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# Evaluation of Maine DOC's Medication-Assisted Treatment Pilot Program

Mary Lindsey Smith, PhD, MSW  
George Shaler, MPH  
Olivia Dooley, MPA  
Evelyn Ali, BS



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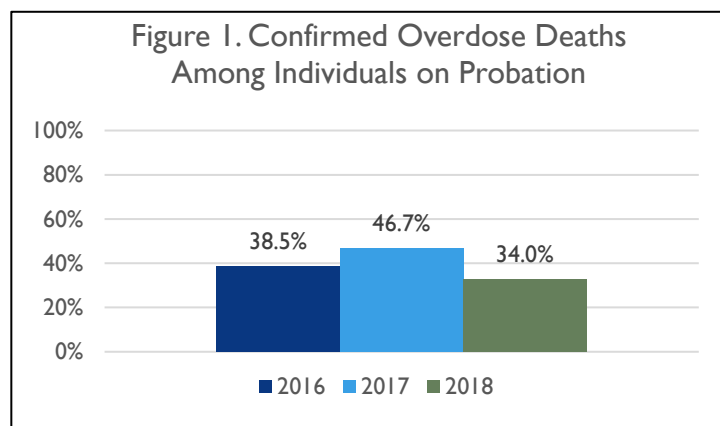
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# I. Scope of the Problem: Opioid Use in Maine

The high rate of opioid misuse and subsequent addiction is an ongoing national and local public health crisis. While there are numerous statewide efforts underway in Maine to reduce rates of opioid prescribing, prevent diversion, and increase access to treatment for opioid use disorder (OUD), rates of opioid-related deaths remain high in the state. In 2017, Maine had the sixth highest rate of opioid-related overdose deaths in the country.<sup>1</sup> While there has been a slight decrease in the number of opioid related deaths in the state, in 2018 there were 354 overdoses involving opioids (pharmaceutical or non-pharmaceutical) in Maine—this accounts for 80% of all drug-related deaths in the state.<sup>2</sup> Additionally, in Maine and nationally, the epidemic of opioid use continues to shift from the use of prescription opioids to illicit drugs. As a result, people living with OUD are increasingly coming into contact with the criminal justice system.



Research indicates that corrections-involved populations have a disproportionately high prevalence of substance use disorder (SUD) relative to the general population.<sup>3</sup> Studies have shown that over 70% of individuals in carceral settings have SUD with 10% of female inmates and over 30% of male inmates suffering from OUD.<sup>4,5</sup> Moreover, post-release opioid-related overdose mortality is the leading cause of death among people released from jails or prisons; the risk of death within the first 2 weeks of release is more than 12 times that of other individuals.<sup>6</sup> In 2018, at least 34% of the overdose deaths in the state were among former Maine Department of Corrections (DOC) clients (See Figure 1).<sup>7,8</sup> While the statistics are alarming, the use of Medication-Assisted Treatment (MAT) is one evidenced-based strategy shown to reduce opioid-related morbidity and mortality (See Table 1 for more details on MAT).

Table 1. Overview of Medication-Assisted Treatment (MAT)	
<b>What is MAT?</b>	MAT is an evidence-based path of recovery from substance use disorders facilitated by medically monitored pharmacological agents approved by the FDA. For opioid use disorder, these medications include methadone, naltrexone, and buprenorphine (common brand names: Suboxone, Vivitrol and Subutex). MAT is the combination of behavioral therapy with medication that is effective for many, but not all individuals.
<b>Who can provide MAT?</b>	In Maine, physicians (MD, DO), nurse practitioners (NP), and physician assistants (PA) can provide MAT for opioid use disorder. To prescribe the FDA-approved medications to address opioid use disorders, providers must take additional training and receive a waiver from the federal government (X-waiver). The provider works with the patient and with behavioral health professionals to provide comprehensive care for the person receiving MAT.
<b>Who is a good candidate for MAT?</b>	The U.S. Substance Abuse and Mental Health Services Agency guidance indicates that a good candidate for MAT: <ul style="list-style-type: none"> <li>• has an official diagnosis of an opioid use disorder;</li> <li>• is willing to fully comply with prescribing instructions;</li> <li>• lacks physical health issues that the medication could possibly exacerbate; and</li> <li>• is fully educated on alternative options.</li> </ul>
For more information on MAT visit: <a href="https://www.samhsa.gov/medication-assisted-treatment">https://www.samhsa.gov/medication-assisted-treatment</a>	

When provided in correctional settings as part of the rehabilitation and re-entry process, MAT can reduce opioid-related morbidity and mortality; contribute to long-term recovery; and reduce recidivism. Recent research from Rhode Island, Massachusetts, and North Carolina indicates that the provision of MAT to people incarcerated can significantly reduce opioid-related morbidity.<sup>9,10</sup> For example, the majority of individuals (82%) who participated in the Rhode Island Department of Corrections MAT program for OUD reported continuation of MAT after community re-entry.<sup>11</sup> Furthermore, a retrospective study examined overdose mortality data in Rhode Island around the time of implementation and found a 61% reduction in post-incarceration overdose deaths after complete

implementation of the protocol.<sup>12</sup> Unfortunately, treatment for SUD is not widely available in correctional settings. Approximately 65% of the nation’s inmates meet diagnostic criteria for SUD, yet it is estimated that only 11% of these individuals receive SUD treatment in jails or prisons.<sup>13</sup> Correctional facilities are uniquely situated to deliver MAT as the period of incarceration provides an opportunity to connect an often hard-to-reach and underserved population to treatment while in a relatively stable setting.

## 2. Addressing the Problem: Maine DOC MAT Pilot Program

### 2.1 Rationale

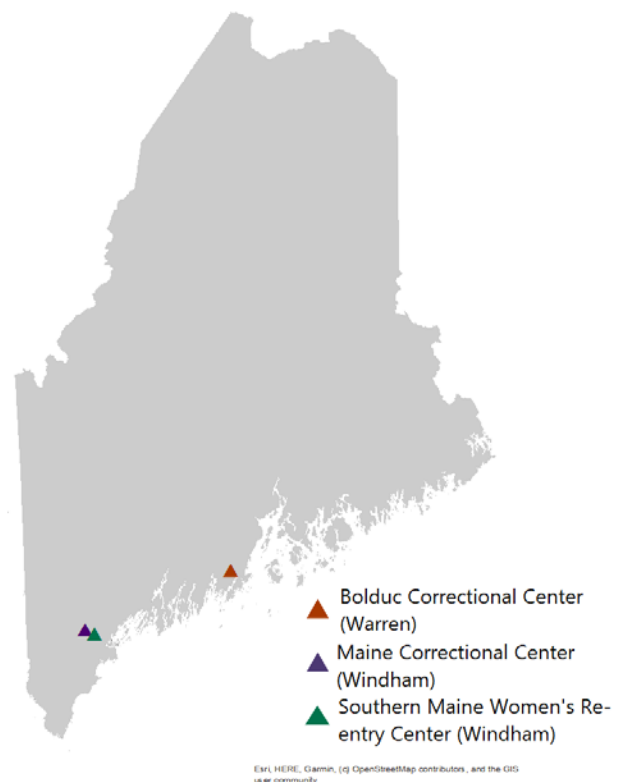
Problematic substance use is common among Maine DOC clients in correctional settings and/or on probation. However, as stated above, the majority of individuals do not receive evidence-based SUD treatment during their incarceration and, given the chronic relapsing nature of the disease, substance use often continues upon release. Numerous studies have documented that people in jail or prison who resume use after incarceration are at greater risk for fatal and non-fatal overdoses—injecting drug users are at a higher risk for transmitting viral infections, such as HIV or Hepatitis C Virus; and mental and physical health status can worsen for individuals with co-occurring disorders.<sup>14,15,16,17</sup> Additionally, research indicates that formerly incarcerated individuals with SUDs or substance-related criminal charges are more likely to be re-incarcerated than those without substance involvement.<sup>18,19</sup> There are a number of factors that contribute to post-release substance use including: poor continuity of care between carceral and community settings; lack of access to treatment in the community; poor mental health; environmental exposures (e.g., substance-using peer groups); or life stressors related to community re-entry such as challenges finding employment, housing and/or transportation.<sup>20,21,22,23</sup>

In February of 2019, in response to the high rates of opioid-related morbidity and mortality in Maine, Governor Mills signed an Executive Order to implement an immediate response to Maine’s opioid epidemic. Given that a substantial portion of the opioid-related deaths in Maine are among individuals who are former DOC clients, the Executive Order mandated that multiple sectors, including the criminal justice system, identify ways to expand access to MAT and recovery supports. While MAT has traditionally not been standard practice in correctional settings, medical providers, the courts, and criminal justice agencies have an increased level of awareness that MAT is a medically necessary treatment. In response to government mandates and in-line with the DOC’s belief that addiction is a chronic disease requiring medically necessary treatment, DOC began a comprehensive planning process to roll-out MAT in facilities across Maine. The pilot initiative was designed to help incarcerated Mainers access MAT services during and after incarceration.

