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Supporting Information

Supplementary material

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Chan J, Cook J, Curtis M, et al. National consensus statement on opioid agonist treatment in custodial settings. *Med J Aust* 2025; doi: 10.5694/mja2.52603.

Appendix 1: Consensus Statement Expert Panel

Name	Affiliation	State/ Territory
Adrian Dunlop	Director and Senior Staff Specialist, Drug and Alcohol Clinical Services, Hunter New England Local Health District, New South Wales; President of the Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians	NSW
Andrew Wiley	Director, SA Prison Health Service, Nurse	SA
Bianca Davidde	Addiction Medicine Physician, Drug and Alcohol Services, DASSA	SA
Christine Watson	Director of the Addiction Medical Services, Northern Territory	NT
David Onu	Forensic Medical Specialist & General Practitioner, Statewide Specialty Director, Correctional Health Services	TAS
Ele Morrison	Director of Advocacy, Australian Injecting & Illicit Drug Users League	VIC
Jeremy Hayllar	Clinical Director of the Alcohol and Drug Service of Metro North Mental Health - Alcohol and Drug Service	QLD
Jocelyn Chan	Addiction Medicine Registrar & Public Health Physician, Western Health Drug Health Services	VIC
Katerina Lagios	Sexual Health Physician and Clinical Director Population Health, Justice Health & Forensic Mental Health Network, New South Wales	NSW
Kevin Fontana	Medical Services Director, Corrective Services, Department of Justice, Western Australia	WA
Mark Stoove	Head of Public Health, Burnet Institute	VIC
Peter Thompson	Co-Clinical Director Drug & Alcohol, Justice Health and Forensic Mental Health Network, New South Wales	NSW
Name withheld	Affiliation withheld	ACT

Rebecca Winter	Deputy Head Justice Health Group, Burnet Institute	VIC
Shalini Arunogiri	Clinical Director, Statewide Centre for Addiction and Mental Health, Turning Point	VIC
Suzanne Nielsen	Deputy Director of the Monash Addiction Research Centre, Monash University; Pharmacist; President-Elect Australasian Professional Society on Alcohol and Other Drugs	VIC
Thileepan Naren	Addiction Medicine Physician, Western Health	VIC
Tom Turnbull	Medical Director, Prison Health Service, South Australia; Chair of the Royal Australasian College of General Practitioners Specific Interest Group for Custodial Health	SA

Appendix 2: PubMed search strategy

(("buprenorphine"[Title/Abstract] OR "methadone"[Title/Abstract] OR "naltrexone"[Title/Abstract] OR "Opiate Substitution Treatment"[MeSH Terms]) AND ("prisoners"[MeSH Terms] OR "correctional facilities"[MeSH Terms])) AND ((english[Filter]) AND (2002:2023[pdat]))

Appendix 3: List of endorsing organisations

“As of 28 January 2025, the statement has been endorsed by Australasian Professional Society on Alcohol and other Drugs (APSAD), Australian Injecting and Illicit Drug Users League (AIVL), Royal Australasian College of Physicians Chapter of Addiction Medicine (RACP), National Prison Hepatitis C Network (NPHN), and the Pharmaceutical Society of Australia (PSA). The statement is also recognised as a ‘supported resource’ by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and approved as an Accepted Clinical Resource by Royal Australasian College of General Practitioners (RACGP).”

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Appendix 4

Item No.	Section	Checklist Item (*help text*)	Page No.
T1	**Title**	Identify the article as reporting a consensus exercise and state the consensus methods used in the title. *For example, Delphi or nominal group technique.*	1
I1	**Introduction**	Explain why a consensus exercise was chosen over other approaches.	
I2		State the aim of the consensus exercise, including its intended audience and geographical scope (national, regional, global).	2
I3		If the consensus exercise is an update of an existing document, state why an update is needed, and provide the citation for the original document.	N/A
M1	**Methods** Registration	If the study or study protocol was prospectively registered, state the registration platform and provide a link. If the exercise was not registered, this should be stated. *Recommended to include the date of registration.*	4
M2	Selection of SC and/or panellists	Describe the role(s) and areas of expertise or experience of those directing the consensus exercise. *For example, whether the project was led by a chair, co-chairs or a steering committee, and, if so, how they were chosen. List their names if appropriate, and whether there were any subgroups for individual steps in the process.*	3
M3		Explain the criteria for panellist inclusion and the rationale for panellist numbers. State who was responsible for panellist selection.	3
M4		Describe the recruitment process (how panellists were invited to participate). *Include communication/advertisement method(s) and locations, numbers of invitations sent, and whether there was centralised oversight of invitations or if panellists were asked/allowed to suggest other members of the panel.*	3
M5		Describe the role of any members of the public, patients or carers in the different steps of the study.	3
M6	Preparatory research	Describe how information was obtained prior to generating items or other materials used during the consensus exercise. *This might include a literature review, interviews, surveys, or another process.*	3
M7		Describe any systematic literature search in detail, including the search strategy and dates of search or the citation if published already. *Provide the details suggested by the reporting guideline PRISMA and the related PRISMA-Search extension.*	3
M8		Describe how any existing scientific evidence was summarised and if this evidence was provided to the panellists.	4
M9	Assessing consensus	Describe the methods used and steps taken to gather panellist input and reach consensus (for example, Delphi, RAND-UCLA, nominal group technique). *If modifications were made to the method in its original form, provide a detailed explanation of how the method was adjusted and why this was necessary for the purpose of your consensus-based study.*	4
M10		Describe how each question or statement was presented and the response options. State whether panellists were able to or required to explain their responses, and whether they could propose new items. *Where possible, present the questionnaire or list of statements as supplementary material.*	4
M11		State the objective of each consensus step. *A step could be a consensus meeting, a discussion or interview session, or a Delphi round.*	4
M12		State the definition of consensus (for example, number, percentage, or categorical rating, such as ‘agree’ or ‘strongly agree’) and explain the rationale for that definition.	4
M13		State whether items that met the prespecified definition of consensus were included in any subsequent voting rounds.	4

