Redefining the Story of Incarceration and Opioid Use

Lived Experience Workshops

Summary Document

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Introduction

A research group from McMaster University led by Fiona Kouyoumdjian is looking at administrative correctional and coronial data on people who died from opioids and experienced incarceration in Ontario from 2015 to 2020. This includes people who died in custody and people who died after release from provincial correctional facilities.

The specific goals for the research project are to:

- Look at changes in opioid-related deaths over time and during periods after release from prison
- Compare opioid-related deaths for those who experience incarceration and others in the general population
- Look at differences in opioid-related death rates by age group and sex

This information will hopefully help inform the need to provide prevention tools and treatment to people who use drugs and are incarcerated, and help create public policy that promotes the health and wellbeing of this group of people.

The project team engaged people who have experience using street drugs and who have been incarcerated in Ontario, and people who have lost a loved one to street drug use in or shortly after incarceration. Participants represented diversity across geography, gender, age, racial identity, and perspective (Appendix A). Lived experience participants were asked to share their unique perspectives to provide better context for the interpretation of the research findings and on the knowledge translation approaches.

The project team hosted a three-workshop series in October 2022. Throughout the workshops, participants learnt about the research project goals, data and results, had the opportunity to provide feedback and insights into the results, and discussed who the findings should be disseminated to.

This document summarizes the feedback received from people with lived experience throughout the 3 workshops. The feedback is aggregated and anonymized to ensure that the privacy of participants is respected, while staying true to the nature of the discussion.

Session Objectives

Workshop 1:
Introduction to the Research Project

Get to know one another and gain a deeper understanding of the project, the hypothesis and the data

Workshop 2:
Data Interpretation and Feedback

Provide feedback and input into the interpretation of the data, results, tables and graphs.

Workshop 3:
Implications and Knowledge Translation

Discuss why the results matter for people with lived experience of incarceration and opioid use, and what the next steps for knowledge translation and implementation should be.

Code of Conduct

At the first workshop participants were asked to co-create a Code of Conduct for how they would like to interact in the space to create an environment of mutual respect. This Code of Conduct was used throughout all three workshops.

We will create an environment of mutual respect and we agree to:

- Keeping yourself muted to respect when others are sharing
- What's said here, stays here
- No one's comments or experiences are wrong
- No judgements
- Commitment to ending on time, and respecting time
- Keep your comments to the point, stay focussed
- Be mindful of how we say something
- Be sympathetic to others traumas and praise their survivals

Feedback on Research Results

Participants were asked their perspectives on the research results of people who died from opioid overdose who experienced incarceration in provincial correctional facilities in Ontario from 2015 to 2020. They provided insights and contextualized the results based on their lived experience, shared whether the results reflected or did not reflect their experiences, and provided causes and reasons for why we are seeing these results.

Section 1: General Results

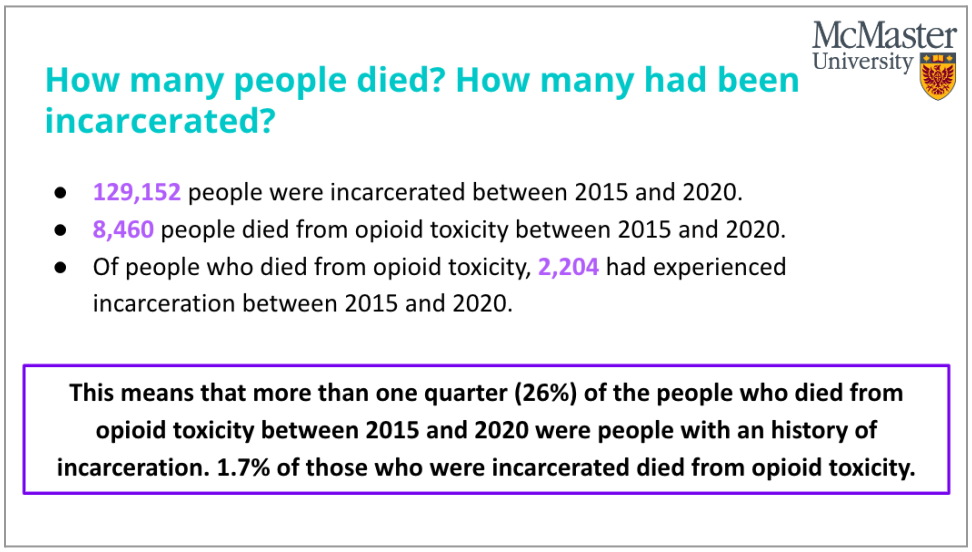


Figure 1. General results on people who were incarcerated and died from opioid toxicity from 2015 to 2020.

