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RESEARCH REPORT

Examining Experiences of Federal Offenders on Opioid Agonist Treatment (OAT) During Release from Incarceration in Ontario, Canada: A Post-Release Report

2023 Nº R-450

ISBN: 978-0-660-45940-0

Cat. No.: PS83-5/R450E-PDF

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Examining Experiences of Federal Offenders on Opioid Agonist Treatment (OAT) During Release from Incarceration in Ontario, Canada: A Post-Release Report

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The views expressed in this report are those of the authors
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Correctional Service of Canada

2023

Acknowledgements

This report was written under a memorandum of understanding between the Research Branch, Correctional Service Canada (CSC) and the Institute of Mental Health Policy Research, Centre for Addiction and Mental Health. The authors would like to thank all of the operational staff at CSC who provided assistance in facilitating this research, as well as the individual participants who provided their time and expertise, without which the study could not have been conducted.

Executive Summary

Key words: *Community Release; Canada; Corrections; Health Services; Opioids; Opioid Agonist Treatment; Opioid Use Disorder; Prison; Re-integration; Recidivism; Transition*

In Canada, correctional populations experience an excess burden of health issues, including a higher prevalence of opioid use disorder (OUD) and increased risk of premature mortality and negative outcomes after release from prison, such as substance use treatment interruptions. Opioid agonist treatment (OAT) has been associated with positive outcomes including reduced rates of illicit drug use, overdoses, mortality, recidivism, and re-incarceration among correctional populations post-release. While a variety of factors determine whether an offender remains engaged in OAT upon community release, little is known regarding these influences, particularly in the Canadian context. The current study was conducted to elucidate this knowledge gap.

This report focuses on the follow-up assessment of a longitudinal mixed-methods study examining OAT and release experiences among a small convenience sample of Canadian federal offenders enrolled in OAT whom underwent baseline (during incarceration) and follow-up (post-incarceration, within one year post-release) assessments. Participants were recruited from federal correctional institutions located in Ontario, Canada. Assessments included the administration of a brief quantitative survey, followed by an in-depth qualitative interview. Thirty-five (*n*=35) participants were retained for the follow-up (from a total of 46 baseline participants). Data from Correctional Service Canada (CSC) were linked with quantitative survey data, and thematic analyses were conducted for qualitative interview data.

Results indicate that the majority (77%) of participants remained engaged in OAT care post-release. Participants described a number of facilitators and barriers to community reintegration and OAT retention. Personal motivation, familial support, employment, access to OAT, and the specific benefits of OAT programs were highlighted as facilitators. Barriers included fragmented OAT transitions, correctional release planning and financial challenges, difficulties adhering to correctional release plans, administrative barriers, and social networks. Two-thirds (67%) of participants had their release suspended, while slightly under half (49%) were returned to custody. Substance use was indicated as a common reason for both of these experiences.

Concrete recommendations to promote positive reintegration experiences and trajectories are proposed in light of the study results. Correctional interventions should focus on continuing to provide educational and correctional programming opportunities to increase motivation and coping skills, and strengthening linkages to community employment and work placements. Additionally, community discharge planning requires improvements to support consistent and seamless linkage to community-based OAT, and policies should be amended to ensure offenders on release have adequate financial and prescription coverage, and access to take-home OAT doses.

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Introduction

In Canada, correctional populations experience an excess burden of health issues, such as elevated prevalence of chronic physical health problems, mental health diagnoses, as well as problematic drug use including substance use disorders; and specifically, opioid use disorder (OUD; Beaudette, 2013; Bozinoff et al., 2018; Brink, Doherty, & Boer, 2001; Fazel, Yoon, & Hayes, 2017; Groot et al., 2016; F.G. Kouyoumdjian, Calzavara, Kiefer, Main, & Bondy, 2014; F. G. Kouyoumdjian, Kiefer, Wobeser, Gonzalez, & Hwang, 2016; F.G. Kouyoumdjian, Schuler, Matheson, & Hwang, 2016; Mullins & Farrell, 2012). For instance, approximately 70% of men and 80% of women admitted to federal custody in Canada during the years 2013-2014 and 2016-2019, respectively, reported a substance use issue. In the sample, 14% of men and 25% of women indicated that they had used opioids in the year prior to arrest, and high rates of polysubstance use and injection drug use were observed among both genders (Cram & Farrell MacDonald, 2019; Kelly & Farrell MacDonald, 2015a, 2015b). Moreover, Canadian incarcerated populations experience difficulties with community reintegration upon release from correctional institutions, and have a substantially higher risk of experiencing adverse health outcomes such as premature mortality, commonly due to drug poisonings and opioid-related overdoses resulting from decreased tolerance to substances while incarcerated (Binswanger, Blatchford, Mueller, & Stern, 2013; Binswanger et al., 2007; Groot et al., 2016; Kouyoumdjian, Kiefer et al., 2016; Kouyoumdjian, Schuler et al., 2016; Madadi, Hildebrandt, Lauwers, & Koren, 2013; Merrall et al., 2010; Wakeman & Rich, 2015). Previous research using Canadian data indicates that one-in-ten drug poisoning deaths among Ontario adults between 2006-2013 occurred among individuals who were released from provincial jail within the last year, with the highest rates in the immediate weeks following release; the majority of deaths involved opioids (Groot et al., 2016). Other Ontario provincial data confirm elevated rates of overdose post-incarceration (Kouyoumdjian, Kiefer et al., 2016). Additional literature exists highlighting the chronic relapsing nature of substance use disorders such as OUD, related risk factors (e.g., injection drug use), and the high incidence of substance use relapse among correctional populations following release from incarceration (Chamberlain et al., 2019; Western & Simes, 2019; Winter et al., 2016).

Therefore, the period immediately following release from imprisonment represents a

critical period posing exceptionally heightened risks of negative consequences for Canadian correctional populations, and particularly those with OUD. These individuals often experience a number of adverse health and social consequences, including treatment interruptions, recidivism, substance use relapse, and both fatal and non-fatal overdose upon release into the community (Brinkley-Rubinstein, Cloud, Drucker, & Zaller, 2018; Brinkley-Rubinstein et al., 2017; Brinkley-Rubinstein, Zaller, et al., 2018; Martin, Gresko, Brinkley-Rubinstein, Stein, & Clarke, 2019; Murphy, Ali, & Fischer, 2018; Schwartz et al., 2019).

OUD is classified as persistent use of opioids that causes clinically significant issues, and is often marked by increased tolerance, dependence, and withdrawal symptoms once use is discontinued (Strang et al., 2020). OUD is a complex disorder that is principally managed via pharmacological treatment with opioid agonist treatment (OAT), which commonly involves methadone and buprenorphine-naloxone [Suboxone] formulations (Bruneau et al., 2018; Stotts, Dodrill, & Kosten, 2009; Strang et al., 2020). OAT is associated with a number of beneficial outcomes among correctional populations upon community release. For instance, offenders treated with OAT within correctional institutions experience lower rates of illicit opioid use, overdoses, mortality, recidivism, and re-incarceration upon release. In addition, those receiving institutional OAT have reported increases in drug treatment retention, greater adherence to OAT and other health services, and are more likely than their peers to become employed upon release (Akinsemolu, Ogston, & Irvine, 2011; Cropsey, Villalobos, & St Clair, 2005; Hedrich et al., 2012; Malta et al., 2019; Moore et al., 2019; Perry et al., 2015; Sharma et al., 2016; Stallwitz & Stover, 2007). Administrative data indicate that Canadian correctional populations who continued methadone post-release had a lower risk of returning to custody than those who discontinued methadone, engaged in fewer violent and non-violent offences, and experienced reduced mortality (Farrell MacDonald, MacSwain, Cheverie, Tiesmaki, & Fischer, 2014; MacSwain, Farrell MacDonald, Cheverie, & Fischer, 2013; Russolillo, Moniruzzaman, McCandless, Patterson, & Somers, 2018; Russolillo, Moniruzzaman, & Somers, 2018). The provision of OAT within correctional institutions, combined with post-release continuous linkage to OAT treatment and broader addiction care and support upon release, is therefore crucial (Binswanger et al., 2011; Fiscella, Moore, Engerman, & Meldrum, 2004; Larney & Dolan, 2009; McKenzie, Nunn, Zaller, Bazazi, & Rich, 2009; Nunn et al., 2009).

Canadian federal correctional institutions thus serve as an opportunity for initial access to

necessary health-related testing and treatments – including OUD interventions – for this underserved population with complex needs in the context of incarceration (Bonnycastle & Villebrun, 2011; Yoko Murphy & Sapers, 2020; Rumble, Pevalin, & O'Moore, 2015; Zakaria, Thompson, Jarvis, & Smith, 2010). For decades, Canadian federal correctional institutions (i.e. the Correctional Service of Canada [CSC]) have offered OAT to offenders with OUD (Correctional Service Canada, 2019, 2021). Uptake has historically been limited; however, in light of the ongoing national opioid crisis and its devastating effects, recent elevated efforts to bolster OAT uptake among Canadian federal offenders have been observed (Correctional Service Canada, 2019, 2021). For instance, the number of offenders who initiated institutional OAT in Canadian federal prisons has increased from 725 individuals to 2,481 individuals between pre-2016 to January 2021 (Correctional Service Canada, 2020b). Moreover, a growing number of offenders are being enrolled in alternative OAT formulations[1] (Correctional Service Canada, 2020b).

Most federally incarcerated individuals are eventually released back into the community, with the goal of rehabilitation and reintegration into society (Correctional Service Canada, 2007; Macmadu & Rich, 2015; McLeod & Martin, 2018). While some offenders are granted discretionary releases (e.g., day or full parole), the majority are legally obliged to be released after serving two-thirds of their full sentence on statutory release. Offenders remain under federal correctional responsibility during these various types of community-based releases, and they are required to abide by specific conditions (e.g., refrain from drug and alcohol use) while reintegrating back into the community (Correctional Service Canada, 2007). This supervised community re-entry period provides an important opportunity to ensure critical connections to health care and substance use treatment – including OAT – are established and retained, particularly as offenders undergo monitoring and are obliged to meet particular conditions towards community reintegration.

However, while a federal offender’s correctional release plan may recommend OAT maintenance upon community release, it is up to them to determine whether they remain engaged in OAT post-release. Additionally, while OAT treatment transitions are part of release planning and supervision supports, upon release, a myriad of factors (e.g., health condition, substance use

[1] As of 2019, CSC now offers long-acting injectable buprenorphine (Sublocade). As of January 2021, there were 190 offenders enrolled in the program.

relapse, social networks and influences) may impact whether or not an individual remains engaged in OAT care and/or experiences positive community reintegration. For instance, the literature has highlighted specific barriers to community re-entry among formerly incarcerated individuals on OAT, including challenges acquiring a family physician, difficulties accessing their necessary medications and social services, housing instability, lack of employment opportunities, as well as poverty and financial instability; all of which are factors that hinder treatment retention and broader community reintegration (Hu et al., 2020; Velasquez et al., 2019). Qualitative data confirm that exposure to drugs, when combined with the stress of reintegration requirements, commonly contribute to opioid use relapse and influence OAT treatment decisions; yet, these data also highlight that overall, OAT is perceived as beneficial in reducing the risk of relapse and re-incarceration (Fox et al., 2015).

Whether an offender remains in OAT care or experiences a substance use relapse post-release is not easily determined, as federal correctional administrative data does not capture this information systematically while an individual is under community supervision (i.e., relapses must be known/reported to parole officers/case managers, or results from regular interval or random urinalysis testing must be available - and currently only screen for prescribed methadone, but not Suboxone; Correctional Service Canada, 2017). Therefore, unless an offender on release has a positive urinalysis test for illicit substances, or voluntarily discloses whether and why they have used drugs and/or continued or discontinued OAT, this information is typically not known. Additionally, once an offender has finished their sentence, correctional departments can no longer monitor how they are faring within the community.

Considering the above described circumstances, limited information is known regarding the specific conditions that lead Canadian federal offenders to remain engaged in OAT care, as well as the factors that contribute to potential substance relapse, return to custody, and general community reintegration experiences upon release. Yet, this information is important to understand as OAT maintenance is integral to mitigating adverse post-release events, such as mortality. In order to address this key gap in knowledge, we conducted the present longitudinal, mixed-methods study, which examined community reintegration transitions and trajectories – including barriers and facilitators of community reintegration, substance use, and OAT retention – among a sample of Canadian federal offenders released from correctional institutions in Ontario, Canada.

