:* ***You can sell a new fit [syringe] for up to three hundred dollars.***

Suboxone was the most commonly injected drug in prison due to the scarcity of alternative illicit options. High demand, coupled with limited access to the legitimate ODTP meant the prison economy became the mechanism to access this drug.

> *Brian [42, Male]:* ***In there [prison], they're getting, $100 a mg [milligram]. That's $800 a strip they'd probably pay 50 cents for, because you can get four a day [Suboxone strips] for $3.50 out here [community].***

However, when the ODTP program moved from the provision of sublingual strips to the use of long-acting injection (see The State of Queensland, Corrective Services, 2024), people changed their practices further. The shift in drug delivery appeared to reshape practices, with people who were incarcerated resorting to increasingly unsafe methods to obtain Suboxone.

> ***Katy [35, Female]:*** ***There was one girl that had the subby [Suboxone] injection in her stomach and after she did the injection they put a Band-Aid on it and then she would mix up the Band-Aid and share it out between a bunch of girls. Her blood and the subby that leaked out on it.***

The 'means' to participate in the economy shaped participants' injecting experiences and thus their BBV and IRBI risks and harms. Greater means meant Stanley could purchase a syringe for exclusive use.

> ***Stanley [41, Male]:*** ***I was pretty lucky, I got to buy one [syringe] off someone who brought one in. I got to use that myself, and especially after the last time I did treatment, because I wasn't going to get hep[atitis] C again.***

Individuals with economic advantage could purchase a personal syringe, which reduced BBV risk, however, IRBI risk remains when syringes are repeatedly used without proper sterilisation. Accessing sterile injecting equipment was often unobtainable. In order to overcome the shortage in access, existing syringe needle tips would be sharpened on concrete floors, and nail files to 'resurrect' them for continued use. Alternatively, participants fabricated makeshift substitutes from repurposed everyday items. The unmet demand to access NSPs exposed people to an elevated risk of injury, BBVs, and IRBIs.

> ***Brian [42, Male]:*** ***One time I used that fit that's made out of a bread bag, a pen and a sunscreen tube. They shot me up in the side of the foot, and it ended up getting infected, and I got hepatitis.***

These experiences demonstrate that the prison economy provides a way to overcome shortfalls to accessing harm reduction services, at a significantly higher risk to the individual. These findings suggest that the informal prison economy increases BBV and IRBI risk, thus supporting the need for formal harm reduction resources in prisons.

See below (Table 2) for a synthesised representation of the risk environment in Queensland prisons.

Table 2. Selected examples representing and summarising the risk environment of people who inject drugs in Queensland prisons.

Domain	Micro-environment (inside prison)	Macro-environment (systemic/structural)
Physical	Injecting with improvised equipment; limited access to sterile supplies; unsafe injecting spaces	Prohibition-focused prison policies; surveillance and punishment approaches; lack of sanctioned harm reduction programs (e.g. NSP, ODTP)
Social	Peer norms of equipment sharing; reliance on prison hierarchies and networks to access drugs	Broader stigma against PWID; limited advocacy for prisoner health rights
Economic	High cost of drugs and equipment within prison; reliance on informal economies and trading	Lack of investment in harm reduction relative to security and enforcement

CONCLUSIONS

The findings of this report collate the LLE of PWIDs who have experienced recent overdose, and incarceration in Queensland. The findings provide evidence regarding how the current prison environment influences BBV and IRBI risk and harms. Taken together, the report demonstrably traces the physical, social, and economic risk environment manifested in a Queensland prison context.

First, physical risks were presented by participants to be centred around barriers to accessing healthcare resources. The lack of access to healthcare influenced their risk of experiencing acute harm (i.e., overdose), as well as potential for chronic harms (e.g., contracting BBVs and IRBIs). This limitation contravenes the '*principle of equivalence*' and Queensland's *Human Rights Act 2019* (Qld), s.37, which recognises the right to access health services without discrimination, including for those in detention. This is particularly exacerbated in the absence of harm reduction resources such as Naloxone, NSPs, and fair access to ODTP.