The disproportionately high number of people who died from opioid toxicity with a history of incarceration reflects the lived experience of participants. Some participants agreed that the overall number of people who died from opioid toxicity is probably even higher than the research findings, especially nationally. Some of the causes and reasons brought forward by participants for these results are:

1. Loss of Tolerance and Dosing

After leaving prison, many people believe they can use the same amount of opioids after their body was detoxed and their tolerance has changed. They are accustomed to the amount of drug that they typically use and may not realize that they have a lower tolerance. People may also not realize the potency of fentanyl and that it is toxic in micrograms (unlike heroin or crack which is measured in milligrams), or if available drugs are more potent than what may have been available when they were incarcerated (i.e. the drug supply is not consistent or predictable). Various participants have seen people pass away from taking too large a dose of a drug after coming out of jail.

2. Changing and unpredictable drug supply

Many people do not realize what drug they're actually taking, what is in the fentanyl or what is added in its place. Drug quality of fentanyl has also worsened and there is currently only a small

amount of actual fentanyl in street fentanyl. The addition of benzodiazepines to fentanyl is causing people to experience psychosis, blackouts or developing another addiction. People who experience incarceration need correct information on what drugs they are actually taking as they often think they know but do not.

3. Support systems
When people are released, they may not have the support systems they had before they were incarcerated. Sometimes their family and friends have abandoned them or they feel uncomfortable seeking help. They also have nothing at the time of release, and may find themselves in an unfamiliar city with no transportation, housing, or access to their usual dealer. Supports and resources need to be provided at release to help prepare for re-entering society. See Section 3 below for more perspectives on how sex and gender impact support system.

4. Criminalization of people who use drugs
People who use drugs are a criminalized group. This is reflected in the fact that 26% of people who died from opioid toxicity had been incarcerated during the same period. Criminalization of drug use means everyone who uses drugs is at risk for imprisonment. One may also interact with the police several times but not every interaction results in an arrest. If you were to consider how many people who have overdosed interacted with the criminal justice system beyond just arrests and incarceration, it would likely be a much higher percentage. When help is needed and people do not have access to naloxone, they may not call 911 for an overdose because they are worried about getting charged. Jail is not a rehabilitative system, it's a life sentence; once you're a prisoner you're always a prisoner.

5. Opioid use, opioid agonist therapy and overdose treatment in jails
There needs to be harm reduction strategies in jails. Drugs are available in prison; bribery is real and both people who are incarcerated and people working in prisons sell drugs make money from selling drugs. Opioid users also end up in infirmary and fake issues to get access to drugs. However drugs are dangerous to use in jail, as one's tolerance has dropped and avoiding being caught by correctional officers leads people to take drugs in secret. There have now been improvements and you can get opioid agonist therapy in jail. However, it can take weeks to get access to treatment even though it should be available within 72 hours, and it's not clear if methadone and suboxone are accessible in all facilities. COVID-19 has also influenced the use of opioid agonist therapy and extended timelines. There is also no naloxone in jail. Correctional officers should be trained in how to use naloxone and should have to attend to an overdose if it happens inside a facility. That is a human right.

6. Health and stigma
There is no connection between healthcare inside and healthcare outside of jail. If there was some connection or it was all one system it would be easier to have continuity of care and access to health care information. Mental health is also an issue, substance users are often not in a good place and battle depression and trauma. There is also a stigma around opioid use, which makes people hide that they are using after they are released and do not seek help.

Section 2: Characteristics of People Who Died and Had Incarceration History

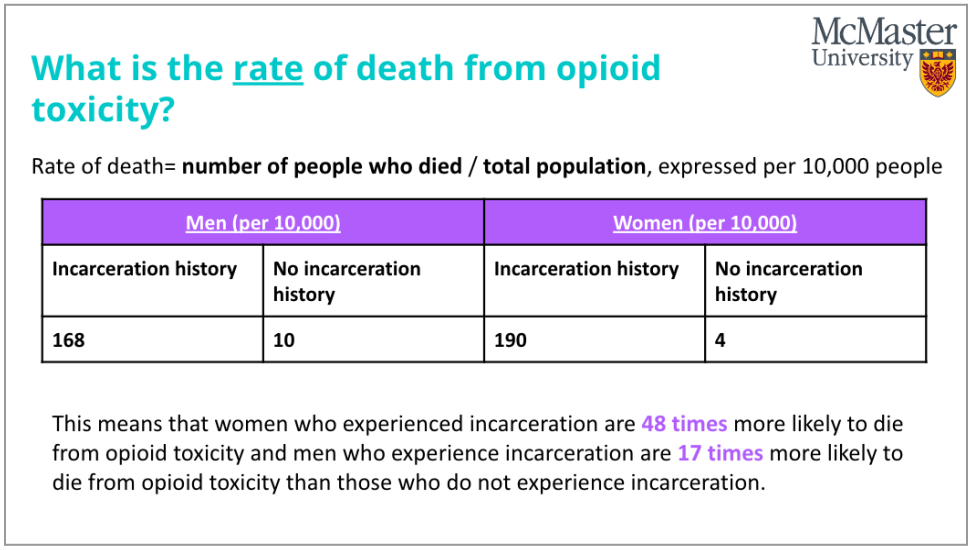
Figure 2. Characteristics of people who died and had incarceration history.

