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Abstract

People who inject drugs (PWID) face disproportionately high rates of drug overdose in the first few weeks post-release from prison, which may be exacerbated by lack of access to healthcare and harm reduction resources. However, little is known about the experiences of PWIDs and the factors that produce the risk of overdose when navigating the critical transition into community. This study aimed to understand the overdose risk environment during transition from prison to community, and what enabling resources are currently being utilized by communities of PWIDs to reduce overdose risk during this transition. A qualitative approach was employed, with semi-structured interviews conducted with 10 PWID who had been incarcerated and experienced an overdose in their lifetime. Data were analysed using thematic analysis through a Risk Environment lens. Participants reported macro-level systemic and structural factors which affected their access to healthcare, including opioid dependence treatment (ODT). At a micro-level, barriers to access often stemmed from stigmatizing interactions with the health workforce. However, peer-led approaches which preference relational care and are focused on building agency were reportedly being used by PWIDs to reduce overdose risk during transition from prison into community. PWIDs suggested naloxone administration and distribution were a key protective factor and critical in mitigating overdose risks post-release, filling current system gaps. Participants suggested enhancing naloxone distribution for PWIDs transitioning out of prison and expanding peer-led education and training in prisons and with service providers involved across all elements of post-release trajectories for PWIDs. The findings underscore the need for systemic changes to improve transitional care for PWIDs. Enhancing capacity for peer-led care, particularly through education and training regarding naloxone administration and distribution, is critical to providing equitable, life-saving care to this priority population.

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Introduction

People who inject drugs (PWID), particularly those who use opioids like heroin, face an increased risk of overdose and are overrepresented in the criminal justice system (Fazel et al., 2016; Young et al., 2018). In Australia, nearly half of the prison population has a history of injecting drug use (Larney et al., 2017), with opioid dependence linked to high rates of re-incarceration (Denton et al., 2017). Most notably, research shows the highest incidence of overdose occurs in the seven days immediately following release from prison (Bukten et al., 2017; Bukten & Stavseth, 2024). Sociostructural barriers like limited healthcare access including opioid dependence treatment (ODT), stigma, and marginalization further elevate post-release overdose risk (Collins et al., 2019; Cossar et al., 2022). While these risks are well documented, less is known about how PWIDs themselves navigate this hazardous period and what forms of support, formal or informal, are available or absent in their transition from prison to community. Hence, this study aimed to understand the environment that produces overdose risk during the transition from prison to community, and what enabling resources are currently being employed by communities of PWIDs to reduce overdose risk during this transition.

Background

Illicit drug consumption harms are influenced by social contexts (Parkin, 2016) and are thus contingent upon the interplay of environmental and social determinants (Rhodes, 2009; Rhodes et al., 2005). Research has identified the prison system as a unique social context that shapes the way people use drugs and, therefore, the associated harms that arise (Duke, 2011; Kolind & Duke, 2016). The carceral risk environment, therefore, must be understood as extending temporally and spatially beyond imprisonment itself, with the post-release period representing a particularly acute phase of structural vulnerability and heightened harm. Of particular concern is the significantly elevated risk of mortality for PWID in the seven days following their release from prison (Binswanger et al., 2012, 2013; Cossar et al., 2022; Michener et al., 2024). For those who survive, the substantial likelihood of recidivism and subsequent reincarceration perpetuates their susceptibility to fatal overdose (Joudrey et al., 2019). This reflects a critical need for approaches in the early period between transitioning from prison and into the community, where PWIDs are at substantial risk of overdose deaths.

The transition from prison to the community presents a critical opportunity for implementing interventions to address the complex challenges faced by PWID upon their release from prison, which include fatal overdose (Denton et al., 2017). Traditional interventions for mitigating overdose risk have emphasized abstinence-based prevention programs (e.g., 12 steps) with continuity of care upon re-entry into the community (Cossar et al., 2022). However, in practice, these models often fail to deliver meaningful care (Cossar et al., 2022; Walker et al., 2018). Alternative approaches for curbing overdose risk are often also hindered by systemic issues within corrections, including policy limitations, cultural attitudes, and resource gaps (Chiu et al., 2024; Lafferty et al., 2021, 2023; Marshall et al., 2023). However, targeting harm reduction interventions for pre-release support and developing a person-centered and community-based network of support for PWIDs has been suggested to reduce drug overdoses, but also has flow-on benefits to reductions in homelessness and reincarceration (Chang et al., 2019; Fazel et al., 2016; Lafferty et al., 2023). Therefore, further consideration of ways to navigate these issues is warranted.