Second, the social risks underscored how stigma acts to further impact peoples' access to timely health care and intervention. Notably, social stigma intersects with current policies in prison and is perpetuated by the fear associated with surveillance, repercussion, and punishment, contributing to unsafe injecting practices. This environment precludes openness and harm reduction influences the behaviours described by our participants, such as using quickly and without opportunity to implement hygiene strategies, magnifying risk to injury, BBVs and IRBIs, as well as, limiting the capacity to dose and subsequent overdose.

Thirdly, without access to NSPs, purchasing and sharing utensils with trusted groups, was a common occurrence owing to the demand for sterile syringes not being met. These economic risks are directly attributable to the shortfalls in access to care and harm reduction services and influence our community's practices associated with attaining substances and utensils that are often unsafe. We note that, in Australia, for every dollar spent on prison NSP, $2.50 could be saved on treatment costs associated with HCV and IRBIs (Houdroge et al., 2025).

Collectively, these data demonstrate a need to establish an environment that enables the provisions of adequate harm reduction resources (e.g., prison-based NSPs, ODTP access, and rethinking the current punitive approach towards prison substance use) and moves towards an environment that meets the required contemporary standards of human rights for people experiencing incarceration. It is essential to ensure individuals can access health care in a timely manner and without fear of repercussion to ensure the reduction in risk related to overdose, BBVs, and IRBIs within the prison context. We identify effective harm reduction strategies that could mitigate risk and harms experienced by PWIDs in Queensland prisons, highlighted in the Recommendations section of this report.

RECOMENDATIONS

A number of key themes consistently surfaced throughout the project engagement, which led the team to raise several recommendations for policymakers and practitioners. For these recommendations to be salient and effective, they must be designed and implemented through peer-led approaches. These are presented here (in no ranked order).

- **Introduce non-punitive NSP models in Queensland prisons**: Explore secure, confidential mechanisms for sterile syringe access modelled on successful community-based NSPs. These should undergo community consultation where possible, ensuring cultural relevance and uptake. Harm reduction strategies in prison settings must be informed by those who have directly experienced incarceration and injecting-related harms.

- **Remove both criminal and correctional penalties for possession of sterile injecting equipment:** Policies that penalise people who are incarcerated for possessing sterile equipment actively undermine their health and human rights and should be reviewed.

- **Expand harm reduction tools:** While ODTP is a vital component of harm reduction, standalone pharmacotherapy is insufficient. Best practice supports and resources (such as sterile injecting equipment, peer educators/ supports, condoms, sharps disposal bins, and safe storage) should be universally available, and as such, incarcerated individuals should not have to rely on access to bleach or other chemicals for harm reduction.

- **Ensure equitable harm reduction access across jurisdictions:** Standardise best-practice harm reduction provision nationally to reduce postcode-based health inequities, especially for people who inject drugs in custody.

- **Support ongoing BBV screening and treatment:** Embed routine, voluntary HCV/HBV & HIV screening and treatment within prison health systems, alongside accessible follow-up upon release.

- **Prison overdose prevention strategy:** Policymakers should implement comprehensive harm reduction measures, such as overdose prevention education, including access and education to naloxone while incarcerated.

REFERENCES

Austin, A., Favril, L., Craft, S., Thliveri, P., & Freeman, T. P. (2023). Factors associated with drug use in prison: A systematic review of quantitative and qualitative evidence. *International Journal of Drug Policy*, *122*. https://doi.org/10.1016/j.drugpo.2023.104248

Australian Institute of Health and Welfare (2020). The health of Queensland's prisoners, 2018. https://www.aihw.gov.au/getmedia/eed8fe1f-1473-4a83-9b2d-62141ff3b23a/prisoners-qld.pdf.aspx

Australian Institute of Health and Welfare (2023, November 15). *The health of people in Australia's prisons 2022: Illicit drug use*. https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/health-risk-behaviours/illicit-drug-use

Australian Society for Infectious Diseases (2024, September 11). Needles and syringe programs needed in prisons. https://asid.net.au/news/needle-and-syringe-programs