Participants felt the **age** representation of people who died and had incarceration history reflected their experiences. Based on their observations, younger people are using opioids in jail.

The representation of **race and ethnicity** did not always reflect participants' experiences. Opioid and substance use may be more common in **white communities**. However, **Indigenous communities** are disproportionately affected by substance use and incarceration. Participants expect the percentage for Indigenous peoples who died and had incarceration history is probably significantly higher than the 9% because the Indigenous population in Ontario jails is at least 30-40%. Participants have also encountered a significant number of Indigenous people in jail being addicted to opioids. Consideration should be made for how Indigenous people have or identify through status, and how self-identified Indigenous people who do not have status may not feel they are able to self-identify. Indigenous people may also have a different experience in jail as their families do not have the collateral or funds to allow access to drugs in jail. The percentage of those who identify as **Black/African/Caribbean** also seemed low based on their experience. Considerations should be made for how privilege and power contribute to the dynamics of self-identified race and who is asking race questions. The percentage by race also speaks to who the court system and Ministry of the Attorney General are releasing and who they're detaining.

Participants felt that **geography** would also be an important characteristic to consider. Breaking down data by facility may show differences by region, as some geographical areas are at higher risk for opioid deaths and have a larger population size. It would also be helpful to think about the overall Ontario average and compare facilities to understand how they treat people who are incarcerated in their facility.

Section 3: Rate of Death from Opioid Toxicity



What is the rate of death from opioid toxicity?

McMaster University

Rate of death= **number of people who died** / **total population**, expressed per 10,000 people

Men (per 10,000)		Women (per 10,000)	
Incarceration history	**No incarceration history**	**Incarceration history**	**No incarceration history**
168	**10**	**190**	**4**

This means that women who experienced incarceration are **48 times** more likely to die from opioid toxicity and men who experience incarceration are **17 times** more likely to die from opioid toxicity than those who do not experience incarceration.

Figure 3. Rate of death from opioid toxicity by gender/sex for those with incarceration history versus no incarceration history.

The higher rate of death in people who have experienced incarceration, compared to people who have no incarceration history, reflected participants' experiences. An important contributing cause is the **lack of housing** for recently released individuals. If someone has a place to go, they are safer. Placement of jails and transportation methods means that individuals are being released in a remote area with no support and may spend a couple of days on the road to get to housing. Provincial half-way houses, although a reformist change, used to fill this gap and should be brought back to deal with the housing shortage. They also serve as an alternative to jail if someone does not have the housing required to fulfill bail conditions.

The higher rate of death for women who experienced incarceration compared to men reflected the experiences of participants. Some of the reasons brought forward by participants for this difference in rate of death by sex are:

1. Lack of services and spaces specific for women
There are not enough thoughtful and appropriate services for women or places where women can go when released. Available services do not pay attention to the unique and complex needs of women and two-spirited people.

2. Societal expectations and responsibilities
Society expects women to care for communities and for men, but women do not receive the same care in return. Women offer continuous care, supporting men while incarcerated (e.g., starting relationships through being pen pals), waiting for and supporting them when they are released, and even being charged on behalf of their male partners. However, women are more likely to come out of jail alone with no connections and less support, have to rebuild their relationships, and have the responsibility of caring for their children which may have been taken

away by the Children's Aid Society. Furthermore, all these structural and systemic pressures put on women can lead women to more drug use.

3. Violence against women
Once released, women are more likely to experience violence and are not able to defend themselves, and drugs are often used as a coping mechanism.

4. Men control their substance use
Women are often in partnerships where they do not hold power and privilege in their substance use. Their male partners control their connection to drugs and control the dosage and supply. Their male partners may also decide who will do the injecting, how frequently and can change their doses at any time.