Method

Study design

This project was a longitudinal, mixed-methods observational study examining OAT-related needs, care, and community release experiences among a sample of incarcerated federal offenders in Ontario, Canada. Assessments were conducted with participants at two time points: 1) during the pre-release incarceration period and within six months prior to community release (baseline); and 2) during the community transition period within one-year post-release (follow-up). This report focuses on the follow-up assessment data.

Eligibility

Participants were initially recruited from multiple Correctional Service Canada (CSC) institutions located in Ontario. An initial baseline assessment was conducted with 46 participants between January-March, 2019, during participants' final phase of incarceration. Initial eligibility criteria included individuals who, at the time of recruitment, were 1) incarcerated at one of the seven federal Ontario-based CSC institutions; 2) had an existent OUD as per requirements to be enrolled in CSC's OAT program; 3) had been engaged in CSC's OAT program for at least 3 months; 4) had a statutory release date, or full parole eligibility date, scheduled within the next 6 months; 5) had an expected release within the Southern Ontario region; and 6) were willing to participate in both the baseline (pre-release) and follow-up (post-release) interviews. At initial baseline assessment, participants were informed of the follow-up portion of the study and were given the option to provide consent and contact information should they be interested in being contacted by the researchers once they were eligible for the follow-up assessment upon release.

Participant follow-up and procedure

Follow-up assessments were facilitated through two main approaches: 1) the assistance of CSC's Research Branch and the study participants' individual parole officers; and 2) by way of individual participant contact information provided at baseline assessment. During the baseline assessment, participants were asked if they preferred to be contacted through their parole officers or through personal contact information. For those who opted for parole officers, CSC's Research Branch provided individual parole officer details (i.e., phone numbers and email addresses).

Study staff reached out to each parole officer via telephone or email to reconnect and

obtain up-to-date participant contact information (including a phone number and current location of residence for each individual participant as long as participants were in agreeance). Study staff then directly contacted research participants via telephone (or other contact details provided directly from participants including personal email addresses, or through staff at community-based residential facilities) to re-assess study interest and to agree upon and arrange a time and location to meet to conduct the follow-up assessment. For participants who had completed their community parole period prior to the follow-up assessment, study staff attempted to contact them a number of times via personal contact information before they were considered lost to follow-up.

Assessment tools

The follow-up assessment consisted of a pen-and-paper quantitative survey followed by a qualitative semi-structured one-on-one interview. The survey took approximately 15-30 minutes to complete and consisted of 20 multiple choice and Likert scale (i.e., poor, fair, good, very good, excellent) questions. Survey questions focused on self-reported information regarding socio-demographic characteristics, health and social well-being, criminogenic and drug use characteristics, as well as OAT treatment post-release. The qualitative interview component took approximately 30-60 minutes and was audio-recorded for transcription purposes. The interview consisted of six open-ended questions and relevant probes which focused on OAT and other reintegration experiences post-release (see Appendix A for survey and interview guide).

In addition, we obtained administrative data from two primary CSC-based data sources: the Offender Management System (OMS), which maintains all offender records from sentence commencement to end (e.g., socio-demographics; Correctional Service Canada, 2013) and the Computerized Assessment of Substance Abuse (CASA) database which documents substance use among individuals (Correctional Service Canada, 2018; Kunic & Grant, 2006). These data were used for triangulation purposes during analyses.

Data collection

Follow-up assessments were conducted in person between October 1st 2019 and March 16th, 2020, in line with the suspension of data collection procedures due to COVID-19 public health restrictions. A member of the research team met with each study participant at mutually agreed-upon locations, based on convenience in addition to safety and privacy/confidentiality

considerations for both parties. The assessments took place within private interview rooms at individual parole offices (*n*=7), community-based residential facilities (i.e., 'halfway houses'; *n*=9), residential addiction treatment facilities (*n*=2), or in correctional institutions for those who had returned to prison following community release (*n*=6). For participants who had either moved out of the province or could not meet the researcher in person (*n*=11), follow-up assessments were completed via telephone. Upon completion of the follow-up assessment, participants were provided with a $50 Visa gift card honoraria for their time, effort, and expertise.

Data timeline

The follow-up assessments were completed within one year of a participant's initial release from incarceration. Each participant's community supervision period varied, which resulted in participants being assessed at different stages of their release (e.g., some individuals had recently been released, some had been released and subsequently re-incarcerated, etc.). The average time from release to completion of the follow-up assessment was 5 months post-release; however, assessments ranged from between 1 to 10 months post-release, with the majority of assessments occurring between 3 and 7 months post-release. Therefore, taken together, the quantitative survey and qualitative interview data represent a temporal snapshot (i.e., past 30 days) of each participant's release experience. Conversely, all administrative data provided by CSC encompassed the participant's entire community release period. Since release details for many participants' entire release period were incomplete at the time of the follow-up assessment interview (i.e., individuals may have returned to custody afterwards), we have used correctional administrative data where possible to highlight a more complete picture of their release trajectory and details.

Data processing and analysis

All personal and identifying information was removed from the survey and interview data. Quantitative survey data were entered into an encrypted Excel database for data cleaning and analysis. Interview audio recordings were transcribed verbatim and transcripts were imported into the qualitative data management software, NVivo 12. Basic descriptive statistics (e.g., mean and frequency counts) were analyzed for select participant characteristics based on both the survey and CSC administrative data.

Qualitative analyses included both deductive and inductive thematic analyses, whereby the research team developed an extensive codebook of initial themes based on the overarching research questions asked in the interview guide. Next, major themes from participants' community release experiences were further divided into sub-themes and added into the codebook based on an iterative process. Coding of the qualitative interview data was performed by a member of the research team, and codebook revisions and coding queries were resolved with the broader team based on ongoing discussions. Final qualitative results were informed by multiple participants conveying similar sentiments and statements until data saturation was met (Ness, 2015; Saunders et al., 2018).

Ethics and consent

Study procedures were approved by the Centre for Addiction and Mental Health (CAMH) Research Ethics Board (REB: #013-2018). Participants were required to provide informed consent for both the baseline and follow-up assessments during the baseline assessment.

Results

Quantitative results

Study sample

A total of 35 participants were retained for the follow-up component of this study, representing a 76% participant retention rate. Of the 46 total participants who completed the initial baseline assessment, eleven were lost to follow-up, including seven participants who had reached warrant expiry (i.e., completed their sentence) and could not be reached using the contact information provided, and an additional four participants who had not been released during the study period. The following section briefly summarizes select variables from our follow-up assessment data in conjunction with administrative CSC data.

Table 1 summarizes the socio-demographic and criminogenic risk information of the study sample. The majority of participants identified as white (66%), men (83%), and had been released from a medium- or maximum-security prison (66%). The average age of participants was 36 years. Approximately two-thirds of participants were assessed as high risk based on static risk (63%) and dynamic need (66%) ratings, with moderate to high need related to substance abuse (91%). Most participants were assessed to have low to moderate reintegration potential (89%) and motivation (71%) at release.

Table 1

Study sample sociodemographic and criminogenic risk information (N=35)

Characteristics	OAT Study Participants	
	%	**(*n*)**
Age in years (*M*±*SD*)	36.0	±8.2
Gender		
Men	82.9	(29)
Women	17.1	(6)
Ethnocultural Background		
White	65.7	(23)
Indigenous/Other	34.2	(12)
Security classification at release		
Minimum	34.3	(12)
Medium/Maximum	65.7	(23)
Static factor rating at release*		
Low/Moderate	37.1	(13)
High	62.9	(22)
Dynamic factor rating at release[&]		
Low/Moderate	34.3	(12)
High	65.7	(23)
Dynamic need domains at release (moderate to high need)+		
Substance abuse	91.4	(32)
Associates	77.1	(27)
Personal/emotional orientation	77.1	(27)
Employment/education	60.0	(21)
Attitudes	60.0	(21)
Community functioning	51.4	(18)
Marital/family relations	34.3	(12)
Reintegration potential at release		
Low/Moderate	> 80.0	(†)
High	< 20.0	(†)
Motivation level at release		
Low/Moderate	71.4	(25)
High	28.6	(10)

Note. *Static risk factors are features of an offender's history that predict recidivism, but cannot change (e.g., age, past offences, etc.). [&]Dynamic risk factors are features of an offender's history that predict recidivism but are amenable to change (e.g., substance use, peer networks, etc.). +Dynamic need domains encompass a variety of specific areas that have a likelihood of interfering with an offender's community functioning (i.e., a high substance abuse need indicates this specific factor may affect the inmate's offender's community reintegration; L. Stewart, Wardrop, K., Wilton, G., Thompson, J., Derkzen, D., & Motiuk, L. , 2017). †Information suppressed due to frequencies fewer than 5 in one category.

Table 2 outlines release, community drug use, and OAT information for the study sample. In regards to release information, the majority (71%) of participants were released on statutory release. All participants had release conditions that included abstaining from substance use and avoiding certain people in their social networks (e.g., criminal associates, victims). For 80% of participants, participation in a treatment program/counseling was an additional requirement for release. Nearly half (49%) of participants obtained employment during their release. In regards to substance use, among those who had submitted urinalysis tests while in the community (91%), more than three-fifths (63%) tested positive for an illicit substance, with opioids as the most common illicit drug used. Twenty-three percent (23%) had received a medical marijuana prescription. Forty percent (40%) of participants received a take-home naloxone kit upon release, with one participant indicating they had used it (data not shown). More than three-quarters (77%) of the sample reported engagement in OAT after release, with most (59%) accessing Suboxone. Two-thirds (67%) of participants had their releases suspended, while just under half (49%) were returned to custody. Substance use was cited as a common factor in both suspension of release (60%), and return to custody (40%), respectively.

Table 2

Study sample release, community drug use and OAT information (N=35)

Characteristics	**OAT Study Participants**	
	%	**(*n*)**
Release Type		
Discretionary Release (day or full parole)	28.6	(10)
Non-discretionary release (statutory release)	71.4	(25)
Release conditions+		
Abstain from substance use	100.0	(35)
Avoid certain people (criminal associates, victims)	100.0	(35)
Participate in treatment program/counselling	80.0	(28)
Residency	34.3	(12)
All other conditions	71.4	(25)
Received take-home naloxone kit at release	40.0	(14)
Community employment	48.6	(17)
Community urinalysis	91.4	(32)
Positive for illicit substances	62.5	(20 of 32)
Opioids+	50.0	(10 of 20)
Cocaine/crack+	45.0	(9 of 20)
Marijuana+	40.0	(8 of 20)
All other substances+	40.0	(8 of 20)
Medical marijuana prescription[a]	22.8	(8)
OAT engagement (past 30 days) [a]	77.1	(27)
Methadone	40.7	(11 of 27)
Suboxone	59.2	(16 of 27)
Suspension of release	66.7	(24)
Substance use as one factor in the suspension+	60.0	(21)
Substance use as the only factor in the suspension+	22.9	(8)
Return to Custody	48.6	(17)
Substance use as one factor in the return to custody+	40.0	(14)
Substance use as the only factor in the return to custody+	< 15.0	(†)

Note. +Indicator is not mutually-exclusive; [a] Data derived from quantitative survey, only indicative of past 30 days at time of assessment. †Information suppressed due to frequencies fewer than 5 in one category.

Qualitative results

Below we present qualitative data results, including the major themes and sub-themes that emerged from the interviews. These data have been categorized under two headings: 1) facilitators for post-release community re-entry (sub-themes: personal motivation and coping mechanisms, familial and social support, employment and educational opportunities, community services, supportive staff and accessibility, and positive experiences and benefits of OAT); and 2) barriers to post-release community re-entry (sub-themes: correctional release planning, fragmented OAT transitional care, financial challenges, adherence to correctional release plans, accessibility and administrative barriers, and social networks).

Participants shared both negative and positive sentiments and discussed various factors that represented barriers and/or facilitators to access and retention in OAT care and abstaining from opioid and/or other substance use. Furthermore, participants described their general post-release experiences and trajectories. For all participants, community reintegration included adherence to correctional release plans and the related stipulations and recommendations (e.g., refraining from drug and alcohol use, remaining engaged in OAT and other substance use treatments, obtaining employment, etc.).

Facilitators for post-release community re-entry

Positive community re-entry experiences included references to living 'pro-social' lifestyles, including contributing to society (e.g., working, attending school, volunteering), obtaining housing, re-establishing interpersonal relationships, and participating in healthy lifestyles and routines. Additionally, many participants discussed specific factors they perceived as facilitators to their community reintegration, which are further described below.