The effectiveness of harm reduction interventions for reducing overdose among PWID transitioning into and out of prison has been established across several key approaches, which include opioid

dependence treatment (ODT) (Larney et al., 2017; Platt et al., 2018) and naloxone distribution (Conway et al., 2021). These approaches have not been consistently implemented or supported at the necessary scale, particularly within Australian prison contexts (Curtis et al., 2023a; Larney et al., 2017). For instance, inadequate referral processes impede ODT and naloxone access, both of which are known to be effective in reducing overdose (Curtis et al., 2023a; Degenhardt et al., 2014; Kim & Nelson, 2015), resulting in reduced support and heightened risk of overdose (Binswanger et al., 2013; Lafferty et al., 2023; Zamani et al., 2010). Further, the take-home naloxone programs have been evaluated as effective in reversing overdose across various studies (Dwyer et al., 2018; Farrugia et al., 2017; Farrugia et al., 2019; Fomiatti et al., 2022; Neale et al., 2022). However, in Australia, naloxone uptake remains low (Fomiatti et al., 2022), and there are identified gaps in community-centred naloxone distribution and administration (Piatkowski, Kill, & Reeve, 2025) which are likely accentuated during the early period following post-release from prison (Curtis et al., 2018; Moradmand-Badie et al., 2021). Similarly, scholars have indicated engagement in ODT both in prison and post-release has many benefits, including the potential to reduce the likelihood of overdose, provided it is accessible (Curtis et al., 2023b; Dunlop et al., 2022; Larney et al., 2017). Yet for PWID, who are evidenced to have the best outcomes with ODT, access during this period has been documented to be challenging (Degenhardt et al., 2019; Stone et al., 2021). The lack of accessibility and functionality around these well-documented harm reduction interventions at the critical time during early post-release places PWIDs at risk of exposure to preventable death. Emerging evidence suggests that peer-led models can be particularly effective in building trust, supporting continuity of care, and responding rapidly to overdose risk during the high-stakes period immediately after release. In this context, peer networks often step in to fill service gaps (Brown et al., 2019; Miler et al., 2020), providing informal support, harm reduction education, and in some cases, direct access to naloxone (Miller et al., 2022).

The Risk Environment

The “Risk Environment” framework developed by Rhodes (2002) describes how social and structural factors exogenous to the person combine to produce or reduce drug-related risks and harms. Risk environments comprise two key dimensions: the type of environment (social, physical, policy, and economic) and the level of environmental influence (micro and macro) (Rhodes, 2002). Microenvironmental factors operate at the level of interpersonal relationships (e.g., negotiation between individuals regarding naloxone use), social group norms (e.g., acceptable injecting behavior), and organizational/institutional responses (e.g., police presence at syringe exchange sites, which may disrupt use and accessibility) (Rhodes, 2002; Rhodes et al., 2005). Macroenvironmental factors operate at the level of laws, policies, and social inequalities (e.g., gender and race), which interact with microenvironmental factors (Rhodes, 2002; Rhodes et al., 2005). Researchers have applied and extended Rhodes’ model (Collins et al., 2019; Piatkowski, De Andrade, Duff, et al., 2025; Rhodes et al., 2003, 2009; Rhodes & Treloar, 2008; Sarang et al., 2010), to indicate how risk environments mediate the incidence and distribution of harms according to the risks generated by “macro” factors like policies and legislative frameworks, along with the “micro” factors such as social norms, rules, and values (Piatkowski, De Andrade, Duff, et al., 2025; Selfridge et al., 2020). For PWIDs, the intersections between these “macro” and “micro” level factors together determine the character and impact of the local risk environment, and the specific ways in which this environment generates, amplifies, or mitigates the distribution of harm (Collins et al., 2019; Friedman et al., 2021). Understanding a specific risk environment is pivotal as intervention efficacy is dependent upon the correct implementation within its contextual settings (Rhodes, 2002).

Therefore, it is important to trace the experiences of PWIDs who have been incarcerated and transitioned back into the community, to better understand the factors of the risk environment that most

contribute to overdose risk. This includes identifying and mitigating those aspects of the local risk environment that amplify the risks encountered in navigating the transition from prison to community for PWIDs, as well as practical means of cultivating “enabling resources” (Duff, 2010) in and for this priority population. Hence, this study aimed to understand the overdose risk environment during the transition from prison to community, and what enabling resources are currently being employed by communities of PWIDs to reduce overdose risk during this transition.