There were some concerns related the **sex/gender label** in the data. The division of woman versus man is over simplistic and excludes or misidentifies trans people and two-spirited people, for example. It is unclear if the sex/gender label is self-reported, based on ID or based on gendered facilities. This sex/gender data is demonstrative of how the system is failing people. Nevertheless, it is still worthwhile to include sex/gender-based data because of lack of appropriate services for women, but while being clear about limitations of the data and whose story is not being told.

Section 4: Timing of Death After Release from Custody

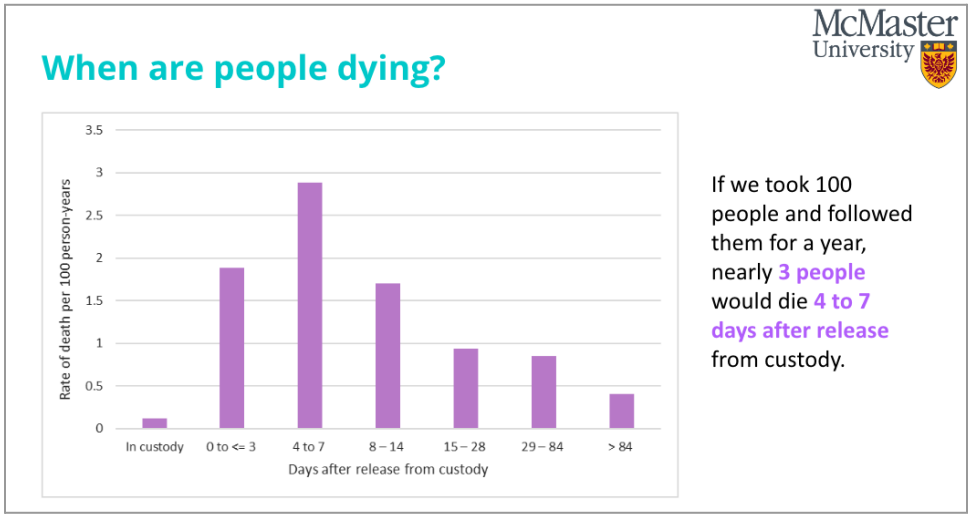


Figure 4. Timing of death after release from custody shown by the rate of death per 100 person-years.

The differences in rate of death (per 100 person-years) at different timepoints after release from custody reflects the experiences of participants. Some of the reasons participants shared for why there is a higher rate of death soon after release from custody are:

1. Higher risk at time of release
'Duty to care' ends at the facility doors and does not continue once people are released, even though they are in the most danger in jail and right when they come out. Support is needed upon release, especially for drug overdose. People are likely trying to stay sober at first, but on day 3 when they do not have the support they need they switch back to using drugs and overdose. Timing of death after release is important for designing services and release plans.

2. Lack of access to safe drugs
People may be on methadone or suboxone in custody but do not have access when they return to community, so when they experience withdrawal and use non-prescribed opioids they may overdose. Upon release people are more susceptible to getting drugs that are contaminated because they may not be able to access their usual supplier. There may also be conditions of release, such as strict parole or probation conditions, which creates additional obstacles for them accessing safe drugs.

3. Addiction and choices
Addiction is dependent on the person and their choices, and that will influence whether or not they will use drugs when released and when. When people who use drugs are told they cannot have their drug of choice in jail it may encourage them to take it more when they leave jail. People turn to what they know and what is familiar.

Feedback on Knowledge Translation

Participants were asked to provide input on the knowledge translation plan that guides how the project team shares the research results and project narrative with the public. Specifically, participants were asked: Who are the key players at different levels of the system that need to hear about this research (e.g., public, community, government)?

The following are the groups, organizations, centres, and audiences that they felt should hear about the results of this study.

1. Health and treatment centres
    a. These are points of contact after people go after jail
    b. Doctors
    c. E.g., CAMH and Waypoint Centre for Mental Health Care
2. Public health services
3. Research centres and pathways
    a. Encourage future research to answer deeper questions
4. Government, politicians, and policy makers
    a. People who make policies and decisions about decriminalization
    b. Opposition MPPs
    c. Lobby groups
    d. Kim Pate (senator who does a lot of work around women and incarceration)
    e. Ontario Drug Strategy
5. Shelter systems
6. Safe injection sites
    a. E.g., Moss Park
7. Nonprofit and support organizations
    a. E.g., Canadian Elizabeth Fry Society (CAEFS)
8. General public
    a. Social media
9. Human Rights Commission
10. Justice system
    a. Judges
11. Individual detention facilities