Bah, R., Sheehan, Y., Li, X., Price, N., Butler, T., Dore, G. J., Grebely, J., Lloyd, A. R., Hajarizadeh, B., & AusHep study group. (2024). Challenges and facilitators in repeated bio-behavioural surveys for blood-borne virus infections in Australian prisons. *The International Journal on Drug Policy*, 104401. https://doi.org/10.1016/j.drugpo.2024.104401

Brothers, T. D., Bonn, M., Lewer, D., Comeau, E., Kim, I., Webster, D., Hayward, A., & Harris, M. (2023). Social and structural determinants of injection drug use-associated bacterial and fungal infections: A qualitative systematic review and thematic synthesis. *Addiction*, *118*(10), 1853–1877. https://doi.org/10.1111/add.16257

Colledge-Frisby, S., Jones, N., Larney, S., Peacock, A., Lewer, D., Brothers, T. D., Hickman, M., Farrell, M., & Degenhardt, L. (2022). The impact of opioid agonist treatment on hospitalisations for injecting-related diseases among an opioid dependent population: A retrospective data linkage study. *Drug and Alcohol Dependence*, *236*. https://doi.org/10.1016/j.drugalcdep.2022.109494

Corrective Services Administrators' Council. (2018). *Guiding principles for corrections in Australia revised 2018*. Government of Australia through the Corrective Services Administrators' Council. https://www.publications.qld.gov.au/dataset/f18ea162-6af3-4302-b5b4-61dc5286e586/resource/7f4fb1bd-27c5-46a3-8957-249fa227b1ff/download/guiding-principles-for-corrections-in-australia-revised-2018.pdf

Cunningham, E. B., Hajarizadeh, B., Amin, J., Bretana, N., Dore, G. J., Degenhardt, L., Larney, S., Luciani, F., Lloyd, A. R., Grebely, J., & HITS-p Investigators. (2018). Longitudinal injecting risk behaviours among people with a history of injecting drug use in an Australian prison setting: The HITS-p study. *The International Journal on Drug Policy*, *54*, 18–25. https://doi.org/10.1016/j.drugpo.2017.12.013

Dolan, K., & Rodas, A. (2014). Detection of drugs in Australian prisons: supply reduction strategies. International Journal of Prisoner Health, 10(2), 111–117. https://doi.org/10.1108/IJPH-06-2013-0025

Dolan, K., Wirtz, A. L., Moazen, B., Ndeffo-Mbah, M., Galvani, A., Kinner, S. A., Courtney, R., McKee, M., Amon, J. J., Maher, L., Hellard, M., Beyrer, C., & Altice, F. L. (2016). Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet (London, England)*, *388*(10049), 1089–1102. https://doi.org/10.1016/S0140-6736(16)30466-4

Duff, C. (2010). Enabling places and enabling resources: new directions for harm reduction research and practice. *Drug and Alcohol Review*, *29*(3), 337–344. https://doi.org/10.1111/j.1465-3362.2010.00187.x

Hendrich, D., & Hartnoll, R.L. (2021). Harm-reduction interventions. In N. el-Guebaly, G. Carra, M. Galanter, & A. M. Baldacchino (Eds.), *Textbook of addiction treatment: International perspectives* (1st ed. pp. 757-775). Springer International Publishing. https://doi.org/10.1007/978-3-030-36391-8_52

Holland, C. et al 'Burkeholderia cepacia complex outbreak in prisoners in Queensland', Australasian Society for Infectious Diseases (ASID), Annual Scientific Meeting (ASM), 3 - 5 April 2025, Canberra.