### 2.2 Overview of Maine DOC MAT Program

The Maine DOC MAT pilot program was designed to enroll up to 100 offenders who are 90 days out from release. The Maine DOC facilities participating include: the Bolduc Correctional Center, the Maine Correctional Center (25 from both the men and women’s units), and the Southern Maine Re-entry Center (see Figure 2). Individuals who are eligible and enroll in the program receive medication to treat their OUD and behavioral therapy during the balance of their incarceration. Prior to

Figure 2. Medication Assisted Treatment Pilot Sites



release, program participants receive a referral to community-based MAT services. It is Maine DOC's hope that this pilot will reduce the number of overdoses and overdose fatalities for justice involved individuals.

## 2.3 Program Planning

Prior to implementing their MAT Pilot Program, Maine DOC engaged in a comprehensive planning process. The program was designed with feedback from key stakeholders listed in Table 2. These key stakeholders met frequently during the first half of 2019 to discuss and design the pilot program. At the initial meeting the Planning Committee formed four sub-committees: Training Plan and Facility Operations/Logistics; Re-entry/Community Corrections; Medical; and Data. At subsequent meetings, the subcommittees would meet first to discuss pertinent issues and then report out at the larger meetings. Specifically, the committee discussed the following among other things:

- ◆ Leadership & project coordination
- ◆ Project goals
- ◆ Organizational capacities (Maine DOC, Wellpath, and Groups)
- ◆ Protocol development
- ◆ Project eligibility & recruitment
- ◆ Treatment regimen
- ◆ Continuity of care (pre-release to post-release)
- ◆ Stakeholder engagement
- ◆ Communicating project details to staff
- ◆ Resources needed
- ◆ Staff training

## 2.4 Program Implementation

Beginning in July 2019, the Maine Department of Corrections began implementing their MAT pilot program at the three participating Maine DOC institutions. In order to be eligible for the program, an individual must meet the following criteria: have a positive screen for OUD; MAT must be deemed medically necessary and the appropriate course of treatment; and the individual must consent treatment. The Maine DOC is implementing the MAT program in partnership with WellPath and Groups Recover Together (Groups). These partners oversee the clinical implementation of the program (WellPath) as well as post-release planning and care coordination (Groups). After initial induction, program participants receive a daily dose of medication (Buprenorphine or Naltrexone) and participate in regular group counseling sessions. In addition, program participants are provided with intensive re-entry planning and, upon release, are given a medication supply to last until their first community treatment appointment as well as Naloxone. Between July and December of 2019, the Maine DOC MAT program successfully served 72 individuals with another 109 on the waiting list for services.<sup>24</sup> Among the 72 individuals transferred to community services: 58 were referred to Groups Recover

### Table 2. Key Stakeholders

#### **Maine DOC:**

- ◆ **Commissioner and Deputy**
- ◆ **Central Office:** Program and administrative employees of the Maine DOC
- ◆ **Facility Administration:** Prison facility leadership, including wardens, deputy wardens, and program staff from the pilot facilities as well as facility leaders from other prisons
- ◆ **Facility Security:** Prison facility correctional officers with specialized involvement in medication administration as a part of the pilot program
- ◆ **Adult Probation:** Adult probation staff at the three Maine DOC regional offices

#### **Wellpath:**

Organization contracted by the Maine DOC to provide healthcare services in prison facilities, responsible for delivering MAT under the pilot program

- ◆ **Administration:** Organizational leadership
- ◆ **Clinical staff:** Physicians and nurses involved with program participant screening, enrollment, and treatment

#### **Groups Recover Together:**

Organization contracted by Wellpath to facilitate transitions to community, and continuity of MAT in the community

- ◆ **Administration:** Organizational leadership
- ◆ **Clinical staff:** Physicians, nurses, counselors, and care managers enabling transition to community care.

Together and an additional 14 were referred to other community-based treatment providers.

## 3. Evaluating the Program

### 3.1 Overview

The Cutler Institute at the University of Southern Maine was contracted by the Maine Department of Corrections to conduct an independent evaluation of the rollout of the Maine Department of Corrections MAT pilot program. This program evaluation was designed to offer a summative assessment of the implementation experience; to document programmatic policies and procedures to examine whether and/or how these approaches affect program delivery; and to provide feedback to Maine DOC and other key stakeholders to help guide the refinement and expansion of the delivery of MAT in Maine correctional facilities.

### 3.2 Evaluation Framework

This evaluation includes a strong public health perspective grounded in the use of the CDC's evaluation framework that applies a population health model ideal for evaluating multi-sector interventions like the Maine DOC MAT pilot program. Evaluation activities were also rooted in the Reach, Efficacy, Adoption, Implementation, Maintenance (RE-AIM) framework and the Consolidated Framework for Implementation Research (CFIR).<sup>25</sup> The RE-AIM framework was used to examine the reach (striving for representative and population-based interventions), and effectiveness of the MAT program, as well as how easily the program can be adopted, implemented, and maintained over time in varied settings.<sup>26</sup> The CFIR framework was used to examine key implementation constructs including intervention (e.g., evidence strength and quality); external context (e.g., client needs and resources); internal context (e.g., organizational culture, leadership engagement); individual characteristics; and process (e.g., planning, evaluation and reflection). The primary goals of the Maine DOC evaluation activities were to:

- ◆ examine the structural factors (external context) and organizational-level factors (internal context) that influence the planning or implementation of MAT in Maine DOC institutions;
- ◆ assess the barriers and facilitators to delivering MAT in correctional settings in Maine; and
- ◆ document successes and lessons learned from initial planning and implementation activities.

### 3.3 Evaluation Questions

The principal goal of the evaluation of the MAT pilot program was to provide the Maine DOC and other relevant stakeholders with feedback on the planning and implementation of the MAT pilot program. Our evaluation questions were focused on examining four key domains of interest: infrastructure and system change; planning and implementation; care delivery and satisfaction; and care coordination. An overview of the evaluation questions by domain is provided below in Figure 3.

The Cutler evaluation is designed to offer a summative assessment of the success of the Maine DOC planning and implementation strategies as well as any preliminary associated outcomes. A detailed discussion of the evaluation activities, data sources, and analytic strategies is provided below in the methodology section.

**Figure 3. Evaluation Questions Used to Address Planning and Implementation Efforts**

<b>Organizational Readiness</b>	<ul style="list-style-type: none"><li>• What role did leadership play in facilitating program planning and implementation?</li><li>• How were the goals of the pilot communicated?</li><li>• How did the Maine DOC garner support for the MAT program?</li><li>• What role did stakeholders play in facilitating the culture change necessary to implement the program?</li></ul>
<b>Infrastructure Development and Systems Change</b>	<ul style="list-style-type: none"><li>• What structural (external) and organizational (internal) factors influence the implementation of MAT in correctional settings?</li><li>• To what extent has Maine DOC been successful in establishing the infrastructure to implement, expand, and sustain MAT in correctional settings?</li></ul>
<b>Planning and Implementation</b>	<ul style="list-style-type: none"><li>• To what extent did the planning activities facilitate program implementation?</li><li>• What were the barriers and facilitators to implementing MAT in Maine DOC?</li><li>• How successful were the training and educational activities at reducing MAT-related stigma in correctional settings?</li></ul>
<b>Care Delivery and Satisfaction</b>	<ul style="list-style-type: none"><li>• How successful were the implementation strategies at increasing access and engaging individuals with OUD in MAT?</li><li>• How successful were the pre-release planning strategies at facilitating linkages to MAT, behavioral health, social service, and recovery supports for individuals upon community re-entry?</li></ul>

## 3.4 Methodology

### 3.4.1 Data Collection

The evaluation team utilized a mixed-methods design that included the use of both primary and secondary data including interviews, focus groups, document review, and administrative Maine DOC data.