Methods

Geographical and Sociopolitical Context

This study is set in Australia, where drug policy is officially guided by a harm minimization framework encompassing harm reduction, supply reduction, and demand reduction strategies (Commonwealth Department of Health (Australia), 2017). In recent years, Australia has seen a rise in drug-induced deaths, particularly linked to pharmaceutical opioids and stimulants (Penington Institute, 2024). At the same time, funding for harm reduction has declined, with just 1.6% of government expenditure in 2021/22 allocated to these services, compared to 65% directed toward law enforcement (Ritter et al., 2024). Despite this, the criminalization of drug use remains entrenched, with possession offenses still attracting criminal penalties in most jurisdictions. For example, in Australia, first-time offences may accrue civil penalties, whereas repeat offences may incur criminal charges (Greer et al., 2022). Therefore, in practice, sentences for drug-related offences may tend to be shorter (Freiberg, 2002) but are often highly disruptive and contribute to cycles of incarceration and overdose risk. Further, it is possible to have multiple thresholds of quantity that differentiate between low- and high-level simple possession. As proposed in some Australian jurisdictions, neither is considered a supply offence, but the former warrants a non-criminal response, whereas the latter receives a criminal one (Ritter et al., 2021). Nonetheless, this sociopolitical context places increased pressure on communities of PWIDs, who are often left to advance harm reduction efforts in under-resourced settings while contending with a punitive legal framework.

Study Design

This exploratory study sought to understand the overdose risk environment for PWIDs transitioning from prison into community. The research employed a peer-led approach (Piatkowski, Kill, et al., 2024). People with lived-experience (LLE) served as peer researchers and shaped the entire research process. Particularly to note is some researchers' experience with ODT and incarceration. This involvement included peers leading the design of the research methodology, leading data collection and analysis, and leading the interpretation and dissemination of findings. By centering peer expertise, the study embedded the perspectives of those with LLE, enhancing the relevance and impact of the outcomes. This project received approval from Griffith University's Human Research Ethics Committee (Approval Number: 2023/782).

Sampling and Recruitment

This study is part of a larger project that qualitatively explores the LLE of drug-related overdose in Queensland, Australia (Piatkowski, De Andrade, et al., 2024; Piatkowski, Kill, et al., 2024; Piatkowski, Kill, & Olsen, 2025; Piatkowski, Kill, & Reeve, 2025). The sample included 34 participants who had used illicit drugs in their lifetime, had witnessed or experienced an overdose, lived in Queensland, and were over the age of 18 years old at the time of interview between November 2023 and August 2024. All participants were recruited using purposive sampling techniques and

included members of the community who met the inclusion criteria. Participants were made aware of their right to withdraw from the study at any point, and a \$90AUD gift card was given to each participant as recognition of their time and expertise.

The analysis for the current study drew on the accounts of 10 PWIDs, who had been incarcerated in their lifetime and had experienced an overdose in their lifetime. All participants had been incarcerated in Queensland. The participants were aged between 42 and 63 ($M = 48.8$, $SD = 4.10$) and included five women and five men. The mean number of overdoses experienced by participants was 8 ($SD = 7$). All participants noted that they had engagement with ODT at multiple points in their lifetime.

Data Collection

Two interviewers (SR and KRP) conducted the interviews. Demographic information was collected to gain an understanding of the participants. The interview guide, developed by the research team and informed by existing literature and LLE, followed a semi-structured format. The semi-structured interview guide implemented open- and closed-ended questions with clarifying prompts that related to participants' LLE experiences of overdose, ODT, incarceration, and naloxone, and how these impacted their harm reduction efforts and overall well-being. Interviews ranged from 47 min to 1 hr and 49 min; the average length was 1 hr and 8 min ($SD = 14$ min). Two pilot interviews were conducted to validate and refine the interview questions, as well as enhance each interviewer's confidence. The semi-structured interview utilized both open-ended and closed-ended questions; examples of open-ended questions include: *Could you please tell me about your experiences with overdose? What preventive strategies, if any, do you and others you know practice to reduce the risk of overdose?* Closed-ended questions implemented open-ended prompts, for example: *During the transition into and out of corrections, were there any additional challenges for you concerning your drug use? Did any community healthcare providers engage with you before release?* Participants were prompted for further details as necessary. Respective prompts include: *If so, what challenges did you experience?* and *What healthcare providers did you engage with?* Interviews were scheduled based on participant availability and conducted via videoconferencing (i.e., Microsoft Teams) and were automatically transcribed. To ensure accuracy, SR and KRP manually reviewed and corrected all 10 of the transcripts prior to analysis.