Houdroge, F., Colledge-Frisby, S., Kronfli, N., Winter, R. J., Carson, J., Stoove, M., & Scott, N. (2025). The costs and benefits of a prison needle and syringe program in Australia, 2025-30: a modelling study. *The Medical Journal of Australia*, *222*(8), 396–402. https://doi.org/10.5694/mja2.52640

Human Rights Act 2019 (Qld) s. 37 (Austl.). Retrieved from https://www.legislation.qld.gov.au/view/html/inforce/current/act-2019-005

King, J., McManus, H., Kwon, A., Gray, R., & McGregor, S. (2022a). *HIV, viral hepatitis, and sexually transmissible infections in Australia: Annual surveillance report 2022: HIV*. The Kirby Institute, UNSW Sydney. https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual-Surveillance-Report-2021_HIV_221107.pdf

Kirwan, A., Curtis, M., Dietze, P., Aitken, C., Woods, E., Walker, S., Kinner, S., Ogloff, J., Butler, T., & Stoové, M. (2019). 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*, *96*(3), 400–410. https://doi.org/10.1007/s11524-019-00353-5

Kwon, J. A., Chambers, G. M., Luciani, F., Zhang, L., Kinathil, S., Kim, D., Thein, H.-H., Botha, W., Thompson, S., Lloyd, A., Yap, L., Gray, R. T., & Butler, T. (2021). Hepatitis C treatment strategies in prisons: A cost-effectiveness analysis. *PloS One*, *16*(2). https://doi.org/10.1371/journal.pone.0245896

Guest, G., Namey, E., Chen, M., & Soundy, A. (2020). A simple method to assess and report thematic saturation in qualitative research. *Plos One*, *15*(5). https://doi.org/10.1371/journal.pone.0232076

Lafferty, L., Wild, T. C., Rance, J., & Treloar, C. (2018a). A policy analysis exploring hepatitis C risk, prevention, testing, treatment and reinfection within Australia's prisons. *Harm Reduction Journal, 15*(1), 39. https://doi.org/10.1186/s12954-018-0246-6

Lafferty, L., Rance, J., & Treloar, C. (2018b). Who goes first? Understanding hepatitis C risk among injecting networks in the prison setting. Drug and Alcohol Dependence, 183, 96-101. https://doi.org/10.1016/j.drugalcdep.2017.10.030

Merone, L., Ashton, S., Harris, A., Edwards, W. S., Preston-Thomas, A., Gair, R., & Russell, D. B. (2022). A complex increase in hepatitis C virus in a correctional facility: bumps in the road. *Australian and New Zealand Journal of Public Health*, *46*(3), 377–381. https://doi.org/10.1111/1753-6405.13238

Morgan, B., Lancaster, R., Boyagoda, B., Ananda, R., Attwood, L. O., Jacka, D., & Woolley, I. (2024). The burden of skin and soft tissue, bone and joint infections in an Australian cohort of people who inject drugs. BMC Infectious Diseases, 24(1), 299. https://doi.org/10.1186/s12879-024-09143-0

Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in development of medical education*, *14*(3), 1-4. https://dx.doi.org/10.5812/sdme.67670

Nathani, J., Iversen, J., Shying, K., Byrne, J., & Maher, L. (2010). Qualitative accounts of needle and syringe cleaning techniques among people who inject drugs in Sydney, Australia. *Drug and Alcohol Review*, *29*(4), 413–419. https://doi.org/10.1111/j.1465-3362.2009.00165.x

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed-method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Piatkowski, T., De Andrade, D., Kill, E., Hawgood, J., & Kõlves, K. (2024). It's Risky Out Where We Are: Exploring Intersectional Factors of Intentional Overdose Among People Who Use Drugs in Regional Queensland, Australia. Archives of Suicide Research, 1–15. https://doi.org/10.1080/13811118.2024.2435549

Piatkowski, T., Kill, E., Duff, C., Jenkins, K., & Hamilton, K. (2025). Mapping the risk environment for peers with lived-living experience working in the alcohol and other drugs sector in Queensland. International Journal of Drug Policy, 137, 104725. https://doi.org/10.1016/j.drugpo.2025.104725

Piatkowski, T., Kill, E., & Olsen, A. (2025). It is the way you treat yourself, but also the way you allow other people to start treating you as well: Perceptions of overdose risk among women who inject drug. Drugs, Habits and Social Policy, 26(2), 73–84. https://doi.org/10.1108/DHS-01-2025-0002