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M14		For each step, describe how responses were collected, and whether responses were collected in a group setting or individually.	4
M15		Describe how responses were processed and/or synthesised. *Include qualitative analyses of free-text responses (for example, thematic, content or cluster analysis) and/or quantitative analytical methods, if used.*	4
M16		Describe any piloting of the study materials and/or survey instruments. *Include how many individuals piloted the study materials, the rationale for the selection of those individuals, any changes made as a result and whether their responses were used in the calculation of the final consensus. If no pilot was conducted, this should be stated.*	4
M17		If applicable, describe how feedback was provided to panellists at the end of each consensus step or meeting. *State whether feedback was quantitative (for example, approval rates per topic/item) and/or qualitative (for example, comments, or lists of approved items), and whether it was anonymised.*	Appendix 4
M18		State whether anonymity was planned in the study design. Explain where and to whom it was applied and what methods were used to guarantee anonymity.	4
M19		State if the steering committee was involved in the decisions made by the consensus panel. *For example, whether the steering committee or those managing consensus also had voting rights.*	4
M20	Participation	Describe any incentives used to encourage responses or participation in the consensus process. *For example, were invitations to participate reiterated, or were participants reimbursed for their time.*	N/A
M21		Describe any adaptations to make the surveys/meetings more accessible. *For example, the languages in which the surveys/meetings were conducted and whether translations or plain language summaries were available*.	N/A
R1	Results	State when the consensus exercise was conducted. List the date of initiation and the time taken to complete each consensus step, analysis, and any extensions or delays in the analysis.	4
R2		Explain any deviations from the study protocol, and why these were necessary. *For example, addition of panel members during the exercise, number of consensus steps, stopping criteria; report the step(s) in which this occurred.*	N/A
R3		For each step, report quantitative (number of panellists, response rate) and qualitative (relevant socio-demographics) data to describe the participating panellists.	Table 1
R4		Report the final outcome of the consensus process as qualitative (for example, aggregated themes from comments) and/or quantitative (for example, summary statistics, score means, medians and/or ranges) data.	Table 2
R5		List any items or topics that were modified or removed during the consensus process. Include why and when in the process they were modified or removed.	4
D1	Discussion	Discuss the methodological strengths and limitations of the consensus exercise. *Include factors that may have impacted the decisions (for example, response rates, representativeness of the panel, potential for feedback during consensus to bias responses, potential impact of any non-anonymised interactions).*	10
D2		Discuss whether the recommendations are consistent with any pre-existing literature and, if not, propose reasons why this process may have arrived at alternative conclusions.	5-10
O1	Other information	List any endorsing organisations involved and their role.	Appendix 3

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O2		State any potential conflicts of interests, including among those directing the consensus study and panellists. Describe how conflicts of interest were managed.	Title page
O3		State any funding received and the role of the funder. *Specify, for example, any funder involvement in the study concept/design, participation in the steering committee, conducting the consensus process, funding of any medical writing support. This could be disclosed in the methods or in the relevant transparency section of the manuscript. Where a funder did not play a role in the process or influence the decisions reached, this should be specified.*	Title page

For more information see: https://www.ismpp.org/accord

Appendix 5

National consensus statement on the provision of opioid agonist therapy (OAT) in custodial settings – survey R1 results and updated recommendations

2 July 2024

Survey R1 Results

We received a total of 14 responses. Responses were received from five states across Australia. The majority of respondents were healthcare providers (64%). (Table 1)

Consensus (i.e. greater than 80% agreement) was achieved for all but one recommendation. (Table 2) Recommendation 2.1 relating to choice of medication achieved 71% agreement among respondents.