#### 3.4.1.1 Interviews

The evaluation team conducted a total of 11 key informant group interviews. A total of 25 stakeholders involved in the planning and implementation of the Maine DOC MAT pilot program participated in the interviews including: Maine DOC Central office leadership and staff (n=3); Maine DOC facility administration (n=4); Maine DOC facility security personnel (n=3); Adult probation staff (n=2); Wellpath administrative (n=4) and clinical staff (n=5); and Groups Recover Together administrative (n=2) and clinical staff (n=2). These interviews covered a broad range of topics and were designed to elicit feedback on topics such as: communication about the pilot; the planning process; views on the implementation strategies and process; the impact of internal and external contexts on the planning and implementation of the program; what factors have served as barriers and facilitators to expanding access to MAT in carceral settings; and respondent's input regarding program improvements and expansion. Each interview lasted approximately 45 minutes and were audio-recorded and transcribed verbatim for analysis.

#### 3.4.1.2 Focus Groups

A total of 5 focus groups were held with Maine DOC clients participating in the MAT pilot program. A total of 20



clients, 17 men and 3 women, from 2 of the pilot sites participated in focus groups; one of these focus groups was held with individuals post-release (n=2). Focus groups were designed to address key domains of interest including: how do program participants describe their experience receiving MAT through the pilot program; how have the services they received impacted their commitment to treatment and quality of life; what has been their experience with clinical and pre-release planning services provided as part of the MAT program; how could the delivery of MAT for OUD in carceral settings be enhanced; what types of support do individuals leaving carceral settings need to sustain recovery; and what are patients recommendations for enhancing the program. The evaluation team worked with Maine DOC staff and Group Recovery Together to recruit focus group participants; all individuals who agreed to participate in the focus groups were asked to sign a consent form. All focus groups lasted approximately 45 minutes and were audio recorded for transcription and analysis.

### **3.4.1.3 Administrative Data**

Whenever possible, we used administrative data from Maine DOC and their clinical partners, Wellpath and Groups Recover Together, to supplement our primary data collection. Administrative data included meeting minutes and other internal Maine DOC documents; Maine DOC Adult Data Report; and information on program enrollment, utilization, and treatment engagement upon release. Administrative data was compared with quantitative data to further explicate and validate findings and to identify other areas needing exploration.

### **3.4.2 Data Analysis**

The evaluation team utilized qualitative data analysis techniques to analyze and triangulate data. In order to maintain the confidentiality of respondents, all data presented in this report has been de-identified and presented in the aggregate. Qualitative data (e.g., interviews, focus groups, key documents) were systematically coded to explore how the implementation of the Maine DOC MAT pilot program unfolded. Qualitative data analysis was done iteratively to build a coding scheme for all textual data using the grounded theory technique, in which codes are drawn from the text and coding involves frequent comparative analysis of the data. All qualitative data files were reviewed by at least two members of the evaluation team, and coding discrepancies were resolved through discussion and/or enhanced definition of codes. We compiled a codebook of emerging themes and constructs with attention to the elements suggested to be important for successful implementation of MAT in carceral settings. Whenever possible, qualitative data was compared with administrative data from Maine DOC to further explicate and validate findings and to identify areas needing exploration.

### **3.4.3 Limitations**

There are several limitations associated with this summative evaluation. First, this implementation evaluation commenced more than three months after the pilot started in July of 2019. Ideally, the evaluation team would have been evaluating the implementation of the project in advance of the start date. However, the evaluation team was able to gather data from a significant number of the key stakeholders involved in planning and implementing the project. An additional limitation of the study is that the results are more reflective of male program participants. It was apparent to the Cutler team that the experiences of female and male pre-release participants differed, at least on the Maine Correctional Center campus. More significantly, the evaluation team was only able to interview two program participants who had matriculated to the community-based program upon re-entry; both of whom had just recently been released. Given the importance of understanding the impact of the program on participants once they return to the community, this study would have benefitted from more post-release perspectives, especially among program participants who had been out of prison for a longer period. Lastly, the evaluation team did not have ready access to outcome data collected by Maine DOC and Groups. While it is still early, and there is not a lot of data yet, it would have been helpful to include more administrative data, particularly on community-based outcomes such as length of treatment engagement post-release, in the report.

## 4. Results

### 4.1 Planning Process

The Department of Corrections team facilitated a comprehensive and purposeful six-month planning process beginning in February of 2019. Throughout this relatively quick planning stage, Maine DOC identified the importance of MAT, created a planning structure to aid in project implementation, focused on education, and created policies and procedures to facilitate the launch of the program.

#### 4.1.1 Rationale of Implementing Maine DOC MAT Program

*“Historically, our society has not been all that interested in making sure that inmates being released from incarceration don’t reoffend. And that’s where we come in. We are interested in it. We are motivated to do it.”*

- Groups Administrator

Key stakeholders in the planning process, including Maine DOC leadership, administration, and clinical staff, reported that they recognized the increased need for more comprehensive treatment options in correctional settings across the state and were motivated to implement the MAT program. Maine DOC leadership spoke of the fact that the MAT program fits with the goals and values of the Maine

DOC, which is focused on rehabilitation. It was mentioned that a very high percentage of individuals entering the Maine DOC system have histories of mental illness, substance use disorder, and trauma, all factors contributing to their incarceration. Therefore, the Maine DOC sees programing, like the MAT pilot, as playing a key role in their organizational mission to provide services aimed at promoting successful reintegration and reducing recidivism.

Maine DOC leadership viewed the MAT program as an opportunity to play a role in enhancing multi-sector initiatives aimed at addressing the opioid epidemic and most importantly to support offenders in their recovery. They saw MAT as a high-priority, evidenced-based treatment that presents Maine DOC with the opportunity to help reduce opioid related morbidity and mortality post-incarceration.

*“We recognized this as the Gold Standard and we know what we have been doing isn’t working and we have an opportunity here with the offenders who are in our care to provide MAT and we feel as though it is the best chance for them to be successful in their recovery.”*

- Maine DOC Leadership

#### 4.1.2 Structure

To facilitate the planning process, the Maine DOC team formed a Steering Committee with internal and external partners. This Steering Committee formed four sub-committees each chaired by internal staff. This structure supported and promoted regular communication, which leadership felt was vital to the process. Maine DOC believed that access to information for all levels and types of staff was essential and encouraged individuals to communicate with one another, especially those groups that were traditionally more secretive such as Special Intelligence and Investigation. All parties interviewed spoke of ongoing communication such as e-mails, regular meetings, and conference calls. Maine DOC knew that communication from administration and facility staff had to be clear and consistent. In fact, clearly articulated goals and strong leadership were mentioned as central components of the planning process and were also seen as key to helping facilitate staff buy-in for the program.

#### 4.1.3 Training and Education

In addition to establishing the value of MAT and creating a structure for the planning stage, Maine DOC focused their efforts on training and education. These education and training strategies were intentionally organized to reduce stigma, create buy-in for the program, and promote staff engagement, all vital components to the success of the program. The messaging needed to be effective, inclusive, and comprehensive, especially given the immense organizational culture shift in moving from a secure facility in which Suboxone was actively kept out of Maine DOC institutions, to a model where the medication was introduced in controlled manner. As one administrator described,

“It’s really the war on Suboxone mindset that we needed to compete with.” Through an inclusive process, Maine DOC was not only able to provide information and education on MAT but also create staff support for the program.