Data Analysis

Transcripts were imported into textual analysis software (NVivo, v12, QSR) for data analysis. The senior author read and re-read the transcripts during this time, and then began to apply reflexive thematic analysis, identifying and developing codes first (Braun & Clarke, 2006, 2019). The specific focus of code identification and development was centred on understanding the risk environment contributing to drug overdose during PWIDs' transition from prison to community. To do so, the senior author drew on Rhodes (2002) risk environment framework, ensuring this theoretical lens was applied throughout the analysis. The senior author identified initial codes, which were refined into cohesive theme-categories. This process persisted until reaching adequate conceptual depth and thematic sufficiency, denoting the point where the accumulated data ceased to offer significant novel insights aligned with the research objectives (Guest et al., 2020). These theme-categories were refined into potential overarching themes through reflexive engagement with the research team, with a mix of traditional researchers (SR), peer researchers (KRP, EK, TP), and those with specific expertise related to injecting drugs and transitioning from prison into community (EC).

The senior author is a peer researcher who acknowledges his LLE of substance use and involvement in the criminal justice system over several years, although he was never formally incarcerated. SR is a traditional researcher and PhD candidate who has some experience in qualitative research with PWIDs

and demonstrated allyship with community. KRP is a clinical support worker in a residential mental health facility for over 5 years and has developed therapeutic relationships within the community of PWUDs. EK is an identified peer researcher in this space with extensive experience working with PWIDs, particularly people who use opioids, as well as expertise in ODT. EC, specifically, has experience in injecting drugs, ODT, and being incarcerated. Collectively, this expertise was pivotal in ensuring the thematic categories represented the narratives of the participants in this research and did so in a way which was respectful and contextually relevant to the community.

The following section presents the findings of the analysis. Two themes were identified and developed through analysis, each with two subthemes. Findings are presented with italicized quotes, preceded by the participant's pseudonym, age, and gender are bracketed.

Results

Theme 1: The Overdose Risk Environment for PWIDs Transitioning From Prison to Community

Sub-Theme 1.1: The macrolevel environment. Participants highlighted the importance of recognizing the factors and conditions that shape experiences of transitions from prison to community for PWIDs. All participants reported that pre-release harm reduction support, specifically support designed to reduce drug-related harms in the post-release period, was minimal to non-existent. This was driven by systemic forces such as the criminalization of PWIDs and the socio-legal environment they must navigate when making the transition back to community.

Pete [45, Man]: Getting back into community [from prison] is huge. When you get out, you've gotta watch your step. You can't tell your parole officer you used [...] one dirty piss test and you're looking at going straight back inside [to prison].

The overarching threat of criminalization and return to prison meant that PWIDs are in a constant state of fear when returning to community. As participants noted, it also poses a major barrier to open, honest conversations about health and well-being between PWIDs and the service providers supporting their transition. Participants' concerns were heightened by the difficulty in accessing healthcare, including drug treatment programs, both during and after incarceration. The core factor related to overdose risk during this time was ODT, which was shaped by several macro-level features of the risk environment. For instance, despite ODT as a protective factor to the well-documented risks of overdose post-release (see Larney et al., 2017), custodial institutions failed to ensure continuity of care for people dependent on opioids. In some cases, institutions allegedly breached conditions of orders to access ODT during incarceration. Participants described substantial obstacles in accessing ODT both during incarceration and upon release. Bureaucratic delays, communication failures, and a lack of prioritization of ODT marked the transition from prison to the community. Several participants reported that their requests for ODT were either ignored or delayed to the point of being ineffective.

Michaela [38, Woman]: I tried to get the subby [Suboxone] injection before release, but even that's a drama. You put a form in and can wait for six weeks, and even then, I didn't get the injection. So then when I got out [exited prison] it wasn't long before I overdosed [...] I didn't even get to see a doctor or anyone about getting on the program (ODT) and honestly, by that point it is too late anyway.

Michaela's experience highlights a broader systemic issue where administrative inefficiencies lead to critical gaps in care. Particularly during the community transition phase, the system is indifferent to

peoples' urgent medical needs. Prolonged wait times mean that, despite PWIDs' attempts to seek treatment proactively, they are left vulnerable. The delay in receiving medication had serious health consequences. This narrative was reflected among other participants who perceived institutional delays as a form of neglect, reinforcing their distrust of formal healthcare systems.