Table 1: Survey R1 participants

Gender	Female	7 (50%)
	Male	7 (50%)
Location	New South Wales	2 (14%)
	Northern Territory	1 (7%)
	South Australia	3 (21%)
	Victoria	7 (50%)
	Western Australia	1 (7%)
Primary field of employment	Advocacy	1 (7%)
	Healthcare administration	1 (7%)
	Healthcare provider	9 (64%)
	Research	3 (21%)

Table 2: Level of agreement for each recommendation

Domain	**Recommendations**	**Level of agreement N=14**
Induction or continuation of OAT	1.1	13 (93%)
	1.2	14 (100%)
	1.3	13 (93%)
	1.4	12 (86%)
	1.5	13 (93%)
OAT options and administration	2.1	10 (71%)
	2.2	13 (93%)
	2.3	13 (93%)
Transition of care to the community	3.1	14 (100%)
	3.2	12 (86%)
	3.3	13 (93%)

	3.4	14 (100%)
Special populations	4.1	14 (100%)
	4.2	13 (93%)
Organisational support	5.1	14 (100%)
	5.2	14 (100%)
	5.3	14 (100%)
	5.4	14 (100%)
	5.5	14 (100%)

Table of revised recommendations

Recommendations have been revised based on qualitative feedback collected in Survey R1. (Table 3)

Table 3: Revised recommendations with track changes

1	**Induction or continuation of OAT**
	We recommend that custodial health services:
1.1	Continue treatment for people entering custodial settings on OAT without interruption.
1.2	Confidentially screen people entering custodial settings for opioid dependence and risk of opioid withdrawal.
1.3	Assess and treat people at risk of opioid withdrawal within 24 hours. They should be monitored by appropriately qualified health care providers for at least 72 hours following detention.
1.4	Offer OAT to all who meet criteria for opioid dependence according to International Classification of Diseases, 11th Revision (ICD-11) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (moderate-severe opioid use disorder, DSM-5). The principles of informed consent should be observed. There should be no arbitrary limits to OAT access based on resource constraints.
1.5	Offer a health assessment to people seeking OAT at any time during their incarceration, within two weeks. Earlier assessment is required for people at risk of opioid withdrawal (see recommendation 1.3). Priority should be given to pregnant women and people with significant physical or mental health comorbidities.
2	**OAT options and administration**
	We recommend custodial health services:
2.1	Use a person-centred approach that allows choice of medication. The choice of medication and formulations offered is a clinical decision that requires thorough consideration of the risks and benefits for each individual.
2.2	Consider maximising access to the long-acting buprenorphine depot, given it may facilitate greater treatment access with the same resources.
2.3	Avoid withholding or discontinuing OAT as a disciplinary measure. Forced tapering and withdrawal of OAT during incarceration increases risk of overdose and death on release.
3	**Transition of care to the community**
	We recommend that custodial health services:
3.1	Actively link people on OAT with community-based OAT providers prior to release to facilitate continuity of care.
3.2	Provide individuals with a bridging prescription and accessible dosing location on release from prison. The script should be of sufficient duration to ensure continuity of treatment while identifying a community prescriber – ideally at least four weeks supply. Ensure that take-away doses are available for days when pharmacies are closed and supervised dosing is not available.

3.3	Implement programs to provide psychosocial support on release, including peer or patient navigators, to improve OAT retention.
3.4	Provide training and access to take-home naloxone during incarceration and on release to reduce the risk of fatal overdose.
4	**Special populations**
	We recommend that custodial health providers:
4.1	Collaborate with Aboriginal and Torres Strait Islander community representatives, including Elders, to ensure culturally appropriate care for Aboriginal and Torres Strait Islander people. Consider establishment of in-reach services in collaboration with local Aboriginal Community Controlled Health Organisations.
4.2	Continue or commence OAT for pregnant women with opioid dependence.
5	**Organisational support**
	We recommend that custodial health services:
5.1	Maintain up-to-date protocols or guidelines for OAT service delivery.
5.2	Implement opioid harm reduction education programs, covering OAT, overdose prevention and stigma, for people in prison, healthcare providers and correctional staff. The program should be culturally appropriate and accessible to people with varying levels of health literacy.
	We recommend that government and relevant health authorities:
5.3	Ensure adequate and sustained funding to support OAT service delivery.
5.4	Implement a jurisdiction-wide electronic medical record in custodial settings to promote continuity of care across settings.
5.5	Monitor key OAT program indicators, including screening, uptake, wait-times, retention, and adverse events to inform ongoing quality improvement.