Stakeholders shared that they started with a survey sent to all staff to gain an understanding of their perceptions of MAT. The team developed the training curriculum based on survey responses and also identified facility champions, people with both formal and informal influence that were respected in the facility, to lead the trainings. Administrators reported that this created engagement and acceptance of the MAT program.

Maine DOC also reflected that it was important to make the mandatory trainings feel more like a conversation. They described the trainings as focus groups that were intentionally small to allow for questions, concerns, and the digestion of the information being presented. Several other stakeholders echoed the effectiveness of the method, especially given the initial tension of introducing Suboxone into the facility. This inclusive approach was highly successful; Maine DOC staff reported that they felt listened to and had input in the process.

*“So I think just having it be a two-way discussion in those sessions is really what helped them feel heard, as opposed to preaching at them and saying, this is the gold standard, and we will do it, and you will like it.”*

– Facility Administrator

Another helpful education and training tool that was consistently mentioned by key stakeholders were the site visits to Rhode Island to observe their DOC MAT program. These trips provided opportunities for hands on education and were valuable to Maine DOC staff because they were able to glean information, collect best practices, and adapt them to Maine. Administrators reported that the trips helped them to understand what to look out for, what to expect, and how best to develop protocols. Several people stated that the trips were “extremely helpful” and a correctional officer noted, “There were things that we never would’ve thought of it we didn’t actually see it ourselves and talk to people that have actually done it.”

#### 4.1.4 Policies and Procedures

Another large component of the planning phase was developing policies and procedures to support program implementation. While it was important for Maine DOC to have staff engagement and support for the program, they also spoke of the need to execute the program safely and securely.

*“It is one thing to know that this is the right thing to do, it is good for people, but it is another to figure out details and the intricacies of implementing something that was not allowed in the facilities that is now going to be distributed. So, the process of just identifying where in the facilities with the systems change, which staff and what kind of trainings they needed, those were all different new pieces.”*

– Facility Administrator

Maine DOC spoke of needing new workflows, staff, and medication lines to support program implementation. Each step needed a standard operating procedure and a protocol that could be adapted to the individual facilities

*“It was creating an MAT process, administration process that was going to be just as bulletproof as we could make it. Not to be punitive, but in keeping with safety and security and order, and not having this thing turn into a mess”*

- Facility Administrator

participating in the pilot. Maine DOC identified the need for staff that adhered to details and could implement system changes and even built in planning time to do dry runs of the medication line before the program started. Administrators also recognized the delicate balance between safety and punishment. A benefit to this process was having Wellpath as an existing partner. As a national company, they had existing processes and policies that could be adapted to the Maine program. Additionally, adult probation shared that MAT was not new to them, the only change was having an existing referral upon release.

Despite mostly positive feedback on the planning process, there was some feedback on challenges. For example, staff spent a lot of time developing standard operating procedures to promote safety and prevent diversion yet not as much time was spent working through clinical procedures and workflows. Many clinical staff indicated that this made it difficult for them to adjust protocols and workflows. Wellpath staff felt that it would have been helpful for them to have had more time to work through how the clinical assessments, medication administration, and counseling components of the program would roll out within the larger context of the facilities' existing procedures.

*“That was our – that was our frustrating point right from the beginning when we sat down, it felt we were being very reactive and try to write down from how are we going to chart this where we’re starting in a few days. I mean, yeah, it was – it put the stress on us that I felt that was not necessary if we could have had more time, and it felt like they had more time to talk about it, and then it came to us.”*

- Wellpath Clinician

In addition, administrative, security, and clinical staff at Maine DOC shared that not having the resources to support the program was a barrier to implementation, especially given the quick timeline from planning to program rollout. The most frequently mentioned resource challenges included: scheduling and having security staff available to support medication lines; physical and mental health providers to run the clinical components of the program; and additional logistics such as finding space for MAT specific medication lines.

## 4.2 Implementation

After six months of intensive planning, Maine DOC and its partners went live with the implementation of the pilot in July of 2019. Based on multiple interviews from various constituencies, the implementation seems to have gone very well. According to Maine DOC administrators and facility officials, the implementation of this pilot has been very successful. Maine DOC, Wellpath, and Groups administrators and staff spent considerable time planning for various contingencies. The four planning committees anticipated many of the possible events, though not all, that might possibly arise. These groups addressed training, facility operations/logistics, medical issues, and data needs. Key stakeholders indicated that the comprehensive planning process played a key role in ensuring the successful implementation of the program.

### 4.2.1 Successes

#### 4.2.1.1 Leadership

A significant amount of success in the program was attributed to departmental leadership during the planning and roll out period of the MAT program. Stakeholders indicated that the clear communication and collaboration facilitated by leadership was instrumental in supporting implementation. Maine DOC leadership was invested and committed to communication, their clear vision help to create clarity and fostered motivation among staff to support successful program implementation. In addition, many interviewees felt that Maine DOC leadership, at both the central office and facility levels, were fully invested in supporting the initiative as well as the staff tasked with implementing the program. For example, facility administration conveyed to security and clinical staff the importance of following protocols strictly.

*“There is nothing in hind sight that I personally think we should have done differently. It came together pretty well honestly because it was controlled by the leadership who controlled it.”*

- Maine DOC Leadership

*“one of the concerns when we went into this was making sure that these officers were supported by not only in my role, but also through administration, in them enforcing the strict protocol..., we stepped it up a little bit, because this is such a controlled substance and is such a security concern. And we just – we wanted them to make sure that they knew they had our support.”*

- Correctional Officer

Knowing that the medication is a controlled substance and that if not monitored closely it could find its way into the wrong hands, facility administration demonstrated to security and clinical staff their support for closely supervising the program participants.

#### 4.2.1.2 Staff Engagement

Several factors supported the adoption of the pilot project. As described above, securing staff support was integral to ensuring the smooth roll out of the program. Maine DOC identified staff who had the trust and respect of their peers as key conduits to all staff. These individuals were tasked with promoting the pilot to their peers. At the outset, this strategy seems to have worked. Using surveys and interactive trainings during the planning phase allowed Maine DOC to address staff concerns and shift individual perceptions as well as organizational culture to gain the support needed to promote successful implementation. One administrator conveyed that staff involvement in the planning and implementation of the pilot was somewhat unusual. The administrator characterized that many Maine DOC initiatives happen in a somewhat top-down manner, a style typical of corrections and law enforcement environments. The administrator indicated that with this pilot, the process was much more collaborative. This change may be due in part to new leadership at Maine DOC.

*“The staff buy in makes the implementation so much more successful. Staff are on board, they see this as part of their job, it isn’t something necessarily forced upon them or that they have to do and they completely disapprove of.”*

- Maine DOC Staff

*“I think staff’s involvement throughout the entire process, I mean staff on all levels, really is kind of one difference than how Maine DOC typically – well, I will say historically, not typically – has operated. It’s usually like the top down, like this is – you’ll do this, and, you know, just get it done. This was very collaborative, I think right from the beginning.”*

- Facility Administrator

#### 4.2.1.3 Organizational Adaptation

While the planning effort was comprehensive, some in the group recognized that some obstacles were inevitable. Several people interviewed anticipated that this would happen and resolved to quickly tackle these issues as they arose. This organizational flexibility/capacity enabled Maine DOC to easily weather these roadblocks and make rapid mid-course corrections to resolve any issues that surfaced. One person said, “...And certainly, there have been little hiccups along the course of the complete system roll out and some of the patients, you know, some of the concerns that they have had and expressed, but for the most part, I believe that the process and the project have been relatively seamless to impact us operationally.” Many Maine DOC staffers took a pragmatic approach recognizing that all the planning could not account for all the extenuating circumstances that might arise.