Rhonda [43, Female]: I've been on it [ODT] twice in jail [earlier reported being incarcerated 20 times], but the second time was only the last time in jail. They kicked me off it [ODT] for most of my sentence, and then two weeks before I got out, they come to me and said, "oh, do you want to get back on it?" And that was like, that was the second time I'd been on it [ODT] in jail. So yeah. So we'd be sick [withdrawing] every couple of days. It just makes you question the system all the time [...] They tell you one thing and [a] different thing happens.

Rhonda's accounts point towards clear inconsistencies between the systemic policies which are said to be supporting PWIDs during a vulnerable period. Further, even when participants were prescribed ODT before incarceration, they frequently experienced treatment discontinuation while in custody, leaving them vulnerable upon release. Rhonda's continued further, highlighting the disconnect of the continuity of healthcare between the transition between prison to community.

Rhonda [43, Female]: So that time I was on Suboxone when I got released. I thought everything was organised to pick up my dose from the chemist, but nothing was sent through. I got so frustrated that I relapsed and overdosed. They [health workforce] weren't there when I needed them the most, and I was left to fend for myself in a dangerous place.

The lack of consistency between harm reduction interventions and the way they are enacted during a critical period of early post-release, contributes to a macro-level risk environment for PWIDs to overdose during this time. The lack of structured support led some people to resort to unregulated opioid use in prison. Many participants noted that ODT discontinuation contributed to their reliance on unregulated opioid markets both inside and outside of prison.

Sera [48, Female]: I've used [heroin] for 30 years, and I couldn't even get on the program [ODT] - the process is punishing [inside prison]; it was just too hard. I ended up just using [drugs] in prison, so it didn't bother me too much [...] I think that's what a lot of people do. Then that lead to you end[ing] up using once you are getting out [of prison] as well, and that's when it [overdose] happens.

The inconsistent provision of ODT also reinforced cycles of dependence and risk rather than supporting PWIDs chosen harm reduction pathways which offer positive health and social wellbeing.

Sub-Theme 1.2: The microlevel environment. Participants consistently described how stigma and neglect from healthcare and correctional systems deepened their sense of marginalization. These interpersonal dynamics shaped the immediate environments they encountered, creating a hostile context during their transition from prison to community. At the micro-level, this pervasive stigma emerged as a key driver of risk for PWIDs navigating re-entry.

Carissa [43, Woman]: We [PWIDs] are treated differently wherever we go. It is the way people view us [...] as [if] there is something wrong with us. And that makes it hard to trust [anyone] when they are treating you like that [...] and it stems back from the way that we're treated everywhere, not just prison.

Participants spoke openly about the pervasive distrust PWIDs feel toward the health workforce, particularly in the context of ODT. This distrust was shaped not only by interpersonal experiences but also by

broader structural inequities in the delivery of care. Many people described encountering stigmatizing attitudes upon returning to community-based ODT services.

Doug [63, Man]: If you're on a [ODT] program like Subutex and you go to the chemist, you just know you're gonna be treated like scum [...] They make it their mission to make sure you know you're a second class citizen.

Due to these past stigmatizing experiences and the way they intersected with macro-level factors (e.g., the fear of legal repercussions, and the risk of losing their place in the ODT program), participants expressed reluctance to seek medical assistance in the event of an overdose after release. Renato's account illustrates how these dynamics compounded over time. Following his transition back into the community from prison, Renato experienced an overdose, after which he was denied re-entry into the ODT program. As he explained, this decision, framed by service providers as a consequence of his behavior, further entrenched his risk of harm.

Renato [42, Man]: At ATODS [Alcohol Tobacco and Other Drug Service], they said I couldn't get on the program because I'd overdosed and taken off [from hospital], so it looked like it was on purpose. It was, but isn't that more of a reason to put me on the program? That caused me to spiral back into full-bore addiction.

His exclusion from treatment following an overdose underscores a broader systemic pattern in which help is made conditional, appearing to hinge on perceived compliance or "appropriate" help-seeking behaviour. These moments of disqualification not only heighten overdose risk but also erode a person's trust that services are genuinely oriented toward care. Further, Connor explained how the service climate caused feelings of shame and anxiety that affected his ability to participate in the service.

Connor [42, Man]: The stigma makes it hard. Hard to get help, hard to be helped. If the stigma wasn't there, then I think it would be different, I would have been able to get the help I needed when I got out [of prison] and I wouldn't have overdosed.