Piatkowski, T., Kill, E., & Reeve, S. (2024). Voices of lived experience: Understanding overdose narratives among people who use drugs in Queensland. Griffith University and Queensland Injectors Voice for Advocacy and Action. https://hdl.handle.net/10072/431160

Piatkowski, T., Kill, E., & Reeve, S. (2025). 'The gear could be cut with fentanyl which is starting to happen more in Australia': Exploring overdose survivors' perspectives on toxic supply and safe consumption. Drugs: Education, Prevention and Policy, 32(1), 42–50. https://doi.org/10.1080/09687637.2024.2392520

Piatkowski, T., Seear, K., Reeve, S., & Kill, E. (2024). How do relational practices co-constitute care for people who use drugs? The social and political dimensions of peer-led harm reduction. International Journal of Drug Policy, 133, 104614. https://doi.org/10.1016/j.drugpo.2024.104614

Penal Reform International (2023). *Global prison trends 2023* [Executive Summary]. Penal Reform International and Thailand Institute of Justice. https://www.penalreform.org/global-prison-trends-2023/

Queensland Human Rights Commission. (2019). *Right to health services*. Queensland Human Rights Commission. https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services

Rance, J., Loveday, S., Lafferty, L., Treloar, C., Dore, G., Lloyd, A., Grebely, J., Butler, T., Martin, N., Chambers, G., Byrne, M., Donnelly, R., McGrath, C., Bowman, J., Trevethan, L., Grant, L., Murrell, T., Bath, N., Harrod, M., et al. (2021). Considering treatment-as-prevention scale-up for Australian prisons: a qualitative sub-study of expert stakeholders from the Australian 'surveillance and treatment of prisoners with hepatitis C' project (SToP-C). *Harm Reduction Journal*, *18*(1), 46. https://doi.org/10.1186/s12954-021-00494-4

Reekie, J. M., Levy, M. H., Richards, A. H., Wake, C. J., Siddall, D. A., Beasley, H. M., Kumar, S., & Butler, T. G. (2014). Trends in HIV, hepatitis B and hepatitis C prevalence among Australian prisoners - 2004, 2007, 2010. *The Medical Journal of Australia, 200*(5), 277–280. https://doi.org/10.5694/mja13.11062

Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, *13*(2), 85–94. https://doi.org/10.1016/S0955-3959(02)00007-5

Rhodes, T., Singer, M., Bourgois, P., Freidman, S. R., & Strathdee, S. A. (2005). The social structural production of HIV risk among injecting drug users. *Social Science & Medicine (1982), 61*(5), 1026-1044. https://dx.doi.org/10.1016/j.socscimed.2004.12.024

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy*, *20*(3), 193–201. https://doi.org/10.1016/j.drugpo.2008.10.003

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity : International Journal of Methodology*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