*“I think just a lesson learned is you can never plan for, control, and account for everything. There comes a point where you just have to say, okay, we – we’ve planned to the best of our ability, and we can expect there will be issues. And when they happen, we will work to resolve them.”*

- Facility Administrator

#### 4.2.1.4 Enrollment

According to most of the participants, program enrollment is straightforward. One inmate mentioned that enrollment was “pretty simple” while another indicated, “I think it [enrollment] was -- I think it was a good way to do it. That way they make sure that everything was covered.” Among the nearly 20 individuals that the Cutler Institute interviewed, program enrollment was lauded as an easy process.

*“I think we are at 50 or 60 folks who are getting treatment and I think that within itself is fantastic and this time last year nobody was... Folks are getting the help and support that they need fantastic.”*

- Central Office

Central office staff were equally pleased. After years of trying to launch such an effort, staff were enthused that the new administration was supportive of such an undertaking. One person was almost relieved to know people are getting treatment.

While enrollment numbers are somewhat lower than expected, Maine DOC is not concerned. The difference is not dramatic and could be resolved if eligibility criteria were expanded. Higher enrollment figures could happen as the program matures and satisfaction with the program spreads throughout the pilot facilities and the other facilities joining the initiative.

#### **4.2.1.5 Treatment and Care Coordination**

What sets this treatment program apart from others is that participants are enrolled in a program that is steeped in evidence-based treatment. From a clinical perspective, Maine DOC, Wellpath, and Groups staff feel that the chances of recovery are more likely with participants receiving medication and counseling services both pre and post-release. Some interviewees mentioned this as an important attribute of the program.

Post-release treatment provides another level of accountability. Participants know that both Maine DOC through probation services, and Groups, through counseling services, will be monitoring them post-release. Many of the individuals interviewed realize that treatment adherence is all that stands between them and a possible return to Maine DOC, a relapse, or an overdose. Most of the participants interviewed for this study want to maintain their recovery, some desperately, and this program affords them that opportunity.

*“So the first part of my answer is the population that is coming out of Maine DOC and entering treatment ...succeeding because we have a clinical model that helps all individuals succeed.”*

- Groups staff member

While some pre-release participants were stressed about some non-treatment issues such as securing affordable housing and adequate transportation once they were released, treatment issues did not weigh as heavily on them. With medications and counseling services set up for them upon release, these issues did not predominate.

*“ they set up my appointment for when I get out, they give me enough medication when I get out to last me until my appointment. When I walk out the door, they give me enough to last me. They've given – they've hooked up a phone for when I get out so I'll have a cellphone when I get out to be able to contact them or whatever. They pay for the first month. So, yeah, they – they set it up really good when you get out. They make sure that you have a provider, an appointment, all of that.”*

- Program Participant

The interview team was struck by the level of concern that pre-release participants had about housing and to a lesser extent transportation and employment issues. Several inmates interviewed for this study were concerned about housing. Some of them did not want to return to the communities they lived in prior to being incarcerated. The use of opioids among peers and family members in their former communities might be triggering to program participants upon release. The interview team talked with several program participants who were within a couple of weeks of being discharged and had not been able to secure housing. While some individuals were opting for sober houses once they got out, others were concerned that their housing situation might not support their sobriety.

A couple of participants were concerned that their occupations (e.g., fishing) might not be conducive for treatment. Some wondered if daytime counseling sessions were feasible in occupations in which getting time off from work was not as likely. For others, securing reliable transportation to get to work and treatment had yet to be resolved as their discharge date loomed.

## 4.2.1.6 Outcomes

Maine DOC staff are very pleased with the way the pilot has been implemented. Having visited the Rhode Island correctional facilities that have implemented a comparable program and engaged its own staff in planning efforts DOC administrators feel the program has been successful in the first seven months. One Maine DOC administrator mentioned, “So, honestly, as far as initiatives that have been implemented in the facility, I’m not sure I’ve seen a better one....super proud of the way this one came together.”

Likewise, Groups is touting some of the initial success that early released participants are showing in the community. Housing stability and employment as well as treatment compliance rates all look promising just a few months into the pilot.

*“94% of those individual are currently employed, and 97% report having safe housing. Beyond that, as of September, [...] of the 48 individuals released from Maine DOC who remained actively in treatment with Groups, 98% remain in compliance, and our retention rate is stronger than our typical retention rate across Groups. [...] So the answer to your question is I feel that the implementation has gone well, has gone even better than planned.”*

– Groups staff member

## 4.2.2 Barriers

### 4.2.2.1 Organizational Capacity

From the time it was approved to its launch in July of 2019, this pilot project required a lot of planning and coordination in a relatively short period. More importantly, it required both intra and inter-organization coordination. While Maine DOC and Wellpath had a long history of working together, both of them had not worked extensively with Groups Recovering Together. While Maine DOC and Wellpath are separate organizations, working within correctional settings they do so in close collaboration and have done so for many years. Many Maine DOC staff interviewed for this evaluation mentioned they relate to Wellpath employees as if they were Maine DOC employees/colleagues. When you have two organizations that have worked closely for many years, as is the case with DOC and Wellpath, the introduction of a new partner is bound to cause “some bumps in the road” as organizations and staff get to know one another.

The pilot required a lot of planning and bringing a large number staff with different levels of understanding and beliefs up to speed on a range of topics related to addressing SUD using MAT. For example, security staff had to implement several new protocols to handle the pilot. While the planning meetings were frequent and covered many procedures in a short period, the planning team members could not account for every possible situation. Among the most significant were staffing issues. This pilot required the addition of more staff or a re-deployment of existing staffing across Maine DOC and Wellpath. The pilot meant new medication lines had to be organized which required more nurses. Additional medication lines also necessitated the need for more security staff to monitor the intake of medications. In addition, the Maine DOC MAT Pilot program involves the use of medication in combination with counseling services which has increased the demand on Wellpath staff.

While Maine DOC and Wellpath exercised considerable effort bringing this pilot to fruition, staffing shortages across various departments created some barriers to implementation. One facility employee stated, “I mean, we pushed our security staff, unfortunately, this last month. We were kind of teetering on we were already full -- med pass was already full at 10, and we had three patients waiting in the wings. So we -- you know, we unfortunately kind of pushed our security staff to the max...” These issues do not seem to have resulted in sub-standard care or security, but it did create some additional stress on employees that already work in a stressful environment. A corrections staff member added, “We’re short staffed and, you know, we’re two officers that as soon as we’re done, we’re put on a post someplace.”

Staffing issues at times disrupted counseling sessions. Some inmates mentioned that weekly sessions were sometimes cancelled because of staffing shortages or holidays. Some inmates the interview team spoke with had only attended a few of the previously scheduled sessions.

*“I think... the biggest challenge has been with two of my groups in particular where we've not been able to meet consistently... - because of lack of Maine DOC staff. So, I have two groups during the week that it's required to have a rover on staff in order to be able to conduct that group. And, you know, I actually asked the guys a couple weeks ago, you know, what – what do you guys need? ... [they responded by saying] the group hasn't really been very cohesive and that's what they said. You know, one guy said I've been in this program for eight weeks and I think we've missed four times. ... From my perspective, Maine DOC actually is taking it very seriously but it's difficult for them to see that when groups are canceled because we don't have the staffing that we need to be able to have them.”*

– Groups staff member

There were some additional logistical challenges with the pilot that were not resolved at the outset. For example, external clinicians that came into the facilities to meet with participants to arrange their post-release treatment did not have places to set-up, computer access and/or a telephone. Access to Wi-Fi, which is limited in a correctional facility, was not readily available for non-Maine DOC employees.

*“we can't bring our computers in to do assessments and to talk to people, so it's like if I need [to make] a doc appointment right off...and he's leaving in three days, so I need to do the intake, get it going, and get this Maine DOC appointment right off and there's – I can't communicate while I'm in the prison system. So, for 12 hours, I go up to MSP and I am like off the grid.”*

– Groups staff member

Clinicians that needed to enter or access notes from an external electronic health record system could not do so readily. This made providing treatment, including counseling, more challenging. The following quote is emblematic of this issue, “I was helping [XXXX] when I was up there last week and tried to access the computer in the substance use room, and it said the computer was on but it wasn't, you know, it wasn't even coming up. So, I'm not sure what was going on with that.”