Participants' access to healthcare and support felt uncertain and precarious, further entrenching their marginalization within these systems. Collectively, these risks and challenges stem from the broader risk environment, where policy and practice intersect, shaping the experiences and wellbeing of PWIDs alongside local "micro" factors.

In response to these institutional failures, peers have developed protective strategies to manage the overdose risk environment when transitioning to community from prison. We map the way this occurs and the ideas they shared with us for expansion of this peer-led approach.

Theme 2: Enabling Resources for Peers

Sub-Theme 2.1 Peer care and naloxone. Failures within institutional support systems led many PWIDs to rely on peer networks to manage overdose risk and navigate the transition from prison to community. Participants described how peer-led harm reduction was already being practiced, grounded in mutual responsibility and shared experience. Across interviews, participants stressed the importance of helping one another in overdose situations as a core community norm. Most expressed strong confidence that peers could recognize the signs of overdose and would intervene to provide assistance.

Doug [63, Male]: When they drop [overdose], they're in your hands. You're the only one they have [and] that's why it is so important to have peers around. We trust each other, we are there for each other.

This peer support and relational care were seen to be critical during the early post-release period because of the propensity for drug overdoses to occur during that time. Current strategies for overdose prevention within peer networks, which pair well within the relational style of peer care, include tools such as naloxone.

Pete [46, Male]: It [getting out of prison] is such a dangerous time. My partner overdosed three times after getting out of prison while at my house. The first night, I called an ambulance. After that, I went to [health and harm reduction service] to obtain naloxone, which works better for us.

Pete's account underscores how overdose can occur repeatedly and rapidly after release, especially in the absence of immediate structural support. His decision to obtain naloxone following his partner's third overdose reflects how peer care is not only reactive but also adaptive, responding to acute need by filling the gaps left by formal services, and demonstrating how trust, experience, and urgency shape harm reduction in real time. PWIDs' distrust of institutional responses to overdose situations, and social disconnection between current services and communities mean that tools like naloxone are important in the context of relational care surrounding overdose. Shaun noted that, particularly during the early transition period during post-release from prison, having a peer with naloxone training can save lives.

Shaun [46, Male]: If you do drop after getting out [of prison], knowing someone, especially someone you've been in jail with, will be ready with naloxone means that having trusted individuals can save lives.

These accounts highlight that relational dynamics play a critical role in overdose prevention. Social connection facilitates trust within communities of PWIDs, which enables collaborative strategies for managing overdose risks, such as naloxone administration, making peer networks excellent channels for care delivery.

Sub-Theme 2.2: Expanded peer-led education and naloxone distribution. Most participants felt that their status as peers enabled them to deliver overdose prevention education in ways that were both compassionate and credible. These connections were grounded in shared experience and a mutual recognition of what it means to survive overdose and institutional harms.

Shaun [46, Male]: When you possess lived experience, others recognise that you share their level of understanding. They realise you're not simply reciting information from a textbook since you've genuinely been through it [...] it's easier to relate to them and build trust because they belong to our community.

Participants believed that overdose prevention initiatives, which include distributing naloxone and thoroughly training first responders, represent contextually-appropriate measures that can meaningfully transform the overdose risk associated with the transition from prison to community. Michaela strongly advocated for peer-led naloxone training and for access to naloxone in prison and during transitions back to the community.

Michaela [38, Female]: Peers could go into jails to train individuals because drug use does occur in prison, and it's an audience that's captive. People being released should receive naloxone upon their exit, as well as at [health] clinics and during parole meetings.

These strategically situated opportunities for education demonstrate how harm reduction practices can be embedded in everyday spaces of interaction, extending their reach beyond conventional healthcare environments. Peer-led advocacy positions PWIDs as knowledgeable actors and agents of change, rather than passive recipients of care. Several participants noted they had undergone training from peers in naloxone administration and felt inspired to inform and train others. They mentioned that other peers

were open to receiving training in naloxone use. Those who took part in the training articulated that they felt more equipped to make informed choices and had increased self-efficacy when addressing overdose incidents. The empowerment derived from social connections built by peers illustrates the resilience and autonomy of those with LLE who are inspired by care and inspire others through care. As Carmel explains:

Carmel [46, Female]: Trained peers can provide quick education and training on naloxone to anyone interested, typically in about five minutes. For drug users, participants leave feeling more empowered as they connect with others and start to break down the shame associated with their addiction. They begin to view themselves in a new light and take [on] improved care of their wellbeing.