Personal motivation and coping mechanisms

For many participants, post-release community reintegration experiences had been positive as they had worked towards re-establishing a 'normal' lifestyle. Many described receiving the supports they needed in order to reach their post-release goals:

> *"Well when I was released, I went back to living a fairly balanced lifestyle. I worked every day. I was exercising, eating well, getting lots of sleep... I had access to everything I possibly needed."*
>
> *(Participant 37[2])*

Participants who acknowledged positive community re-entry experiences described key facilitators of their experience, the most common of which was personal motivation. Many participants indicated that they had reached a point in their lives where they no longer desired to use drugs and had developed a strong will to avoid re-incarceration:

> *"I just don't want to go back to prison. I don't want to go back to life as living before prison. I want to be able to be around my family…It's been nine years since I was around family for anything...When I'm using, nobody wants to be around me."*
>
> *(Participant 36)*

Among participants who had abstained from substance use post-release, many suggested this was due to achieving a specific mindset; often using terms such as 'maturity', 'strong-minded', and 'time to grow up' to describe their experience. Additionally, many had developed resilience and cultivated specific coping mechanisms and skills that facilitated recovery and reintegration, such as reflecting on the past. For instance, when asked what had helped them abstain from opioid use since their release, one participant described:

> *"I remember the hard times, like when I had no money and I had no drugs, and I was sick, and I was hurting, you know? I was willing to turn a deed for ten bucks, stuff like that. Like those are the things that I remember and I think about it. Sometimes I just play the thought out in my head to the very end – not just the high – but to the whole extent of where it will go. Let's think about the police looking for you, let's think about the doors coming off, let's think about the going back to jail, let's think about the disappointment."*
>
> *(Participant 32)*

Many participants elaborated on these skills and explained that they were able to draw on them to resist drugs they had encountered and were offered via homophilous social networks. Additionally, a few participants suggested that correctional programming they had undertaken during their incarceration period equipped them with the skills necessary to deal with personal triggers for drug use and crime:

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[2] Participant identification numbers correspond to initial numerical codes provided at baseline assessment

> *"There's a couple of different things. The main thing is there's this tool that I learned in prison that they also use here [at the halfway house] that is called CPR. It's 'Consequences Points Check', 'Personal Values Check' and 'Reality Check'. So, whenever you are triggered to drink or use drugs, I think what the consequences are of me doing that. Whether or not it has, if it goes against my personal values. And whether or not I think it's realistic."*
>
> *(Participant 36)*

Familial and social support

Participants also described how interpersonal relationships were integral to positive community reintegration trajectory and experiences. For instance, some participants explained that they were working on rebuilding broken and tumultuous relationships, while others provided anecdotes and elaborated on the ways in which familial and social support were essential for achieving their goals:

> *"I found that I do have great family support, which has been absolutely huge in helping me. Since I've been out, and I've been out maybe, what, seven months or something like that... to be sitting in the position I am right now today. I feel confident, I feel great, with my ability to be back working very soon. I feel like I'm ready to start my life again. And I'm clean and I'm sober."*
>
> *(Participant 01)*

Participants deemed family and social relationships as fundamental for providing both emotional as well as material support. For instance, the ability to rely on family for housing, money, transportation, clothing, and other forms of material support was an essential contributor to positive community reintegration experiences:

> *"It's hard to go from what I had, to where I live at, with nothing. Like, I had no clothes, nothing. So, really did start from the bottom-up. Like, all the way from buying clothes and getting my own place, to getting a vehicle. My family helped a lot, which is huge. I don't think I'd be where I'm at without my family."*
>
> *(Participant 07)*

With respect to abstaining from opioid and other drug use, many participants described that it was their families – and more specifically, the desire to be actively involved in their children's lives – that provided the primary incentive to refrain from drug use:

> *"My son was born while I was in jail. When I got out, me and my son have been, like, pretty much inseparable. I love it though. It keeps me good and it shows me that I don't want to mess up. I'll do everything I can to stay out of jail, stay off drugs, to just be part of his life. My son, my wife, my daughter. My son's the main thing though. So like everything I do, I have to be very careful. I don't want him copying me, right? I get cravings every day. Every single day. Then I just look at my son."*
>
> *(Participant 12)*

Employment and educational opportunities

Employment, often shaped by intersecting social and structural factors (e.g., communities, policies, etc.) was perceived as a precursor to positive community re-integration experiences and trajectories. Among participants who had been able to secure employment during their release, many described feeling better once they were able to work as the structure enabled them to start actively attaining the rest of their release goals and plans:

> *"I guess for the first month I didn't really do much of anything, and then I just got a job and I've been working full time since then. I work a lot. I tend to just work as much as I can. It keeps me out of the halfway house. I got that job actually through someone else that lives at the halfway house. Yeah, [it's going good], I manage to put some money away anyways. Once I started working, everything went pretty smooth. [Work] has been the biggest help I guess, more than anything."*
>
> *(Participant 25)*

Some participants further described the importance of being able to obtain necessary education required to secure specific jobs or career paths (e.g., high school diplomas, professional certificates, license to operate machinery, etc.) during their incarceration. Some elaborated on the benefits of unions or colleges that had courses and paid work placements, which would teach them a trade and support employment opportunities afterwards:

> *"I'm finishing up this 'Skills Advanced Ontario' course…it's basic training on measurements and stuff like that they expect in the steel industry. So, I should find out next week when I'm going to be starting [the placement]. It's an eight-week work placement and I guess at the end of eight weeks you sit down with the company, and it's paid. This school thing [has been going well]. You know, having a goal I set out to accomplish and finally seeing the end of it come to fruition."*
>
> *(Participant 08)*

Community services, supportive staff, and accessibility

Several participants mentioned the role of community-based services and specific staff members from health and social service organizations who had provided positive experiences during the provision of support and/or care. For instance, one participant who was in the process of applying for government assistance to cover their OAT, but whom could not afford it in the meantime, described the support he received from a service provider:

> *"And my family, being on their limited retired pension, it was hard to figure out how I was going to pay for [OAT]. And I had to wait about eight days to get to my appointment when I'd be able to get [government] benefits to cover it. And I found [addiction clinic name], and I contacted [staff name], and I explained my situation to her on the phone and she was fantastic. She said, 'Come on in and see me now.' So, I went into town right away, explained my situation to her, and she was so helpful. She said, 'Leave it with me, I'm going to talk to my manager, I'm going to see what we can do because this is a terrible situation. How is a guy supposed to pay for this every day when you don't have anything?' So, I left there and she called me, and she says, 'Look, I calculated up the amount of days of Suboxone, the total amount, come into my office tomorrow, I have a cheque here for you.' And through donations, or whatever, to their addiction service, she came up with the exact amount that it would cost for my Suboxone every day until my [government assistance] appointment, and she had that cheque waiting there for me."*
>
> *(Participant 01)*

Other participants mentioned that specific individuals they had met – such as employers, chaplains, volunteers, and social workers – provided them with different forms of practical support, such as driving them far distances to visit their families or accompanying them on community outings. In some instances, participants had developed positive rapport with their parole officers, whom they found helpful. Others described how trusted staff members at their halfway houses were a helpful source of material and emotional support, as illustrated in the following anecdote:

> *"Like [the halfway house] has helped me with [bus] tokens, they've helped me with transportation stuff, like they've helped me with a lot of stuff. My worker takes me out for lunch, just a lot of stuff. And she's not CSC, so she's not obligated to talk about anything. I can be honest with her, like yeah, I fucking feel like getting high right now, and she's not going to run back and tell my parole officer."*
>
> *(Participant 32)*

In addition, participants indicated the availability and variety of free, community-

based/not-for-profit social service organizations was helpful in supporting them to reach their goals, and contributed to positive community reintegration experiences:

> *"I guess like there's tons of programs for people looking for a job, like the Employer Resource Centre downtown. Like I didn't know when I got out but like people told me where you can go, and they'll help you get like work clothes and work boots and all that kind of stuff. Because, when you get out you really, you got nothing, right? I didn't know like Goodwill does programs where they'll help you get clothing. And so, that kind of stuff's cool. Like I'd never heard of that stuff before until I came to this halfway house, and then they have like a bulletin board full of different things you can go, you know, like different programs that they have around the city."*
>
> *(Participant 25)*

Other participants indicated that addiction services such as self-help groups, (e.g., Alcoholics/Narcotics Anonymous) and/or mental health providers were extremely helpful. Some noted that securing a stable, community-based/primary care physician whom provided them with physical and mental health care, and related prescriptions, was crucial for stabilizing their health status and daily routines. Those attending residential (inpatient) treatment facilities also indicated that these programs were beneficial, and had taught them the necessary skills to enable them to reach their release goals:

> *"So [treatment facility name] is a high-intensity drug and alcohol treatment centre. It's called a therapeutic community, because it gets the treatment facility residents engaged in also teaching some aspects of the program and teaching you to build self-esteem and confidence in yourself. You can go to a treatment for like 90 days, 60 days, but it's not enough. Six months gives you the opportunity to move at your own pace to really unpack those negative defects, those things that have been really dragging me down. But there's no pace, there's no, like, 'oh I got to get it done in 90 days or I'm out of here', right? So I was able to discover like why is it I self-sabotage all the time. Work on my social anxiety. Work on my self-esteem, my negative self-talk, my self-worth, my self-compassion. These are all aspects of my recovery that I believe are going to help to keep me sober and out of prison and handcuffs."*
>
> *(Participant 15)*

Positive experiences and benefits of OAT

In regards to abstaining from opioid and other drug use, many participants elaborated on the specific benefits of community-based OAT as a key facilitator for community reintegration. Many perceived OAT as a main contributor to being able to refrain from drug use, desist from

crime, and ultimately achieve their personal goals. Even for participants with longstanding and complex opioid use histories, many indicated that OAT had been integral for disrupting their substance use habits:

> *"Well, I'll tell you, I was in the penitentiary 10 years ago, I was in and out of provincial jail, and I would go back to using opiates. Upon my release, I would go right back to my prescription. And I was always right back into the cycle of using opiates, constantly. And from getting on the Suboxone program in there [during incarceration], I think it was the best thing I ever did. I should have did it years ago. It has changed me, period."*
>
> *(Participant 01)*

Participants elaborated on the specific ways in which OAT had been advantageous for them, both physiologically and psychologically. Specifically, some participants explained that OAT in general (including adherence to an OAT medication regimen and the process of finding a comfortable dose) not only helped to alleviate physical pain, but also crucially worked as a psychological disincentive and reduced their cravings for drugs. In terms of preferences for OAT formulations, most participants expressed a partiality to Suboxone, and shared that it was specifically the naloxone component within Suboxone treatments that worked as an effective psychological deterrent to opioid use. Even for those who expressed that they still frequently experienced cravings and triggers for drugs while on Suboxone, the idea that the naloxone component would precipitate withdrawal supported them in abstaining from opioid use:

> *"I get cravings every day. Every single day. The cravings are always there, even with the Suboxone. But the way I look at it is like, my downfall was opiates. With the Suboxone, I keep it in my head that if I do any opiates, I'll go into withdrawal. So that keeps me away from the opiates."*
>
> *(Participant 12)*

Some participants – particularly those who had experienced difficulties accessing Suboxone during their incarceration period – discussed the conditions and rationale around their decision to switch from methadone to Suboxone upon release:

> *"I was on methadone when I left [prison]. And I did the switch the first week I was out. I didn't like feeling the way I did [on methadone], you know what I mean? I didn't like the side effects, the methadone. And I'd been on Suboxone before, so I knew that it was better than being on methadone. Methadone made me sweat all the time and I was anxious."*
> *(Participant 37)*

Participants further described specific components of OAT programs as beneficial, such as the ability to choose the type of OAT that worked best for them, developing positive rapport with their OAT physicians, and working along with their physicians to reach a comfortable dosage. Furthermore, being in close proximity to OAT clinics with extended operational hours and securing adequate financial support/coverage for treatment, were reported as key facilitators to OAT engagement and adherence. While some participants described mixed feelings towards having to visit the clinic weekly to provide urinalysis tests, and described the process of attending the clinic burdensome, many also recognized that these routines held them accountable. For instance, one participant who had stopped taking Suboxone, and subsequently relapsed and had their parole revoked, reflected on the benefits of the community-based OAT regimen, including the urinalysis test specifically:

> *"I didn't [use drugs while I was on Suboxone] or piss dirty once. I did drink while I was on it. Like after I found out she was cheating or whatever, like I would drink on the weekends, right? But, I didn't use any drugs or anything. Just the amount of pain in the ass it was to have to go down every week to provide the urine sample, which is fine. I didn't feel I needed it anymore, you know? And it turns out that I couldn't have been more wrong, because it provided motivation to stay clean."*
> *(Participant 06)*

Overall, participants described a number of general and OAT-specific facilitators which worked alone or in tandem to support positive community reintegration experiences and trajectories, and ultimately allowed participants to reach their post-release goals.