#### 4.2.2.2 Communication

This initiative requires frequent communication and sharing of information/intelligence within and among the three organizations. Maine DOC received high marks for communication efforts within the facilities. There are daily debriefings among facility supervisors about how medication administration worked the previous day.

That said, some adult probation staff were not as clear with what was going on, especially during the pre-release planning period. Many adult probation officers (PO) interviewed for this study were already familiar with MAT. Depending on the availability, many adult POs refer their probationers to these services whether they are coming from a facility or the community. For some POs, there was limited communication from facility caseworkers about particular inmates' participation in the pilot. One PO was quick to point out that the lack of communication was not new to this pilot, but was an issue that pre-dated the pilot. This person went on to say, “We've been dealing with lack of communication, quite frankly both ways. I'm not trying to say this is a facility issue. This is a facility and Probation issue. Long before MAT was around. So this is not a new issue.”

One PO said the only way they find out about an inmates involvement in the pilot is if it is integrated into their CORIS during the pre-release period. One PO suggested that enrollment in the pilot was not being entered into CORIS. Another PO characterized the communication as follows, “I would argue almost none, communication from the caseworker directly to the PO about the participation, involvement and referral process. The PO is having to just simply look in CORIS to try and get that info.”



Groups staff interviewed for this evaluation mentioned that they would have preferred more frequent communication, especially in the early implementation period. This would have helped them learn the status of participant enrollment, get feedback from facility staff and share updates with Maine DOC and Wellpath staff. It seems that communication improved somewhat over as the program matured, but may have benefitted from more attention during the planning period.

*“...And we need to be more at the table because they talk about the program but nobody's come and talked to [us]... I'm expected to do the intake and work with the guys there when they get out but they – like, the case workers get really mad if we can't, ...we don't have telehealth, so we can't get them in for like a week or two until they get out. Well, I thought they were supposed to be – because of miscommunications and stuff.”*

– Groups staff member

Some miscommunication arose around what the initiative was to be called. Was it a program or was it treatment. Initially, some people referred to it as a program, which it was not. Programs are required, while treatment initiatives are optional. This is an important distinction in correctional settings and led to some confusion as well as delays in developing clinical workflows until it was clarified by leadership.

*“I think one of the biggest hurdles... we had to overcome is that when we first started talking about MAT – ...– we started calling it a program, and in Maine DOC language, program means something very different than treatment. So programs in the Maine DOC world are... required. It's like substance abuse, sex offender programs versus mental health and medical treatment, which are optional. So we started down kind of the wrong path of calling it an MAT program, and it sort of got away from us. So we were able to pull it back in before we started and really sort of focused on MAT as a medical treatment...”*

– Wellpath staff member

#### **4.2.2.3 Dosage and Diversion**

Pilot participants receive a 16 mg Suboxone sublingual strip once a day, usually in the morning. This strip is placed under the person's tongue, close to the base, on either the left or right side. The strips can take a while to dissolve and while the person has it under their tongue they are not supposed to drink which would compromise the effectiveness of the medication. Some people have problems generating saliva while they have the strip under their tongue which can aid absorption.

In many outpatient treatment settings, the patient receives two or more strips a day, typically at a lesser dosage. This enables the individual to receive a steadier dose of the medication throughout the day instead of all at once which is what the pilot did. One post-release participant suggested, “I would've liked to have had one like one in the morning and then one later on at night.” The pilot did so because it was easier to administer one medication line a day opposed to multiple.

Since many participants had not been on any medications for some time while they were in prison, the initial dose of 16 mg all at once was intense for some participants. The high dosage all at once made some inmates sick. One staff member commented, “I think medical dosing at a street level ... And I think initially, people were really having some pretty bad side effects.” Soon after the rollout, dosage levels were adjusted to a lower level and then gradually increased over time. Some inmates mentioned they would like to get their dosage split up so they do not go an entire day between strips. One post-release participant cautioned that some inmates might want a higher dosage and not really want to be sober, “...but a lot of the girls' mentality was I want to be on the highest dose. I think there needs to be a little bit more restriction on that because if all I had to do was put in a med slip and boom, I was upped...”

Soon after the pilot started, some diversion concerns were raised. Knowing that other inmates were receiving Suboxone, non-eligible participants were being “triggered.” In addition, the draw of profiting from others SUD cravings or in some cases intense pressure from other inmates, led to some fairly ingenious diversion efforts. At least one participant tried to sell his Suboxone-laced saliva, which can remain in the throat for some time, to non-pilot participating inmates.

*“And so what we have noticed now is when certain prisoners are returning to their housing units they’re bringing the saliva up and then selling it directly or they are storing it in little empty pens and they are selling that to another prisoner or they are drying it and prisoners are purchasing that and snorting it and so that is the type of diversion we are seeing which we did expect at all.”*

– Maine DOC Leadership

One post-release indicated these diversion efforts may have been somewhat overstated. This former inmate said, “I don't think -- how do you control your saliva? We never had an issue with like girls cheeking or trying to do shit like that, it never happened.” According to Maine DOC officials these diversion efforts were pretty minimal, but it nevertheless led to more careful monitoring of medication administration. Subsequently, participants has to sit quietly in a room while they took the medication, with their hand on their legs and out of reach of other prisoners. Inmates are observed closely to make sure they are not removing the strips from their mouth. Some inmates report they felt this treatment was harsh and unnecessary.

Participants that did not comply with expectations could be subject to some form of disciplinary action. One post-release participant mentioned that it took a while for the strips to dissolve and that the security staff would get impatient with him. This person stated, “It took forever. And the taste in your mouth is so nasty and if you like move your mouth or go like that or anything, they think you're cheeking [holding onto it] so you're going to seg [segregation].” One participant mentioned that he was sent to segregation for inadvertently swallowing a strip. One post-release participant indicated that the guards would get frustrated with him over his inability to complete the strip that they suggested he drink some water, which would have minimized the medication’s impact.

One post-release interviewee said while many of the guards treated him well in the pilot, he intimated that a few staff could use some training when it comes to the ways they treat someone with an addiction. He recounted the fact that MAT participants were identified over the intercom when it was time for treatment. He indicated this practice was humiliating. One male post-release participant stated, “I don't know how it was for the women, but I know us on the men's side, anyone that was on Suboxone was looked down upon by the COs bad -- bad.” This same participant said he was subjected to more shakedowns than others in the dorms were because he was receiving Suboxone.

#### **4.2.2.4 Continuity of Care/Care Coordination**

One of the highlights of this pilot is that there is a community-based treatment option already lined up for Maine DOC inmates once they leave the facility regardless of geography. Groups, Wellpath and Maine DOC have established what is known as a warm hand-off for released prisoners. Their prescription and counseling needs are arranged for and covered by MaineCare ahead of time so that these obstacles to remaining sober are minimized. Sometimes MaineCare coverage was not seamless and it caused some angst for participants.

In interviews, Maine DOC staff voiced support for expanding the program since it is only available to those 90 days from release. If more resources can be secured, Maine DOC would like to extend the eligibility period. Several inmates expressed an interest in having treatment available from admission through release for those receiving a short sentence. Inmates did not address what short sentence length might be, but some of them could understand not providing this level of treatment for someone serving a lengthy prison sentence.

Maine DOC is working with the county sheriffs to discuss what types of treatment they are providing. Since many people sentenced to a Maine DOC facility come from one of the 15 county jails, Maine DOC wants to make sure their treatment is aligned with that being offered at the jails. That being said, people in jail on pre-trial detention spend less time in that type of facility and as a result may not be getting extensive treatment services. Some of the larger jails that have experience with MAT are a little further along than other jails. In short, Maine DOC administrators want to ensure continuity of care between the jails, prisons, and the community.

When the pilot was first implemented and some of the first participants were released, Maine DOC staff had some concerns about Groups' ability to manage care for individuals leaving for all parts of the state. The interview team received the impression that Groups was not ready right away for all of the discharges and not responsive to Maine DOC's needs. Maine DOC recognized that the community infrastructure was not in place.