In this way, naloxone training provides more than just education, it provides the social connection through peer relationships to promote solidarity. This solidarity embodies an evolution of peer care, where the relational dynamics among individuals move beyond the traditional confines of institutional frameworks, enabling more responsive and authentic support. Peer-led education and care should be expanded into new spaces, such as prisons, where it will be able to have impact for people. Doing so would mean that all people leaving prison could also be equipped with naloxone, and, collectively, peer-led education with the correct tools could save peoples' lives during this vulnerable period.

Discussion

The current study sought to understand the overdose risk environment for PWIDs during transition from prison to community, and what enabling resources are currently being employed by PWIDs to reduce overdose risk during this transition. It documented the macro-level factors of the prison-to-community risk environment (e.g., criminalization and inequitable health access) which impede access to healthcare and treatment (e.g., ODT), for PWIDs transitioning from prison to community, chiming with extant work (Larney et al., 2017). At a micro-level, participants' narratives of both prison and community-based health services were strongly characterized by a perception of distrust, shaped by repeated experiences of stigmatizing and punitive healthcare interactions. This aligns with research by Benintendi et al. (2021), who found that patients undergoing opioid tapering described being surveilled, invalidated, and ultimately marginalized by institutional practices that eroded their trust in health systems. Similarly, Paquette et al. (2018) documented how PWIDs experienced stigma across multiple service settings, including pharmacies, emergency care, and drug treatment, leading to delayed care, reduced service access, and feelings of exclusion. These studies collectively highlight how stigma is embedded in both interpersonal interactions and structural systems, compounding PWID's sense of alienation and distrust in health services, a dynamic mirrored in our participants' accounts. In response to these institutional and systemic failures, communities of PWIDs focus on relational care strategies to keep each other safer (see Piatkowski, Kill, et al., 2024). The key enabling resources (see Duff, 2010) which assisted peers to reverse overdose and ensure community care were peer networks and naloxone. We discuss the practical implications of these findings below.

The core macro-level factor which potentiated overdose risk for PWIDs transitioning into community was equitable access to healthcare, particularly ODT. Despite the overwhelming evidence of the protective effect of ODT against drug-related mortality in the high-risk period of the first four weeks post-release (Larney et al., 2017), all participants reported issues with ODT access. This aligns with Larney et al.'s (2017) global findings, which show that ODT coverage remains critically low in most countries, with fewer than 20 recipients per 100 PWIDs and only a handful of countries meeting WHO benchmarks. Our study contributes a nuanced, qualitative layer to these statistics, revealing how the absence of ODT access often leads to the use of unregulated drugs within prison settings, compounding health risks even before release. In line with Colledge-Frisby et al. (2023), who demonstrate a

slight global increase in harm reduction service coverage over the past 5 years, our findings suggest that such modest gains have not translated into meaningful access for highly vulnerable subgroups, particularly incarcerated PWIDs. While global policy discourse increasingly recognizes the importance of scaling up ODT implementation remains piecemeal, with only 2% of the global PWID population having access. The accounts in this study highlight how this structural inadequacy manifests on the ground: participants described a complete lack of continuity in care, pointing to the absence of any form of wrap-around support to ensure timely ODT access during the transition from prison to community. This inequity among populations of PWID represents a profound lack of equitable care and disregard for human rights, leaving this already vulnerable group exposed to drug overdose.

These health inequities underscore the gaps in the intersecting carceral and healthcare systems for PWIDs in Australia. Current systems do not provide adequate transitional planning and support for PWID leaving prison. Medical, mental health and criminal justice agencies should more closely analyse how they could cooperate to reduce barriers to healthcare and the associated production of risk for PWID. Enhanced coordination of harm reduction efforts between prison and community-based health providers, social service agencies, and criminal justice agencies could improve the transitional process. Given that participants frequently had difficulties in accessing ODT immediately after release, which led to higher risk and occurrence of post-release overdose incidents, an urgent need exists to address this issue. It is, therefore, crucial to implement and extend effective interventions at the time of release.