Barriers to post-release community re-entry

While most participants expressed positive experiences related to their community release, many described mixed and/or negative feelings, and described a variety of specific challenges that hindered their ability to establish daily routines and meet their personal goals, including accessing and remaining engaged in OAT and refraining from drug use. Participants described a variety of barriers to community reintegration, which are outlined and further

contextualized below.

Correctional release planning

One of the most common barriers to community reintegration described by participants involved organizational-level issues associated with correctional release planning. Participants mentioned they often did not find out specific details regarding their release, such as which city and/or halfway house location they would be going to, until shortly prior to their release. In some instances, offenders preparing for release were not informed of which location they were going to until the day of their release, as discussed by the following participant:

> *"They don't give you any help here [in prison] at all. And when they do, it's, like, the last minute. So you can't even say, 'Hey, like, what the hell is going on here?' I didn't even know I was going to [halfway house name] until 30 minutes before I got released. Like, I thought I was going to [city name], but they're, like, 'No, you're going to [halfway house name].' And I had no say in that."*
>
> *(Participant 43)*

Additional issues included institutional lockdowns or security issues within correctional facilities which occasionally resulted in participants not receiving OAT on the day of their release. For participants who had residential restrictions or conditions that stipulated they must reside in a halfway house, acceptance to these facilities was often contingent on bed availability, which would fluctuate and change daily. Additionally, acceptance to a community residential facility is not a given and some will decline high-risk offenders, rendering obtaining community support difficult. As such, some participants were required to live and stay in locations that they did not choose and/or were undesirable and inconvenient, as they were located far from support systems. For example, when asked about any difficulties they had experienced reintegrating into the community, one participant explained:

> *"Just putting you in an unfamiliar area where you don't know anybody. And for someone that suffers from social anxiety the way I do, to put me in such a large city right downtown with everybody is just – it was a little overwhelming."*
>
> *(Participant 19)*

A few participants reported release planning challenges had directly resulted in negative effects. For example, one participant was placed in a city they did not choose and subsequently

went 'on the run' shortly after their release. This individual consequently discontinued their OAT and relapsed into drug use. Other participants were placed in locations they perceived as high-risk for personal substance use triggers. For instance, one participant explained that the halfway house they were scheduled to reside in unexpectedly closed for renovations a day before their release, forcing them to pay out of pocket for a motel in an area known for drug use. Another explained how a roommate at the halfway house they were residing in enabled easy access to drugs, which resulted in relapse:

> *"I was put in a very high-risk situation when I got to the halfway house. An inmate, or a resident, at the halfway house, was selling drugs and they put me in his room. The drugs were readily available the day I got to the halfway house, so I did eventually end up using methamphetamines. And then I got a urinalysis a few days later, so, obviously the urinalysis was positive, and they sent me back in on a prob [release] violation. It was terrible. I mean, ultimately, I made a decision to use, but I was put into a situation that I don't handle very well, like immediately."*
>
> *(Participant 22)*

Fragmented OAT transitional care

In regards to release planning challenges, one of the major community-level challenges identified by participants was fragmented OAT transitional care. Nearly a quarter (23%) of participants experienced issues accessing OAT directly after release. Most commonly, the OAT clinics or pharmacies that participants were supposed to attend for medication had no indication or record of them, and paperwork containing proof of identification and the individual's last OAT dose (sent by correctional facility staff) was often improperly faxed or was lost en route to the recipient. Some participants were therefore unable to receive their OAT on the day of release and were required to wait several days. Others were eventually successful in receiving OAT on the first day of release, but only after successfully contacting their parole officers and/or various clinics, which often required waiting for their paperwork to be confirmed and re-sent. In particular, this was a salient issue for those who had missed their last OAT dose while incarcerated. Some participants explained that they had to report directly to their halfway house and were not allowed to leave for 48 hours, thus preventing them from attending their OAT appointment, while others stated that their designated clinic had closed by the time they arrived, further complicating the process:

> *"[The prescription] never got faxed over or something, it didn't work out. So [the OAT clinic] closes at five o'clock. So because I didn't get my dose, they had to call [the pharmacy] and get everything set up there through CSC, and it was like 11 o'clock at night before I got it. Initially [the OAT clinic] was open, so at that point they were in contact with CSC. They had my information, but they didn't have proof of last dose, so that's what didn't get shipped or faxed or whatever. So that's why everything had to wait, because they didn't have proof about last dose. So when they closed out before five o'clock they had all my information sent to [the pharmacy], because [it's] open until midnight. So it was a big hassle because at that time, my curfew [at the halfway house] was nine o'clock. So, on my first day I had to get like a curfew extension, which had to be approved through the police, and it was hell. I didn't know if I was going to get my [OAT] at first, because my parole officer is like, 'I'll get back to you', and it was like a couple of hours and then she came back and said, 'if it's before midnight, you can go get the prescription'."*
>
> *(Participant 15)*

Financial challenges

While fragmented connections to OAT providers occurred, another major structural issue conveyed by participants related to financial challenges, including a variety of economic and monetary struggles both in general and related to OAT. For instance, participants residing at a halfway house or within a residential treatment facility, and not working, relied on a release 'maintenance allowance' (a stipend of approximately $28.00 per week) to cover their basic needs such as food, clothes and transportation costs to attend appointments. Many participants felt that this amount was insufficient, and for some participants, this financial instability was a personal trigger for committing crimes to alleviate boredom (due to lack of money to engage in entertainment) or to generate income. For example, one participant who resided at a residential treatment facility discussed the financial challenges they experienced:

> *"Definitely the financial situation is very difficult. Every time I go in the community, I need to go somewhere, I have to catch the bus, and just on the weekend I spend like - half the money I get for the week is just spent on the bus. And then once I get somewhere, I don't have money to like buy something to eat, or see a movie, or whatever. I don't really understand what I'm expected to do in the community for the whole weekend without money. It doesn't make any sense to me. And then, like, in the past, every time I was broke I would go commit a crime to get money. Being broke here really is triggering to just go do something to get money. I don't like the feeling of not having any money to rely on. I just don't like having that feeling."*
>
> *(Participant 36)*

Other participants elaborated on financial challenges and discussed encountering issues when trying to navigate and apply for government and social assistance such as welfare, disability, or low-income benefit payments. Participants described a fundamental disconnect between the various financial benefit systems they needed to enroll in in to be able to cover the cost of OAT and other medications. Additionally, some participants did not have proper identification and required tax information readily available, and described complications while applying for financial assistance, such as having applications returned as 'incomplete', or incorrect entry of information, which ultimately delayed the application, by months in some cases. While CSC will cover most medications for a short amount of time for participants in this situation, other participants, including those who do not have residency restrictions, must transition to social assistance, work benefits, or pay out of pocket. Taken together, these challenges left many participants in a vulnerable financial position, and without coverage for OAT and other medications:

> *"Last time I was at the halfway house, CSC paid for all your medication. But they had done a bunch of budget cuts and stuff, so they would only pay for them for three months. You had to apply for Trillium. And in order to get benefits and stuff from Trillium, you had to have done your taxes and stuff. I haven't done my taxes in four years."*
>
> *(Participant 37)*

Furthermore, many participants who were employed did not always qualify for company benefits, yet were disqualified from the criteria and thresholds imposed by government assistance programs. For instance, one participant who was employed described having to pay out of pocket for their OAT, which they considered a major obstacle to accessing OAT:

> *"Well when I was released, the halfway house covers [OAT] for three months, but then you got to apply for the Trillium benefit thing. But what happened was on the three-month mark I was supposed to send an application to get it so I could be covered for the next three months, but instead of putting the correct date to the next three months, I put when I got released for those three months. They didn't explain it to me properly. So, after weeks of that, I started paying out of my own pocket. But thank god I was working because it was pretty much $9 a dose every day. I paid almost $400 for the month of September."*
>
> *(Participant 18)*

When asked about their current financial situation, another participant described being in

the position of having to pay out of pocket for OAT but being unable to afford to do so; this individual resorted to borrowing money from family and friends. Others described having to pay large sums of money up front, during periods of lapses in financial coverage. Such circumstances were also considered a major deterrent to remaining on OAT:

> *"I'm struggling with that. So I don't know how we're going to do this right now. I'm trying to fill out the papers for myself because I am eligible for [government disability assistance]. Right now, I'm just running up debts, and it's not good. Just to get my [OAT] medication for the first two weeks, I was spending $60 a day... I didn't even want to go get my medication half the time because I'm like, I have to pay $20 there for the Uber, $20 back for the Uber, and then $20 for the medication. It's like, $60 every single day."*
> *(Participant 12)*

Other financial challenges described by participants involved owing substantial amounts of money for child support payments or other outstanding (licit and illicit) debts. Debts often resulted in unanticipated effects, for instance, unresolved driving tickets were related to higher insurance rates, thus resulting in difficulties reinstating one's driver's license and hindering one's ability to afford a vehicle for reliable transportation. Notably, many participants described concerns regarding the inability to afford rent payments for an apartment or house once their release/sentence had ended and they were no longer allowed to reside at the halfway house. Others believed that they may have to resume illegal activities to secure housing. One participant described their housing concerns related to long waiting periods for social housing programs:

> *"So I'm frightened right now. Where do I live? And I've been on the [housing] list from 2017, and it's just taking me so long. And I'm frightened now, because if I don't have anywhere to go, what am I going to do? And because I'm not on probation either. So it's almost like, I kind of wish I was on probation because that way, I'd have the place to stay, you know? I just don't want to put myself in predicaments again."*
> *(Participant 28)*

Other participants explained that even once they were able and ready to leave the halfway house, they were unable to afford to rent a house or apartment. Some expressed challenges regarding landlords who did not want to rent to people on government assistance. These participants described being forced to stay at the halfway house for longer than they desired.

Adherence to correctional release plans, accessibility, and administrative barriers

In addition to these barriers, many participants indicated challenges associated with adhering to the stipulations laid out in their correctional release plans, including balancing their OAT and other reintegration requirements, and having to modify their work commitments and other schedules to obtain daily OAT medication. Additionally, many participants described challenges in accessing clinics due to proximity or transportation-related issues, for instance, such as being unable to afford the bus or find a ride to the clinic. Some described challenges associated with limited OAT clinic operational hours which required individuals to either wake up very early, or to find and attend a clinic that was open later in the day (which often required travelling far distances). Participants also described experiences accommodating their work schedules, such as working nightshifts or asking their employer for time off work in order to be able to adhere to their OAT treatment, which in some cases involved being reprimanded or having their employment terminated. Many participants did not feel comfortable disclosing their OAT status with their employer, creating additional treatment-related barriers. These challenges are described by the following participant:

> *"Well they want me to work earlier, but I've got to figure out how to get this Suboxone out of my way, so I can get it at night. I'll have to talk to my boss about it. I find it interrupting [sic] for me to go there first thing in the morning, you know? But that's what I do, that's my routine. I mean the fact that I got to get up at six, every 24 hours, six o'clock in the morning, every single day. [My work] don't know about it…there's lots of stuff like that I like to keep private. So I don't want to really open up to them about it."*
> *(Participant 14)*

Another participant described the challenges individuals in their position face while trying to 'get their lives on track' after incarceration. Specifically, they described difficulties in trying to meet all of the requirements outlined in their correctional release plans (including obtaining employment) while also attending mandatory OAT appointments. For some, balancing these commitments was a challenging aspect of community reintegration:

“[The OAT doctor] is only in the clinic in [city name] on Thursdays, and they're closed at 5pm. And you have to make in that window. And, like I said to him, when I'm in a union job, we work every day, five in the morning till six, seven at night. There is no way possible, especially when you get back with the union, you start with a new company, there is no way possible that I could book off an afternoon every Thursday or every other Thursday to do a urinalysis and pick up a [OAT prescription]. It doesn’t work with people who are working, and it shouldn’t be like that because you’re clean, you’re moving ahead, you’re moving forward with your life. There should be some way that it works with employment because your number one goal of being clean and sober, or reintegrating back into society from prison, is to be clean and sober, and have employment.”