*"That is probably the most difficult piece to implement...setting up community appointments and making sure there is follow through on that. Number one Groups is sort of in a new space in corrections and two the community wasn't really ready for this process, the community in general just because the community treatment providers are developing their own infrastructure as we speak."*

– Maine DOC Leadership

This sentiment has changed since Groups has become more familiar with the process. One facility administrator mentioned, "What I have heard from some of the case workers when it first kicked off is that Groups were a little bit unprepared for the amount of releases they were getting." While interviewees have mentioned there has been an improvement in services, they would like to see more data from Groups as to how participants are doing in treatment. In short, Maine DOC and Wellpath would like to see more outcomes data.

In several interviews, Groups staff addressed this point by stating the pre-release period can be challenging from a continuity of care standpoint. During this period, Wellpath staff are providing medical and substance abuse services while a Maine DOC caseworker is working on pre-release planning. Sometimes a participant's release date can change or be moved up and this can compound communication and continuity of care issues. Early in the pilot period Groups was getting used to this process. One Groups staff member commented, "...If we say their release date's December 1st, and then all of a -- and we have a follow up appointment scheduled for December 3rd, and then they get out November 20th, it's often a challenge to see if we can get them in earlier to make sure that they have that continuum."

While Groups has nine locations throughout the state there are some areas where they have to contract out for local MAT services. Groups is also reliant on other vendors to supply post-release participants with cell phones and getting a prescription for Narcan in the event of a relapse. This makes pre-release planning and treatment follow-up more challenging. One Groups staff member spoke to this point,

*"I think there's an important distinction to be drawn here between two different categories of pilot participants. One category is individuals who participate in this pilot, and then are released to Groups, [and] our team is taking care of both in-facility and then in the community, we're highly effective at coordinating care and making that a seamless transition. The second challenge is around individuals who are releasing to communities where we do not have a physical presence."*

– Groups staff

## 4.3 Feedback

To date, the majority of the feedback regarding the Maine DOC MAT Pilot Program has been positive. This positive feedback has come from Maine DOC staff and program participants as well as individuals in the community including: state Legislators, District Attorneys, community members, treatment providers and employers.

*"From where I sit I get feedback from different legislators about this is fantastic you are offering MAT in the facilities, this is so great. I get comments from agencies that we work with. We work with a lot of businesses in the State, do a lot of conversations with businesses and the stake holders and the labor field and they are happy to know that as employers that the inmates and clients that we are working with retraining them for jobs and retraining them"*

– Maine DOC Leadership

### 4.3.1 Program Benefits

Overwhelmingly, individuals who have participated in the pilot program feel there have been a number of benefits. Participants frequently mentioned that being in the MAT program curbed their cravings, reduce anxiety and helped clear their minds so they could focus on making plans for community re-entry.

*“You know, we've got a lot of guys who have a lot of anxiety about, you know, getting close to release, going back to their homes, back into that environment that they've used. We've had guys that have had multiple overdoses, a couple of guys that have had, unfortunately, you know, where they've been clinically dead from an overdose and brought back. So yeah, we have a lot of anxiety around that. And so a lot of people are very thankful.”*

-Program Participant

Many of the individuals we interviewed indicated that this is the first time that they had hope that they could remain in recovery after completing their sentence. Some participants stated that Suboxone has cleared their minds and improved their confidence in their ability to remain sober. Others discussed the benefit of working with program staff on re-entry planning and having the time to make decisions that support long-term recovery. For example, one individual discussed working on a re-entry plan that includes moving to a different community to avoid contact with people and environments that could be triggering.

*“The first thing you're thinking oh, I'm gonna get high when I get out. I don't think about – I've got a – I've done a lot of bids and every time I get out oh, I'm gonna get high, as soon as I get out. That's not on my mind now, so the stuff works.”*

-Program Participant

### 4.3.2 Areas for Improvement

#### 4.3.2.1 Treatment Initiation

While inmates participating in the program indicated a wide range of benefits from receiving MAT, they also had suggestions for moving treatment itself forward. Feedback indicates that there may be opportunities to refine the program including examining initial induction timeframe, working to improve scheduling and communication about program components, and addressing stigma among facility staff. They attributed problems with program scheduling and access to staff stigma and emphasized that the facility security should better understand MAT to decrease stigma that impacts inmates' day-to-day access to and experience of the treatment program.

*“we have a right to be in control of our medical things and some of the girls are just – and, you know, I guess anybody who's incarcerated and if you're not ready to be sober then they look at that upon we're going to get high in jail, what's better than that, but it was quite pushed.”*

-Program Participant

*“From my personal experience, I was on drug court, and that was the MAT's part of their program, and when I messed up, they put me back in jail, which all York County is their whole program is MAT. I got back out into their rehab, which is MAT, but when I messed up in rehab, they threw me back in, I got – kept coming off the medication. So when I got here, I would've liked to be put right on it but of course they're not going to let you do that but I think if you have a history of it that they should keep you on it because it was just like cruel and unusual behavior for the person, for me, to go through withdrawal like that so many times”*

-Program Participant

Many of the participants offered feedback on the timing of induction, pointing out that initiating MAT earlier in an individual's sentence can have benefits. One major reason inmates cite for starting the induction process at intake was that it would help reduce withdrawal symptoms. Numerous program participants discussed the fact that they did not understand why treatment for their substance use disorder is addressed differently than other chronic conditions that are treated with medications.

*"I think that if we had a longer period of time on it, you'd be able to be more prepared when you're on the outside of being – staying on that track of being sober."*

**-Program Participant**

This further substantiated their beliefs that MAT should be continued (if on prior to incarceration) or initiated immediately upon entry into the facility. In addition, supporting continuity of treatment and/or addressing withdrawal symptoms, many program participants felt that earlier induction would allow them to have a longer sustained period of recovery ultimately making them more prepared to maintain their sobriety upon release.

#### 4.3.2.2 Medication Administration

Program participants provided feedback on medication administration and dosing as well as the timing of MAT initiation. Several participants indicated that there has been some inconsistency in when medication is administered. In addition, some inmates noted that there are challenges to participating in both the MAT program and continuing with their ongoing educational or work opportunities because of the timing of daily medication administration.

*"Mine ain't horrible, (consistency of medication administration) but I think it should be – I certainly think that it should be on a certain time, you know, due to like classes and stuff like that but I actually had to drop one of my classes because I couldn't make it there on time."*

**-Program Participant**

Program participants also discussed a need for a more patient-centered model of care where they have greater autonomy over their medication dose levels as well as how the medication is administered. Several participants mentioned that they would like more ongoing communication with clinical staff about adjusting and/or tapering their medication dose. Other program participants indicated that they felt they were encouraged by staff to take a higher dose of Suboxone than they felt were necessary. Overall, responses point to a potential need for more shared-decision making between program participants and clinical staff to ensure that individuals are obtaining the most appropriate level of medication for their specific needs.

*"I think it should be split...Because by the next day, you know, you're kind of not feeling that great and whenever, you know what I mean?"*

**-Program Participant**

The majority of program participants we spoke with mentioned that it might be helpful to consider a medication administration model that more closely mirrors how Suboxone is administered in the community with doses being administered twice a day (morning and evening). Some felt that taking their entire dose in the morning caused fatigue and often lead to them feeling sick later in the day or the next morning.

Finally, program participants repeatedly discussed issues with the medication administration process including the length of time associated with medication administration, policies and protocols which can be stigmatizing, and punitive actions taken for perceived infractions. While we recognize the need to ensure facility security and mitigate diversion, there appears to be a need to examine existing policies and procedures related to medication administration to ensure that the process is not stigmatizing to program participants.