Prior research shows high acceptability of take-home naloxone among people in prison, particularly those with a history of injecting drug use, and strong support from key stakeholders for in-custody training and naloxone provision at release (Curtis et al., 2018; Dwyer et al., 2018; Moradmand-Badie et al., 2021). For instance, Curtis et al. (2018) found that a significant proportion of male prisoners in Victoria were willing to participate in prison-based naloxone programs. Similarly, Moradmand-Badie et al. (2021) reported that people released from prison in New South Wales viewed naloxone programs as both feasible and acceptable. Despite these positive perceptions, research has highlighted that formalized and standardized naloxone distribution programs across Australian jurisdictions remain inconsistent, leaving many people leaving prison to navigate naloxone access independently in the community (Dwyer et al., 2018; Stam et al., 2019). Our study reinforces the importance of prison-based naloxone provision and further highlights the unique and under-recognized role of peer networks in bridging post-release gaps. While previous studies have primarily focused on the feasibility and acceptability of naloxone programs, our findings are a reminder of the important of the operational role of peer networks. Participants in our study described how peer-led initiatives not only facilitated naloxone administration but also provided trusted education and support, filling critical voids left by formal services. This points to the urgent need for models and frameworks that embed peer-led naloxone distribution and training into the transition from prison to community to more effectively reduce preventable overdose deaths.

In response to the hostile and punitive environment which meets PWIDs when transitioning from prison to community, participants noted the importance of peer-led care (see Piatkowski, Kill, et al., 2024). Participants in this study emphasized the importance of trust as a fundamental principle to mitigate overdose-related risks for PWIDs during the prison-to-community transition, supportive of extant work (Lafferty et al., 2023). Notably, Lafferty et al. (2023) highlighted that trust in service providers is often compromised for PWIDs post-release, with participants reporting a lack of fidelity and experiences of exploitation by service providers, particularly community corrections officers. This erosion of trust impedes effective service engagement. Our findings extend this understanding by illustrating how peer-led care can fill this trust void, offering support that is perceived as more authentic and aligned with the needs of PWIDs. The social dynamics among communities of PWIDs are critical components of the way in which they provide care and support for one another (Piatkowski, Kill, et al., 2024). Participants built on the concept of peer-led care to and offered valuable perspectives that could

enhance support for PWID transitioning from prison to community. For instance, participants were adamant regarding the importance of peer-led education, support, and outreach around naloxone. As current research demonstrates (see Fomiatti et al., 2022) there is a critical need to amplify and extending naloxone's reach and uptake.

The current findings build on extant work and underscore an urgent need to shift to peer-led education approaches for overdose prevention, particularly for PWIDs transitioning from prison to community. We suggest providing a standardized, pre-release prison intervention to effectively engage PWIDs in non-stigmatizing comprehensive peer-led overdose prevention. The peer-led education and outreach could be delivered in prisons for those expecting to transition back into community within 3 months (i.e., delivered quarterly), and could include safer use information regarding drugs, naloxone administration, and a naloxone kit to be given to all people on release. Community-based organizations in each state and territory (e.g., drug-user organizations) are well positioned to collaborate with policymakers and Australian departments of health to incorporate this peer-led education and naloxone uptake initiative as a standard procedure for all people leaving prison. This type of approach, according to the current study and extant literature, would likely reduce the mortality risk for this vulnerable group at a critical timepoint.

Limitations

We acknowledge a number of limitations related to this research. For instance, we did not document and quantify some participant characteristics which may have been of interest (e.g., the exact numbers for the number of times incarcerated, time since last incarcerated, times between release and overdose, and injection rates while incarcerated). However, we note that when we did ask participants the quantifiable questions we had listed (e.g., number of overdoses), these were challenging for participants to quantify and retrospectively calculate. Nonetheless, future studies should aim to systematically collect quantitative data on incarceration history, timing of overdose in relation to release, and injecting behaviors while incarcerated to strengthen the evidence base and better inform policy and intervention design. A further limitation of this study is the underrepresentation of people from marginalized groups (e.g., Aboriginal and Torres Strait Islander people) as well as people with disabilities and those of diverse gender identities. Future research should prioritize a more diverse sample to better explore how intersectionality may influence drug use and peer-led interventions. This could offer deeper insights into how gender and other identity factors interact with consumption practices, and how these dynamics shape experiences of belonging, inclusion, and exclusion in the context of intersecting forms of marginalization, violence, and discrimination.


Conclusions

This research suggests a need to continue to ensure current overdose prevention approaches for PWIDs transitioning from prison to the community are peer-led. The findings demonstrate that, at a macro-level, existing health systems often fail to provide adequate, equitable care during this vulnerable period, leaving many without access to healthcare and treatment, including ODT. Expanding access to ODT within prison and post-release settings is critical for preventing overdose during this vulnerable time period. At a micro-level, stigma continues to potentiate systemic inequities for PWIDs. Peer-led approaches which prioritize trust and solidarity, are key to mitigating these sociostructural risk factors. Expanding peer-led education and naloxone distribution will reduce overdose among PWIDs and promote enhanced health and social well-being.

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