(Participant 01)

These issues were compounded by the institutional and administrative policies at most halfway houses prohibiting participants from keeping any take-home OAT medication doses (i.e., ‘carries’) on the premises. Participants who had been engaged in OAT care for months, and whom had abstained from substance use, were still required to go to the OAT clinic daily to receive their medication while they resided at the halfway house. Many participants expressed contempt for these policies, which they considered arbitrary, as halfway houses would often hold onto other types of medications (e.g., other opioids and/or medical marijuana) for residents:

“So here at the [halfway] house, they don't allow Suboxone or methadone. So it's kind of provided me with a roadblock for the reason that I have to go to the clinic every day, which doesn't open until 8 o'clock or 9 o'clock sometimes on the weekend. So it kind of affects the ability for me to have a day job. I'm not saying it's prevented me from having a job period, it just makes it more difficult. So, I've asked them if we could change the rule…it would be nice to fight it because it's a lot easier for me just to be able to get my pills in the morning and just go to work…Yeah, they don't allow carries here. But they allow prescription marijuana. That's a point that everyone brings up. You know. Even my worker here, he says that they keep hydromorphs [opioids] here for people... Like the question I've been asking myself for over the past while too, is just like, what am I going to do [if I have to work before 8am]?”

(Participant 08)

Another participant reiterated this issue and elaborated on how ‘no-carry’ policies, and subsequent requirements for daily clinic attendance while balancing work and other correctional plan requirements, was hindering their ability to reintegrate into the community and achieve their personal goals:

> *"I don't know why, but we can't have Suboxone here [at the halfway house]. But guys are prescribed marijuana here. They can take their marijuana in a lock box, keep it in their office. So I don't see what's the difference? It's a controlled substance that's ordered in a lock box, but I can't have my Suboxone here in a lock box... So it's like being married to a drug store. I get my Suboxone at [clinic name], which takes me 45 minutes from here to get there on busses. So, if we don't have a day off work, or I'm off sick, I still got to go all the way up there and get it. So I'm married to this drug store now, and it's really frustrating."*
>
> *(Participant 15)*

Participants described additional issues around receiving carries, for instance, not knowing that the OAT clinic requires sufficient advance notice for a predetermined period of time (e.g., weekend). For one participant, this issue and an inability to receive carries on a weekend they were visiting their family resulted in relapse into opioid and other drug use in order to stave off withdrawal symptoms. The ability to access carries was therefore identified as crucial for participants to meet their reintegration goals and 'get back on their feet'.

Furthermore, many participants described that adjusting after extended periods of institutionalization, and acclimatizing to life in the community, was complicated by the time constraints associated with attending multiple appointments mandated by their correctional release plans in addition to OAT:

> *"It's pretty dramatic with all the appointments and stuff that they want me to do, like all my conditions that I got to abide for, so it's kind of hectic. Like I have to do NA counselling and a program three times a week. But then, I'm supposed to be working full-time as well, so I don't know how that all fits in. It's kind of hard to obtain full-time employment during the day when you've got all these appointments during the week, and I have to come to the parole office every week to see her too, so. Then I have to be at the [clinic name] twice a week Tuesdays and Thursdays for urinalyses and to get my [Suboxone] scripts faxed over."*
>
> *(Participant 18)*

In general, most participants described experiencing stress and concerns about being able to accomplish all of their release requirements while also adhering to OAT and working towards a positive community re-entry experience.

Social Networks

A final barrier to community reintegration commonly conveyed by participants involved social and interpersonal networks. Often, contact with homophilous drug-using peers and

acquaintances was described as an easy pathway and access point to drugs, as well as a trigger for relapse. Many participants expressed a fear of running into individuals whom they used to use drugs with and/or sell drugs to, and provided anecdotes of encountering acquaintances who offered them drugs post-release. These encounters were described as increasing the likelihood of participants relapsing into drug use, having their release revoked, and returning to custody. For instance, one participant recalled how an encounter with old acquaintances led to subsequent drug use:

> *"I guess like three months ago or something, I fucked up and I got high. There was a couple other guys that were here [at the halfway house] that I knew from like a long time ago. And I'd say that's probably the only like really shitty thing that's happened. So I've got a couple buddies I knew for a long time, they were into all that shit. And like they were just bugging me to like hang out with them. And then we got high."*
>
> *(Participant 25)*

Notably, many participants expressed specific apprehension towards attending OAT clinics located in proximity to peers and/or individuals who were actively using and/or dealing drugs. For some participants, this fear directly contributed to their decision to wean off and cease OAT prior to release. For others, such conditions caused individuals to relapse into drug use. For instance, one participant described how they were tempted into using drugs following an encounter with an acquaintance close to their methadone clinic:

> *"I was a little bit worried about coming back to [city name]. I have been using and selling drugs here for the past 10 years. So, I was just worried about running into people. And I used with my mom, so I'm not allowed there, and I was worried about wanting to go there and stuff. So I went to the methadone clinic and I ran into someone that I used to sell drugs to, and they were smoking crack in the back of the clinic there and offered me some. I resisted at first and I should have just removed myself from the situation, which I didn't. I was still, you know, lingering around, and they offered again and I – giving in to temptation, and I took it."*
>
> *(Participant 30)*

Many participants who indicated they had relapsed into drug use post-release discussed problematic intimate partner relationships, or difficult social and interpersonal situations, that were an underlying cause for their substance use. Some participants described conflicts in their relationships with former intimate partners, including trust issues or child custody battles, while

others described difficulties encountered in newer intimate relationships, such as requirements around parole officer approval of new romantic relationships following release. Specifically, a number of participants indicated that they had relapsed into substance use as a direct result of stress brought on by intimate partner relationship issues, which had precipitated feelings of hopelessness:

> *"I've just been going through some rough patches in my life over Christmas and shit…Well what really set me off was the whole getting kicked out of my girl's house at Christmas. And me, like, just being played for a fool and shit. It just really fucked up my head. It's kind of what fucked me up…It was, uh, drinking, you know just some drinking, like smoking, alcohol. And then, you know, turned to doing coke. And turned from spirits and coke to, you know, methamphetamines, and just a rollercoaster of drugs…And I just fucking haven't stopped."*
>
> *(Participant 47)*

Therefore, in certain circumstance, personal and social networks rendered participants vulnerable to easy access to drugs and were viewed as triggers for drug use. Dysfunctional interpersonal and romantic relationships were also a common catalyst for relapse.

Discussion

This longitudinal, mixed-methods study examined the experiences of recently-released offenders from federal correctional institutions in Ontario, Canada. The objective of this study was to better understand the various factors, including barriers and facilitators that influence community reintegration, substance use, and OAT adherence, following release from incarceration. Results highlighted a myriad of individual- and system-level factors, in addition to dynamics that work in conjunction to impact community reintegration experiences, including transitions, and trajectories.

Most participants described overall positive community re-entry experiences, and the majority of participants (77%) remained engaged in community OAT at the time of their follow-up assessment. Participants indicated key facilitators to community reintegration, including personal motivation, familial and social supports, employment opportunities, and the overall benefits of community-based OAT towards attaining their post-release goals. Some of these facilitators, such as individual motivation, have been associated with positive community re-entry experiences in the literature, and underscore the need to foster incarcerated individuals' personal coping mechanisms and skills towards establishing greater motivation as a means to increase reintegration potential (Abad, Carry, Herbst, & Fogel, 2013; Binswanger et al., 2012; Doekhie, Dirkzwager, & Nieuwbeerta, 2017; Kendall, Redshaw, Ward, Wayland, & Sullivan, 2018; Malouf, Youman, Stuewig, Witt, & Tangney, 2017). Individualized correctional plans are developed and provided to each offender based on their specific criminogenic and other risks and needs, and appropriate supports, programs, and interventions are offered during their incarceration period; some participants expressed the specific benefits of these correctional interventions and described applying the skills and coping mechanisms they had acquired in the community setting. However, while offenders are expected to actively participate in their correctional plans (including completing any required programming/interventions), some may choose to opt-out of these programs for various reasons. A recent CSC evaluation of correctional reintegration programs indicated program barriers such as a lack of resources, availability, delayed starts, and occasional mismatches between risk and need profiles and program stream and intensity (Correctional Service Canada, 2020a). Additionally, the findings indicated that men who completed programing had similar results for institutional urinalysis tests, and that non-

participants trended towards having lower rates of substance use-related community outcomes (i.e., either a positive urinalysis or a suspension due to a breach of a substance use related supervision condition) compared to program completers; this patterns was also observed for women (Correctional Service Canada, 2020a). Furthermore, many offenders indicated that they anticipated challenges when applying the skills learned through correctional programming, and few agreed that substance use was sufficiently addressed, implying that current programming does not necessarily result in the desired community outcomes in relation to substance use (Correctional Service Canada, 2020a). Thus, correctional programing should adapt content to focus on substance use risks and needs in order to better address offenders' risk factors, and programs should provide individuals with key skills to handle substance-use related issues such as triggers and cravings. Options for offenders to re-take these and other skill-building programs upon release are offered during community release, yet it is up to the participant to remain enrolled, and many extenuating factors (e.g., motivation, substance use, etc.) may influence program uptake and adherence. Therefore, CSC should continue to encourage participation in maintenance programs which may assist offenders on release in applying the skills learned in real-world community settings. Furthermore, some participants indicated that gaining employment skills and certificates during incarceration was a major facilitator to post-release employment attainment, and an evaluation of CSC's educational programs found that educational programming had a positive impact on public safety outcomes, and program completers had a higher rate of obtaining community employment (Correctional Service Canada, 2015). As such, CSC should continue to promote and offer employment programming to bolster the potential for offenders to obtain tangible skills and certificates during incarceration, combined with stronger linkages to education, employment and/or work placement opportunities, and partnerships that support individuals in applying these skills post-release (Correctional Service Canada, 2007, 2020a; Regis & Dillon Jr, 2020).

In regards to OAT programs, some participants described that treatment had beneficially disrupted their longstanding substance use and related criminal behaviour patterns, and effectively diminished their cravings; for instance, none of the participants returned to custody for new offences. Many participants conveyed the importance of being able to choose the OAT formulation that worked best for them since individuals have varying physiology and preferences, in addition to working with a trusted OAT physician to reach their OAT objectives

(e.g., comfortable dose). Participants emphasized the necessity of having reliable connections to OAT providers in the community post-release, in addition to the importance of having options for OAT formulations and formats such as oral methadone and/or Suboxone, and also newer, more novel options such as extended-release monthly injectable formulations which obviate the need to visit an OAT clinic or pharmacy daily (Health Canada, 2019). Of note, there are now three available buprenorphine formulations available in Ontario; buprenorphine-naloxone (Suboxone) tablets, a buprenorphine subdermal implant (Probuphine) and an extended-release buprenorphine injection (Sublocade; Ng, Kim, Veljovic, & Zhang, 2020).

While most participants remained engaged in OAT during their release period and described specific facilitators which bolstered OAT adherence and positive community reintegration experiences, participants also provided a number of specific barriers that rendered community re-entry challenging, thus leaving offenders under community supervision vulnerable to relapse, release revocations, and eventual re-incarceration. Many of these specific barriers have been highlighted and corroborated in the existing literature. For example, issues such as a lack of prescription coverage, lack of reliable transportation, returning to previous lifestyles and homophilous social networks, adjusting to non-institutionalization, financial challenges, lack of employment, unstable housing, general material hardship, administrative/accessibility issues, as well as substance use issues, have all been identified as major post-release barriers to reintegration (Binswanger et al., 2012; Brown, 2004; Doherty, Forrester, Brazil, & Matheson, 2014; Hu et al., 2020; Martin et al., 2019; Sung, Mahoney, & Mellow, 2010; Western, Braga, Davis, & Sirois, 2015). In addition, the current study identified challenges associated with correctional release planning and consequently fragmented OAT transitions. Similarly, the balance required to adhere to release conditions (e.g., obtain employment, attend parole officer meetings and treatment appointments) while also maintaining OAT and related requirements (e.g., daily attendance at OAT clinics, provision of urinalysis tests) was cited as a substantial hurdle. While all offenders agree to specific stipulations outlined in their correctional release plans which are tailored and developed with the goal of assisting individuals in making pro-social and law-abiding choices (Correctional Service Canada, 2018), participants indicated that restrictive release plans tend to place a heavy burden on them, making community reintegration difficult. Further exacerbating these challenges are institutional and administrative policies at some community based residential facilities which strictly forbid stocking OAT medication

carries, thus forcing participants to continue to attend OAT clinics or pharmacies daily to obtain their medication, even after they have proved capable of obtaining carries based on general community OAT guidelines (Eibl, Morin, Leinonen, & Marsh, 2017). Taken together, these issues posed difficulties for continued OAT engagement and community reintegration post-release.