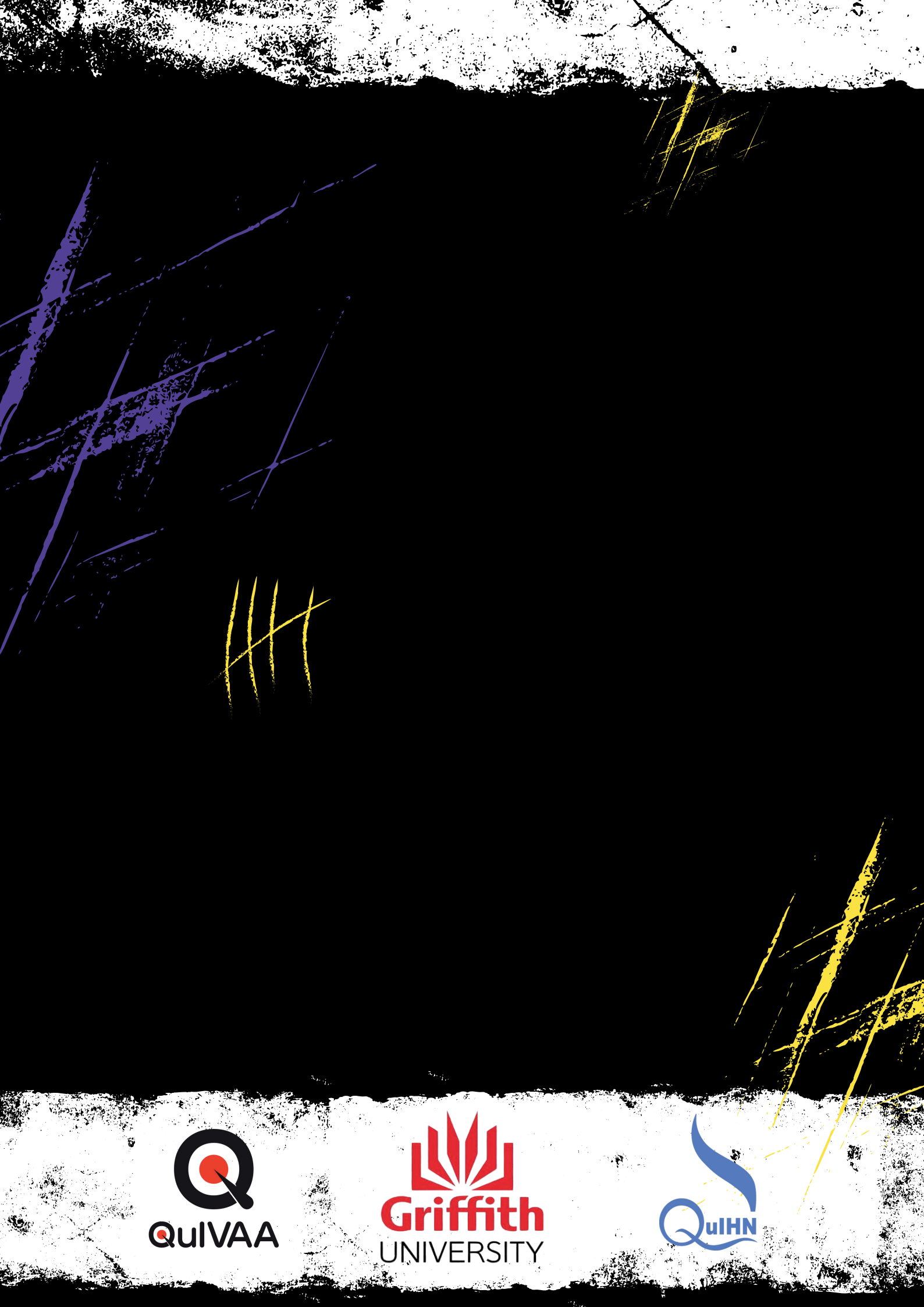
Shik Luk, K., Tsang, Y., Ho, A.Y., To, W., Wong, B.K., Wong, M .M., & Wong, Y (2022). Invasive Burkholderia cepacia complex infections among persons who inject drugs, Hong Kong, China, 2016-2019. *Emerging Infectious Diseases*, *28*(2), 323–330. https://doi.org/10.3201/eid2802.210945

Simpson, P. L., Gardoll, B., White, L., & Butler, T. (2023). HIV policies in Australian prisons: a structured review assessing compliance with international guidelines. *The Lancet Regional Health - Western Pacific*, *41*. https://doi.org/10.1016/j.lanwpc.2023.100813

The State of Queensland, Queensland Corrective Services. (2024). *Annual Report 2023-2024* [Annual Report]. https://www.publications.qld.gov.au/dataset/qcs-annual-reports/resource/3aefbc0f-63fa-4ded-ad46-1c0298ffc6c5?inner_span=True

Treloar, C., McCredie, L., Lloyd, A. R., & Selvey, L. A. (2016). The prison economy of needles and syringes: What opportunities exist for blood-borne virus risk reduction when prices are so high? *PLoS ONE, 11*(9). https://doi.org/10.1371/journal.pone.0162399

United Nations. (2015). *Nelson Mandela Rules*. United Nations Office on Drugs and Crime. https://www.unodc.org/unodc/justice-and-prison-reform/nelsonmandelarules.html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