These above described challenges and barriers highlight the need for improved correctional release planning to ensure that federal offenders are prepared and more adequately set up for seamless OAT transitions post-release, which can ultimately contribute to more positive community reintegration experiences. Studies have identified associations between discharge planning and relapse into substance use, engagement in criminal activity and/or sex in exchange for drugs, money, or transportation, and ultimately, recidivism (Hu et al., 2020; Johnson et al., 2013; Luther, Reichert, Holloway, Roth, & Aalsma, 2011). These studies have called for reforms to correctional release planning in order to more effectively connect offenders with the tailored supports and services they require during release. Since most of the participants in this study eventually had their release suspended and/or revoked – largely due to relapse into substance use – the barriers to community reintegration identified should be better reflected in release plans and more closely considered in relation to release planning.

The current study participants offered concrete recommendations towards alleviating reintegration challenges. With respect to OAT adherence, participants indicated that identifying trusted clinicians and OAT providers, as well as the ability to receive take-home OAT medication carries was crucial as these conditions rendered it easier to maintain employment and adhere to release requirements. These factors also helped to reduce experiences of withdrawal and/or relapse, therefore increasing the likelihood that participants meet their post-release goals. To address this issue, organizational policies could be amended to allow community-based residential facilities to store OAT medications for residents onsite, as this is the status quo for other essential medications. Participants also suggested alternative options, such as mobile OAT delivery and hybrid/telemedicine possibilities for OAT care. Telehealth and mobile OAT delivery are low-barrier novel interventions that have shown promise for improving treatment access and retention, and can reduce barriers to treatment entry among remote and marginalized - including correctional – populations (Hall et al., 2014; Krawczyk et al., 2019; Krsak, Montague, Trowbridge, Johnson, & Binswanger, 2020; O'Gurek et al., 2021; R. E. Stewart et al., 2021).

Additionally, participants indicated a need for more reliable administrative processes associated with OAT care transitions, such as the provision of extended OAT prescriptions to individuals upon release, as well as consistent options for financial coverage of OAT medications. Offenders with residency restrictions residing within community-based correctional facilities are subject to Ontario health authority policies which can be restrictive for this population. For instance, the Ontario Works (or 'welfare') policy currently indicates that individuals residing in a community-based residential facility are only eligible for a limited stipend for personal needs (and the application can only be initiated within 10 days pre-release, provided they meet eligibility and have a secured residential address; Ontario Ministry of Children Comunity and Social Services, 2018); Ontario's Disability Support Program (i.e., ODSP) prohibits income support altogether (Ontario Ministry of Children Comunity and Social Services, 2021). These individuals can apply for the Ontario Trillium Drug Program (for those who have high prescription costs in relation to their household income) to cover the cost of their OAT and other prescriptions. However, this program has lengthy approval periods (e.g., 90 days) and onerous requirements (i.e., strict application deadlines, valid identification, and proof of income/completion of federal income taxes), and applications are not allowed to be initiated during incarceration (Ontario Ministry of Health and Long-Term Care, 2013). Therefore, these provincial financial support programs should be amended to allow those under community supervision (whether or not they reside within a community residential facility) to receive adequate funding, and applications to be initiated in a timely manner, pre-release (where possible). Minimally, for participants who require financial assistance, appropriate applications/paperwork should be verified pre-release and application support should be provided upon meeting community parole officers. Furthermore, the Ontario government should work more closely with CSC to more effectively align policies to ensure that individuals are financially covered for prescriptions – including OAT – so that they do not end up in positions where they cannot afford their prescriptions and are facing the possibility of interrupted or discontinued treatment. Tangible solutions and recommendations such as these can and should be implemented in order to ensure that those on release from federal corrections are set up for the best possible community reintegration prospects, in light of the known and identified barriers and challenges they commonly face.

This study involves a number of limitations. First, due to the small number of participants and convenience sample, the results of this study are not generalizable to other settings or

populations, but instead, highlight common themes described by a subset of individuals (primarily men) on OAT who were recently-released from federal incarceration in Ontario, Canada. Inherent biases in self-report data, such as recall bias, response bias, social desirability bias, and negativity bias (the proclivity to elaborate on negative experiences over positive experiences) may have influenced participant's responses and these should be taken into consideration with respect to the findings. Additionally, participant interviews were conducted at various time points during each participant's release, and therefore naturally represent a temporal snapshot rather than a comprehensive picture of respective community release experiences.

Conclusions

While the study revealed that study participants experienced positive community re-entry experiences, almost half eventually had their release revoked, with a large percentage due to relapse to substance use. This underscores the complex nature of OUD, as well as the complicated realities of community reintegration for many offenders engaged in OAT upon release from federal incarceration in Ontario, Canada. Furthermore, findings from this study place emphasis on the need to address identified barriers to reintegration, including the improvement of correctional discharge planning, specifically as it relates to transitional OAT care. Policy changes and interventions to increase motivation and ensure seamless linkage to OAT as well as social supports upon release are needed in order to reduce negative effects during community re-entry among this population.

References

Abad, N., Carry, M., Herbst, J. H., & Fogel, C. I. (2013). Motivation to reduce risk behaviors while in prison: Qualitative analysis of interviews with current and formerly incarcerated women. *Journal of Qualitative Criminal Justice & Criminology, 1*(2), 347-363. https://pubmed.ncbi.nlm.nih.gov/26693183

Akinsemolu, A., Ogston, S., & Irvine, L. (2011). P2-354 Effectiveness of opioid substitution therapy among prisoners with drug dependence: A meta analysis. *Journal of Epidemiology & Community Health, 65*(Suppl 1), A320-A320. DOI:10.1136/jech.2011.142976k.86

Beaudette, J. (2013). *Prevalence of mental health disorders among incoming federal offenders: Atlantic, Ontario, & Pacific regions* (ERR-13-3). Ottawa, ON: CSC.

Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of Internal Medicine, 159*(9), 592-600. doi: 10.7326/0003-4819-159-9-201311050-00005

Binswanger, I. A., Nowels, C., Corsi, K. F., Glanz, J., Long, J., Booth, R. E., & Steiner, J. F. (2012). Return to drug use and overdose after release from prison: A qualitative study of risk and protective factors. *Addiction Science & Clinical Practice, 7*(3), 1-9. DOI: 10.1186/1940-0640-7-3

Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). "From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry, 34*(4), 249-255. doi: 10.1016/j.ijlp.2011.07.002

Binswanger, I. A., Stern, M., Deyo, R., Heagerty, P., Cheadle, A., Elmore, J., & Koepsell, T. D. (2007). Release from prison: A high risk of death for former inmates. *The New England Journal of Medicine, 356*(2), 157-165. doi: 10.1056/NEJMsa064115

Bonnycastle, K. D., & Villebrun, C. (2011). Injecting risk into prison sentences a quantitative analysis of a prisoner-driven survey to measure HCV/HIV seroprevalence, risk practices, and viral testing at one Canadian male federal prison. *The Prison Journal, 91*(3), 325-346. https://doi.org/10.1177/0032885511409893

Bozinoff, N., DeBeck, K., Milloy, M. J., Nosova, E., Fairbairn, N., Wood, E., & Hayashi, K. (2018). Utilization of opioid agonist therapy among incarcerated persons with opioid use disorder in Vancouver, Canada. *Drug and Alcohol Dependence, 193*, 42-47. https://doi.org/10.1016/j.drugalcdep.2018.09.003

Brink, J. H., Doherty, D., & Boer, A. (2001). Mental disorder in federal offenders: A Canadian prevalence study. *International Journal Of Law And Psychiatry, 24*(4-5), 339-356. doi:

10.1016/s0160-2527(01)00071-1

Brinkley-Rubinstein, L., Cloud, D., Drucker, E., & Zaller, N. (2018). Opioid use among those who have criminal justice experience: Harm reduction strategies to lessen HIV risk. *Current HIV/AIDS Reports, 15*, 255-258. https://dx.doi.org/10.1007/s11904-018-0394-z

Brinkley-Rubinstein, L., Cloud, D. H., Davis, C., Zaller, N., Delany-Brumsey, A., Pope, L., Martino, S., Bouvier, B., & Rich, J. (2017). Addressing excess risk of overdose among recently incarcerated people in the USA: Harm reduction interventions in correctional settings. *International Journal Of Prisoner Health, 13*(1), 25-31. doi:10.1108/IJPH-08-2016-0039

Brinkley-Rubinstein, L., Zaller, N., Martino, S., Cloud, D. H., McCauley, E., Heise, A., & Seal, D. (2018). Criminal justice continuum for opioid users at risk of overdose. *Addictive Behaviors, 86*, 104-110. doi: 10.1016/j.addbeh.2018.02.024

Brown, J. D. (2004). Challenges facing Canadian federal offenders newly released to the community. *Journal of Offender Rehabilitation, 39*(1), 19-35. https://doi.org/10.1300/J076v39n01_02

Bruneau, J., Ahamad, K., Goyer, M.-È., Poulin, G., Selby, P., Fischer, B., Wild, T. C., & Wood, E. (2018). Management of opioid use disorders: A national clinical practice guideline. *Canadian Medical Association Journal, 190*(9), E247-E257. https://doi.org/10.1503/cmaj.170958

Chamberlain, A., Nyamu, S., Aminawung, J., Wang, E. A., Shavit, S., & Fox, A. D. (2019). Illicit substance use after release from prison among formerly incarcerated primary care patients: A cross-sectional study. *Addiction Science & Clinical Practice, 14*(1), 1-8. doi: 10.1186/s13722-019-0136-6

Correctional Service Canada. (2007). *Protecting society through community corrections*. Publications. https://www.csc-scc.gc.ca/publications/005007-9003-eng.shtml

Correctional Service Canada. (2013). *The offender management system*. Information Sharing with Partners from the Criminal Justice System. https://www.csc-scc.gc.ca/oms/004003-0001-eng.shtml

Correctional Service Canada. (2015). *Evaluation report: Offender education programs and services*. CSC Education Programs and Services Evaluation http://publications.gc.ca/collections/collection_2016/scc-csc/PS84-55-2015-eng.pdf

Correctional Service Canada. (2017). *Commissioner's directive 566-10: urinalysis testing*. Ottawa, Ontario: CSC.

Correctional Service Canada. (2018). *Commissioner’s directive 705-6: correctional planning and criminal profile*. Ottawa, ON: CSC.

Correctional Service Canada. (2019). *Opioids*. Quick Facts. https://www.csc-scc.gc.ca/publications/005007-3017-en.shtml

Correctional Service Canada. (2020a). *Evaluation of correctional reintegration programs*. Evaluation at CSC. https://www.csc-scc.gc.ca/005/009/092/005009-0003-en.pdf

Correctional Service Canada. (2020b). *Guidance on opioid agoinst treatment (OAT)*. Health Services. https://www.csc-scc.gc.ca/health/002006-3004-en.shtml

Correctional Service Canada. (2021). *Opioid agonist treatment.* Health Services. https://www.csc-scc.gc.ca/health/002006-3000-en.shtml

Cram, S., & Farrell MacDonald, S. (2019). *Substance use patterns of indigenous and non-indigenous women offenders* (RIB-19-08). Ottawa, ON: CSC.

Cropsey, K. L., Villalobos, G. C., & St Clair, C. L. (2005). Pharmacotherapy treatment in substance-dependent correctional populations: A review. *Substance Use & Misuse, 40*(13-14), 1983-1999. doi: 10.1080/10826080500294866

Doekhie, J., Dirkzwager, A., & Nieuwbeerta, P. (2017). Early attempts at desistance from crime: Prisoners' prerelease expectations and their postrelease criminal behavior. *Journal of Offender Rehabilitation, 56*(7), 473-493. doi:10.1080/10509674.2017.1359223

Doherty, S., Forrester, P., Brazil, A., & Matheson, F. I. (2014). Finding their way: Conditions for successful reintegration among women offenders. *Journal of Offender Rehabilitation, 53*(7), 562-586. https://doi.org/10.1080/10509674.2014.944740

Eibl, J. K., Morin, K., Leinonen, E., & Marsh, D. C. (2017). The state of opioid agonist therapy in Canada 20 years after federal oversight. *The Canadian Journal of Psychiatry, 62*(7), 444-450. doi:10.1177/0706743717711167

Farrell MacDonald, S., MacSwain, M.-A., Cheverie, M., Tiesmaki, M., & Fischer, B. (2014). Impact of methadone maintenance treatment on women offenders' post-release recidivism. *European Addiction Research, 20*(4), 192-199. doi: 10.1159/000357942

Fazel, S., Yoon, I. A., & Hayes, A. J. (2017). Substance use disorders in prisoners: An updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction, 112*(10), 1725-1739. doi:10.1111/add.13877

Fiscella, K., Moore, A., Engerman, J., & Meldrum, S. (2004). Jail management of arrestees/inmates enrolled in community methadone maintenance programs. *Journal of Urban Health, 81*(4), 645-654. doi: 10.1093/jurban/jth147

Fox, A. D., Maradiaga, J., Weiss, L., Sanchez, J., Starrels, J. L., & Cunningham, C. O. (2015). Release from incarceration, relapse to opioid use and the potential for buprenorphine

maintenance treatment: A qualitative study of the perceptions of former inmates with opioid use disorder. *Addiction Science & Clinical Practice, 10*(2), 1-9. https://dx.doi.org/10.1186/s13722-014-0023-0

Groot, E., Kouyoumdjian, F. G., Kiefer, L., Madadi, P., Gross, J., Prevost, B., Jhirad, R., Huyer, D., Snowdon, V., & Persaud, N. (2016). Drug toxicity deaths after release from incarceration in ontario, 2006-2013: Review of coroner's cases. *PloS One, 11*(7), 1-11. doi:10.1371/journal.pone.0157512

Hall, G., Neighbors, C. J., Iheoma, J., Dauber, S., Adams, M., Culleton, R., Muench, F., Borys, S., McDonald, R., & Morgenstern, J. (2014). Mobile opioid agonist treatment and public funding expands treatment for disenfranchised opioid-dependent individuals. *Journal of Substance Abuse Treatment, 46*(4), 511-515. https://doi.org/10.1016/j.jsat.2013.11.002

Health Canada. (2019). *Regulatory decision summary - Sublocade*. Review Devisions. https://hpr-rps.hres.ca/reg-content/regulatory-decision-summary-detail.php?linkID=RDS00462

Hedrich, D., Alves, P., Farrell, M., Stöver, H., Møller, L., & Mayet, S. (2012). The effectiveness of opioid maintenance treatment in prison settings: A systematic review. *Addiction, 107*(3), 501-517. doi:10.1111/j.1360-0443.2011.03676.x

Hu, C., Jurgutis, J., Edwards, D., O'Shea, T., Regenstreif, L., Bodkin, C., Amster, E., & Kouyoumdjian, F. G. (2020). "When you first walk out the gates… where do [you] go?": Barriers and opportunities to achieving continuity of health care at the time of release from a provincial jail in Ontario. *PloS One, 15*(4), 1-13. doi: 10.1371/journal.pone.0231211

Johnson, J. E., Schonbrun, Y. C., Nargiso, J. E., Kuo, C. C., Shefner, R. T., Williams, C. A., & Zlotnick, C. (2013). "I know if I drink I won't feel anything": Substance use relapse among depressed women leaving prison. *International Journal of Prisoner Health, 9*(4), 169-186. doi: 10.1108/IJPH-02-2013-0009

Kelly, L., & Farrell MacDonald, S. (2015a). *Comparing lifetime substance use patterns of men and women offenders* (RIB-14-44). Ottawa, ON: CSC.

Kelly, L., & Farrell MacDonald, S. (2015b). *Lifetime substance use patterns of men offenders* (RIB-14-43). Ottawa, ON: CSC.

Kendall, S., Redshaw, S., Ward, S., Wayland, S., & Sullivan, E. (2018). Systematic review of qualitative evaluations of reentry programs addressing problematic drug use and mental health disorders amongst people transitioning from prison to communities. *Health & Justice, 6*(4), 1-11. doi:10.1186/s40352-018-0063-8

Kouyoumdjian, F. G., Calzavara, L. M., Kiefer, L., Main, C., & Bondy, S. J. (2014). Drug use prior to incarceration and associated socio-behavioural factors among males in a

provincial correctional facility in Ontario, Canada. *Canadian Journal of Public Health, 105*(3), e198-202. doi: 10.17269/cjph.105.4193

Kouyoumdjian, F. G., Kiefer, L., Wobeser, W., Gonzalez, A., & Hwang, S. W. (2016). Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: A retrospective cohort study. *CMAJ Open, 4*(2), E153-161. doi:10.9778/cmajo.20150098

Kouyoumdjian, F. G., Schuler, A., Matheson, F. I., & Hwang, S. W. (2016). Health status of prisoners in Canada. *Canadian Family Physician, 62*(3), 215-222. https://www.cfp.ca/content/cfp/62/3/215.full.pdf

Krawczyk, N., Buresh, M., Gordon, M. S., Blue, T. R., Fingerhood, M. I., & Agus, D. (2019). Expanding low-threshold buprenorphine to justice-involved individuals through mobile treatment: Addressing a critical care gap. *Journal of Substance Abuse Treatment, 103*, 1-8. https://doi.org/10.1016/j.jsat.2019.05.002

Krsak, M., Montague, B. T., Trowbridge, P., Johnson, S. C., & Binswanger, I. A. (2020). Opioid use and chronic infections: The value of addressing the syndemic in correctional settings via telemedicine guidance and broader use of long-acting medications. *The Journal of Infectious Diseases, 222*(Supplement_5), S486-S493. doi:10.1093/infdis/jiaa001

Kunic, D., & Grant, B. A. (2006). *The computerized assessment of substance abuse (CASA): Results from the demonstration project* (R-173). Ottawa, ON: CSC.

Larney, S., & Dolan, K. (2009). A literature review of international implementation of opioid substitution treatment in prisons: Equivalence of care? *European Addiction Research, 15*(2), 107-112. doi: 10.1159/000199046

Luther, J. B., Reichert, E. S., Holloway, E. D., Roth, A. M., & Aalsma, M. C. (2011). An exploration of community reentry needs and services for prisoners: A focus on care to limit return to high-risk behavior. *AIDS Patient Care and STDs, 25*(8), 475-481. doi:10.1089/apc.2010.0372

Macmadu, A., & Rich, J. D. (2015). Correctional health is community health. *Issues in Science and Technology, 32*(1). 26-36. https://issues.org/correctional-health-care-community-health-prisons-jails/

MacSwain, M. A., Farrell MacDonald, S., Cheverie, M., & Fischer, B. (2013). Assessing the impact of methadone maintenance treatment (MMT) on post-release recidivism among male federal correctional inmates in Canada. *Criminal Justice & Behaviour, 41*(3), 380-394. http://dx.doi.org/10.1177/0093854813501495

Madadi, P., Hildebrandt, D., Lauwers, A. E., & Koren, G. (2013). Characteristics of opioid-users whose death was related to opioid-toxicity: A population-based study in Ontario, Canada. *PloS One, 8*(4), e60600. https://doi.org/10.1371/journal.pone.0060600

Malouf, E. T., Youman, K., Stuewig, J., Witt, E. A., & Tangney, J. P. (2017). A pilot RCT of a values-based mindfulness group intervention with jail inmates: Evidence for reduction in post-release risk behavior. *Mindfulness, 8*(3), 603-614. doi:10.1007/s12671-016-0636-3

Malta, M., Varatharajan, T., Russell, C., Pang, M., Bonato, S., & Fischer, B. (2019). Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review. *PLoS Medicine, 16*(12), e1003002. doi:10.1371/journal.pmed.1003002

Martin, R. A., Gresko, S. A., Brinkley-Rubinstein, L., Stein, L. A. R., & Clarke, J. G. (2019). Post-release treatment uptake among participants of the Rhode Island Department of Corrections comprehensive medication assisted treatment program. *Preventive Medicine, 128*, 105766. https://doi.org/10.1016/j.ypmed.2019.105766

McKenzie, M., Nunn, A., Zaller, N. D., Bazazi, A. R., & Rich, J. D. (2009). Overcoming obstacles to implementing methadone maintenance therapy for prisoners: Implications for policy and practice. *Journal of Opioid Management, 5*(4), 219-227. doi: 10.5055/jom.2009.0024

McLeod, K. E., & Martin, R. E. (2018). Health in correctional facilities is health in our communities. *CMAJ, 190*(10), E274-E275. doi: 10.1503/cmaj.171357

Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction, 105*(9), 1545-1554. doi: 10.1111/j.1360-0443.2010.02990.x

Moore, K. E., Roberts, W., Reid, H. H., Smith, K. M. Z., Oberleitner, L. M. S., & McKee, S. A. (2019). Effectiveness of medication assisted treatment for opioid use in prison and jail settings: A meta-analysis and systematic review. *Journal of Substance Abuse Treatment, 99*, 32-43. https://doi.org/10.1016/j.jsat.2018.12.003

Mullins, P., & Farrell, S. (2012). Offender substance use patterns - Aboriginal and non-Aboriginal offenders (RS 12-10). Ottawa, ON: CSC.

Murphy, Y., Ali, F., & Fischer, B. (2018). Health and service access challenges for correctional offenders with mental health and substance use problems in transition from incarceration to community: A literature review (R-398). Ottawa, ON: CSC.

Murphy, Y., & Sapers, H. (2020). Prison health as public health in Ontario corrections. *Journal of Community Safety and Well-Being, 5*(1), 19-25. https://doi.org/10.35502/jcswb.122

Motiuk, L. (1998). Using dynamic factors to better predict post-release outcome. *Forum on Corrections Research, 10*(3), 12-15. https://www.csc-scc.gc.ca/research/forum/e103/e103c-eng.shtml

Ness, L. R., & Fusch, P. (2015). Are we there yet? Data saturation in qualitative research. *The*

Qualitative Report, 20(9), 1408-1416. https://doi.org/10.46743/2160-3715/2015.2281

Ng, K., Kim, J., Veljovic, S., & Zhang, M. (2020). *Buprenorphine for opioid use disorder treatment: Focus on new formulations and alternative induction protocols*. Pharmacy Connection. https://pharmacyconnection.ca/opioid-use-disorder-treatment-spring-summer-2020/

Nunn, A., Zaller, N., Dickman, S., Trimbur, C., Nijhawan, A., & Rich, J. D. (2009). Methadone and buprenorphine prescribing and referral practices in US prison systems: Results from a nationwide survey. *Drug and Alcohol Dependence, 105*(1-2), 83-88. doi:10.1016/j.drugalcdep.2009.06.015

O'Gurek, D. T., Jatres, J., Gibbs, J., Latham, I., Udegbe, B., & Reeves, K. (2021). Expanding buprenorphine treatment to people experiencing homelessness through a mobile, multidisciplinary program in an urban, underserved setting. *Journal of Substance Abuse Treatment, 127*, 108342. https://doi.org/10.1016/j.jsat.2021.108342

Ontario Ministry of Children Comunity and Social Services. (2018). *6.12 Persons detained in custody*. Ontario works directives. https://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ow/6_12_OW_Directives.aspx.

Ontario Ministry of Children Comunity and Social Services. (2021). *2.6 Incarceration*. Ontario disability support program (ODSP) income support directives. https://www.mcss.gov.on.ca/documents/en/mcss/social/directives/odsp/income_Support/2_6.pdf.

Ontario Ministry of Health and Long-Term Care. (2013). *A guide to understading the trillium drug program*. https://www.health.gov.on.ca/en/pro/programs/drugs/funded_drug/fund_trillium.aspx.

Perry, A. E., Neilson, M., James, M.-S., Glanville, J. M., Woodhouse, R., Godfrey, C., & Hewitt, C. (2015). Pharmacological interventions for drug-using offenders. *Cochrane Database of Systematic Reviews, 19*(12), 1-80. doi: 10.1002/14651858.CD010862

Regis, A. K., & Dillon Jr, G. L. (2020). Gradually reintegrating ex-offenders into the workforce. In M. Jackson, A. Regis, & K. Bennett (Eds.), *Career development interventions for social justice: Addressing needs across the lifespan in educational, community, and employment contexts* (229-247). Rowman & Littlefield.

Rumble, C., Pevalin, D. J., & O'Moore, É. (2015). Routine testing for blood-borne viruses in prisons: A systematic review. *European Journal Of Public Health, 25*(6), 1078-1088. doi:10.1093/eurpub/ckv133

Russolillo, A., Moniruzzaman, A., McCandless, L. C., Patterson, M., & Somers, J. M. (2018). Associations between methadone maintenance treatment and crime: A 17-year

longitudinal cohort study of Canadian provincial offenders. *Addiction, 113*(4), 656-667. doi:10.1111/add.14059

Russolillo, A., Moniruzzaman, A., & Somers, J. M. (2018). Methadone maintenance treatment and mortality in people with criminal convictions: A population-based retrospective cohort study from Canada. *PLoS Medicine, 15*(7), e1002625. doi: 10.1371/journal.pmed.1002625

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, 52*(4), 1893-1907. doi:10.1007/s11135-017-0574-8

Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., & Jaffe, J. H. (2019). Initiating methadone in jail and in the community: Patient differences and implications of methadone treatment for reducing arrests. *Journal of Substance Abuse Treatment, 97*, 7-13. https://doi.org/10.1016/j.jsat.2018.11.006

Sharma, A., O'Grady, K. E., Kelly, S. M., Gryczynski, J., Mitchell, S. G., & Schwartz, R. P. (2016). Pharmacotherapy for opioid dependence in jails and prisons: research review update and future directions. *Substance Abuse and Rehabilitation, 7*, 27-40. https://dx.doi.org/10.2147/SAR.S81602

Stallwitz, A., & Stover, H. (2007). The impact of substitution treatment in prisons ─ A literature review. *International Journal of Drug Policy, 18*(6), 464-474. doi: 10.1016/j.drugpo.2006.11.015

Stewart, L., Wardrop, K., Wilton, G., Thompson, J., Derkzen, D., & Motiuk, L. (2017). *Reliability and validity of the dynamic factors identification and analysis – Revised* (R-395). Ottawa, ON: CSC.

Stewart, R. E., Shen, L., Kwon, N., Vigderman, J., Kramer, S., Mandell, D. S., Candon, M., Lamb, R., & Rothbard, A. B. (2021). Transporting to treatment: Evaluating the effectiveness of a mobile engagement unit. *Journal of Substance Abuse Treatment, 129*, 108377. https://doi.org/10.1016/j.jsat.2021.108377

Stotts, A. L., Dodrill, C. L., & Kosten, T. R. (2009). Opioid dependence treatment: Options in pharmacotherapy. *Expert Opinion on Pharmacotherapy, 10*(11), 1727-1740. doi: 10.1517/14656560903037168

Strang, J., Volkow, N. D., Degenhardt, L., Hickman, M., Johnson, K., Koob, G. F., Marshall, B., Tyndall, M., & Walsh, S. L. (2020). Opioid use disorder. *Nature Reviews Disease Primers, 6*(3), 1-28. doi:10.1038/s41572-019-0137-5

Sung, H.-E., Mahoney, A. M., & Mellow, J. (2010). Substance abuse treatment gap among adult parolees: Prevalence, correlates, and barriers. *Criminal Justice Review, 36*(1), 40-57.

doi:10.1177/0734016810389808

Velasquez, M., Flannery, M., Badolato, R., Vittitow, A., McDonald, R. D., Tofighi, B., Garment, A. R., Giftos, J., & Lee, J. D. (2019). Perceptions of extended-release naltrexone, methadone, and buprenorphine treatments following release from jail. *Addiction Science & Clinical Practice, 14*(37), 1-12. doi:10.1186/s13722-019-0166-0

Wakeman, S. E., & Rich, J. D. (2015). Substance use disorders and avoidable mortality after prison. *The Lancet Psychiatry, 2*(5), 369-370. http://dx.doi.org/10.1016/S2215-0366%2815%2900125-X

Western, B., Braga, A. A., Davis, J., & Sirois, C. (2015). Stress and hardship after prison. *American Journal of Sociology, 120*(5), 1512-1547. doi:10.1086/681301

Western, B., & Simes, J. T. (2019). Drug use in the year after prison. *Social Science & Medicine, 235*, 1-7. https://doi.org/10.1016/j.socscimed.2019.112357

Winter, R. J., Young, J. T., Stoové, M., Agius, P. A., Hellard, M. E., & Kinner, S. A. (2016). Resumption of injecting drug use following release from prison in Australia. *Drug and Alcohol Dependence, 168*, 104-111. doi:https://doi.org/10.1016/j.drugalcdep.2016.08.640

Zakaria, D., Thompson, J. M., Jarvis, A., & Smith, J. (2010). *Testing and treatment for human immunodeficiency virus and hepatitis c virus infections among Canadian federal inmates* (R-223). Ottawa, ON: CSC.

Appendix A: Assessment #2 Study Questionnaire

1. When were you **RELEASED** from your most recent incarceration period?
   ____

2. Where did you **LIVE** (i.e., city/town and province, with postal code if known) in the **PAST 30 DAYS**?
   ____

3. Where did you **STAY/SLEEP** (most of the time) in the **PAST 30 DAYS**? (*please check all that apply)*
   ☐ My own place (e.g., rented or owned house/condo/apartment with or without roommate)
   ☐ Living with friends or family (e.g., parent, guardian, relative)
   ☐ Shelter/drop-in
   ☐ Institutionalized/hospitalized
   ☐ Community-based residential facility (e.g., correctional transition facility)
   ☐ Street
   ☐ Other (please specify)______________________________
   ☐ I don't know
   ☐ I prefer not to answer

4. What was your main **SOURCE** of **INCOME** in the **PAST 30 DAYS**? (*please check all that apply)*
   ☐ Legal employment/work
   ☐ Illegal employment/work (e.g., paid under the table, etc.)
   ☐ Illegal activities (e.g., selling drugs, etc.)
   ☐ Social benefits/assistance (e.g., welfare, disability, etc.)
   ☐ Family/friends
   ☐ Personal savings
   ☐ Other (specify)________________________
   ☐ I don't know
   ☐ I prefer not to answer

5. Did you **PARTICIPATE** in any of the following **ACTIVITIES** in the **PAST 30 DAYS**? (*please check all that apply)*
   ☐ Producing, selling or trafficking drugs
   ☐ Selling stolen goods
   ☐ Shoplifting
   ☐ Robbery/theft
   ☐ Property crime (e.g., vehicle theft, break and enters, etc.)
   ☐ Fraud/forgery (e.g., cheques, prescriptions, etc.)
   ☐ Assault

☐ Sex work
☐ Other (specify)________________________
☐ I don't know
☐ I prefer not to answer

6. How often did you have **CONTACT** (e.g., call, visit, etc.) with **CLOSE FRIENDS** and/or **FAMILY** in the **PAST 30 DAYS**?

1 Never	2 Rarely (once or twice)	3 Occasionally (a few times - once/week)	4 Often (several times a week)	5 Very often (daily or near-daily)
☐	☐	☐	☐	☐

7. How would you **RATE** your overall **CURRENT PHYSICAL** health status?

1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
☐	☐	☐	☐	☐

8. How would you **RATE** your overall **CURRENT MENTAL** health status?

1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
☐	☐	☐	☐	☐

9. How would you **RATE** your **CURRENT SUBSTANCE USE** (i.e., in terms of how **DISRUPTIVE/NOT DISRUPTIVE** it is to your life)?

1 Not Disruptive	2 Mildly Disruptive	3 Moderately Disruptive	4 Disruptive	5 Very Disruptive
☐	☐	☐	☐	☐

	10. Which of the following **DRUGS** did you use **NON-MEDICALLY (i.e., without a medical prescription)** in the **PAST 30 DAYS**?	11. For those checked in **Question 10**, please specify on **HOW MANY DAYS** you have used each drug during the **PAST 30 DAYS**:
Alcohol	☐	
Tobacco	☐	
Cannabis or Cannabis Products (e.g., edibles, concentrates, oils)	☐	
Synthetic Cannabinoids (e.g., Spice, K2)	☐	
Methamphetamines/Amphetamines (e.g., crystal meth, ADHD drugs)	☐	
Hallucinogens/Psychostimulants (e.g., LSD, psilocybin, MDMA, GHB, K)	☐	
Cocaine	☐	
Crack-cocaine	☐	
Weak Prescription Opioids (e.g., codeine, hydrocodone, percocet, tramadol)	☐	
Strong Prescription Opioids (e.g., morphine, hydromorphone, meperidine, fentanyl, methadone/buprenorphine)	☐	
Heroin	☐	
Other Illegal Opioids (e.g., synthetic-laced prescription opioids and/or heroin)	☐	
Benzodiazepines	☐	
Other Psychotropic Drugs (e.g., antidepressants, antipsychotics)	☐	
Other (*please specify*):	☐	

	12. Please check any (non-OAT) substance use-related **TREATMENTS/SERVICES** you engaged in/used in the **PAST 30 DAYS**:	13. For the (non-OAT) substance use-related **TREATMENTS/SERVICES** you checked in **Question 12**, please specify **HOW MANY TIMES** you **USED (e.g., how many use 'episodes')** each service in the **PAST 30 DAYS:**
Hospital	☐	
Inpatient/Residential Treatment	☐	
Outpatient Treatment (e.g., group therapy, counseling)	☐	
Detoxification/Withdrawal Management	☐	
Self-help Programs/Support Groups (e.g., Alcoholics Anonymous, Narcotics Anonymous)	☐	
Harm Reduction Services (e.g., needle exchange program, safer use kits, naloxone kits)	☐	
Other (*please specify*):	☐	

14. Did you **INJECT** any drugs in the **PAST 30 DAYS**?

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

15. Did you **OVERDOSE** in the **PAST 30 DAYS**?

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

16. Did you **RECEIVE** a **NALOXONE KIT** upon release from your institution? (If **NO,** skip to **Question 18**)

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

17. If so, did you **USE** the **NALOXONE KIT**?

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

18. Have you been **ENGAGED** in **OAT** in the **PAST 30 DAYS**? (If **NO**, skip to **Question 21**)

☐ Yes
☐ No
☐ I don't know
☐ I prefer not to answer

19. If so, which **OAT** medication(s) have you been **USING** in the **PAST 30 DAYS**?

☐ Methadone (Methadose)
☐ Buprenorphine (Subutex)
☐ Buprenorphine/Naloxone (Suboxone)
☐ Naltrexone (Vivitrol)
☐ Diacetylmorphine (medical heroin)
☐ Hydromorphone (Dilaudid)
☐ Other (*please specify*)___________________________________
☐ I don't know
☐ I prefer not to answer

20. If so, where do you **ACCESS OAT**?

☐ Primary physician/general practitioner
☐ Private company (OATC, etc.)
☐ Community health clinic/walk-in center

☐ Hospital
☐ Correctional setting (e.g., detention, jail, prison)
☐ Other (*please specify*)______________________________
☐ I don't know
☐ I prefer not to answer

QUALITATIVE QUESTIONS (NOTE: these questions and responses will be audiotaped)

In your response, please try to answer the questions chronologically, starting from immediately after release until now.

21. Please **DESCRIBE** your **GENERAL** life situation and experiences (e.g., related to health, relationships, work/finances, housing) **SINCE** your **RELEASE**:

    1. **Prompts:** How was the transition back into the community immediately after your release? Was the experience generally positive or negative?
    2. What has been going well for you?
    3. What has not been going well for you?

22. Please **DESCRIBE** your experiences with **OPIOID/ OTHER DRUG USE SINCE** your **RELEASE**:

    Prompts:

1. Have you been using opioids/other drugs? Why/why not?
2. **If participant currently using opioids/other drugs:** How has opioid/other drug use impacted the following areas of your life: Health? Relationships? Work/Finances? Housing?
   If participant is not currently using opioids/other drugs: What, if anything, has helped you manage your opioid/other drug use?

23. Please **DESCRIBE** your experiences with **OAT SINCE** your **RELEASE**:

    Prompts:

1. Did you access OAT after your release? Why/why not? Tell me about this experience.
2. **If 'accessed' OAT after release:** Have you remained engaged in OAT since you accessed it? Why/why not? Tell me about this experience.
3. Are you currently engaged in OAT? Why/why not? Tell me about this.
4. **If 'currently engaged' in OAT:** How has OAT been working for you? Is there anything you would change?
5. Aside from OAT, have you sought out or used any opioid or other drug use-related services since your release? If so, tell me about this.

24. Please describe any challenges or barriers that you have experienced regarding OAT.

1. Are there any specific factors that have made it difficult to access and/or remain engaged in OAT? Please tell me about these.

25. Please describe any factors, supports or services that have been important or helpful for you regarding OAT.

1. Are there any factors, supports or services that could have been helpful for you, or made your overall transition into the community easier, particularly in regards to OAT?
2. Are there any factors, supports or services that could have been helpful for you, or made your transition into the community easier in general?

26. Please **DESCRIBE** where you see yourself in a **YEAR**:

Prompts:

1. Specifically regarding your opioid/other drug use?
2. Specifically regarding OAT?
3. What do you want to see happen in your life over the next year, more generally?