*"I mean, some of the guards are for the MAT program and there's other ones that will make their jokes about it and they're against the MAT program. So when it comes to coming to group or coming here to get your daily dose in the morning, some have issues with it, some don't. Some will forget to call it in the dorm intentionally, oh, I forgot to call, tell your guys, MAT, they'll wait until they call them again."*

**-Program Participant**

### 4.3.2.3 Care Coordination and Transitions

Facets of the program such as counseling and support services had strong implications for inmates' transition to the community. Although Maine DOC staff and their contractors have aimed to provide robust support to program participants, Groups stakeholders suggested that an additional strategy of having external counselors interface with clients in order to establish a relationship prior to release would ease their transition to treatment in the community. In addition, a number of respondents discussed the need for the re-entry planning to begin earlier in the process; as one program participant stated: "Now, I -- four times she set up for me to have an intake so that I can have a provider when I get out. I have seven to eight working days left, business days, for them to do this. They haven't done it yet. So, you tell me where my brain is, how stressed my brain gets, not knowing if that's going to happen or not." Additional topics of concern regarding care coordination and transitions discussed by program participants included: finding safe and secure housing; needing assistance with transportation; help signing up for MaineCare; coordinating

*"I'm wishing they'd bring that system, the groups would bring that here into the facility because some of us that are on this that really want to change or don't have a place to go because we burned our bridges because of our drug use, that we need that help to get into a sober house some because this place, as the Department of Corrections, our case workers, they're not helping."*

-Program Participant

with clinical staff to go back to an established provider or identifying one within their target release community; and supports to assist them in educating their families on their course of treatment.

While we recognize that many of these aspects are out of the control of the Maine DOC, it appears there is a need to strengthen existing collaboration between clinical providers implementing the program to strengthen care transition as well as working to expand upon the existing model of pre-release planning. Moreover, Maine DOC may consider engage a broader group of community stakeholders to work on identify mechanisms to enhance community supports for individuals transitioning from correctional settings.

### 4.3.2.4 Stigma

The provision of treatment for substance abuse in facilities represents a significant cultural shift for the Maine DOC and while great efforts were made to reduce stigma among facility staff, feedback from program participants as well as key informants indicates that stigma related to SUD and MAT remains an issue among some facility staff. Inmates both pre and post release, specifically in the male facilities, reported experiencing a level of stigma from staff in the form of inappropriate language, targeted shake-downs and assumptions of diversion leading to placement in segregation.

*"Where do they get confused? I don't know. Because this place there's no -- I miss substance abuse all the time, my substance abuse class, and I miss the groups for this MAT all the time. It's like, you know what I mean, so really it's like somebody that doesn't understand that doesn't value -- subconsciously is not going to value their recovery because they don't understand it, what's going on. They don't understand that security is the reason why we're missing it but they -- at some point they're going to have to say okay, we need to bring programs up, security needs to bend. They've got to bend it so these guys can value their sobriety."*

-Program Participant

Program participants discussed the continued need to address stigma amongst facility staff; better understanding of MAT may help to decrease the stigma experienced by program participants which impacts their day-to-day access to and experience of the treatment program. While leadership-level buy-in and institutional policies set top-down cultural change in motion, findings indicate there is a need for ongoing education to facilitate system-wide understanding of MAT. This aligns with the idea shared among post-release program participants that building integrity and self-respect was crucial to recovery, in stark opposition to the shame and stigma that participants, as well as individuals in recovery at-large, are subjected to.

Clinical and administrative staff are hopeful that the change in philosophy implied by the expansion of best practice treatment for inmates with SUD will help to further reduce stigma. In addition, working with staff to reduce stigmatizing language such as “drug addict” is an important next step to normalizing SUD as a chronic medical condition.

*“if you use drugs inside the walls, it's bad. You know, you've done something bad. You need to be punished. You need to go to segregation, you need to be fined, whatever. Instead of looking at like this is a person who needs treatment. And so it would be a totally different way of looking at how you manage people who are utilizing drugs inside the walls. So I think that'll be an interesting direction for us to head next and how we actually achieve some of those principles.”*

-Wellpath Administrator

## 5. Next Steps

### 5.1.1 Refining the Program

Stakeholders had a wide range of suggestions regarding how inmates might receive treatment in the program going forward. In particular, suggestions included how and when patients might be enrolled in the future. For example, Maine DOC leadership as well as other stakeholder groups raised the possibility of extending the treatment timeline multiple years before release. They referenced other state DOC programs, such as Rhode Island, which offer a longer treatment period in advance of release.

*“One is as we bring MSP on line with the 90 day project pilot but then really expansion is you increase that time frame. We should be opening up MAT to by in large the population, short of some sentence I think Rhode Island is like 4 years or less they get access to it, some States are 2 years, whatever the happy medium if someone is coming with a 10 year sentence you taper them.”*

-Central Office Stakeholder

A caveat of program expansion in which induction preceded 90 days pre-release is an increased need for alignment between Maine DOC and county facilities and the ability to taper an individual receiving MAT. If an inmate was transferred from a county facility on MAT, a Maine DOC facility should have the capacity to accommodate that individual through tapering if the individual didn't qualify for their standard MAT program. Similarly, the issue of tapering using MAT was raised as a possibility for new inmates who did not qualify for the standard program.

*“A big factor is if we decide to go in a different direction with a different drug, that would really require some thought and planning to figure out what that would look like.”*

- Facility administration

Facility leadership also suggested that program expansion might demand a review or reselection of the different medications associated with SUD treatment. The medication itself has significant implications for both facility security and medication administration protocols as well as staffing profiles.

In addition to discussing potential modifications to the original program design regarding enrollment and medication administration, stakeholders discussed the potential to refine the program to be more flexible. In order to meet the complex needs of individuals with SUD, programs need to be patient-centered and recognize the chronic, relapsing nature of SUD. Several interviewees discussed creating more flexible protocols that encourage ongoing program participation such as providing more times for medication administration to help facilitate participation among individuals who have conflicting work or program requirements. Maine DOC staff also acknowledge the need to potentially modify the MAT program to support individuals with polysubstance use or other substance use disorders.

## 5.1.2 Expanding the Program

Stakeholders conveyed similar ideas about what expansion of the pilot program would look like in the context of time and geography. All stakeholders endorsed the idea that the program should continue at the pilot sites, and that other Maine DOC facilities should offer MAT. Allowing inmates at all Maine DOC facilities to receive MAT was recognized as the way to improve outcomes for the incarcerated population re-entering the community. Facility administration also expressed the need for a robust planning process to support a statewide expansion to ensure the safety of all members.

*“I want enough lead time that if we're going to do that, that we can really do some projections, get a good handle on how many numbers we're going to expect, and start to go through a similar process to begin to expand in a very thoughtful way that maintains, yes, provide the treatment, but do it safely and securely at the same time.”*

– Facility Administration

Increasing enrollment and expanding access to services in facilities across the state is endorsed by Maine DOC leadership, clinical partners and facility staff; all stakeholders agree that to have a measured impact on reducing opioid related morbidity and mortality among individuals leaving carceral settings, MAT needs to be broadly available to inmates both in facilities and upon re-entry into the community. However, the greatest challenge to expansion is having the resources to support expanded service delivery with Maine DOC facilities as well as having the treatment and recovery support infrastructure within the community to support individuals upon re-entry.

*“So if we're going to have – So we're going to have the largest impact on the community side, it's going to be having that available in all of our facilities.”*

– Adult Probation

### 5.1.2.1 Training and Education

Facility security officers at the pilot sites demonstrated a high willingness to assist other facility security teams in developing protocols for their MAT programs. They reported that receiving input from Rhode Island DOC stakeholders had been extremely helpful in designing their program, and having an opportunity to do the same for other Maine facilities would facilitate continued successful implementation across Maine DOC sites. To date, interviewees did not report receiving any resistance from other facilities, but suggested that future sites' openness to training, education and recommendations from the pilot sites might be a challenge due to organizational context and corrections culture that exists within the Maine DOC system.

*“And ego is a huge part of this job as far as getting in the way of being productive and being effective. There are certain places that you can go where if we send our officers there, that – that ego is going to kick in, and they're not going to want to take advice from somebody at different facilities. And that is going to be a downfall of that program if it happens.”*

– Facility Security

Facility security indicated that the success of expansion efforts would be greatly enhanced if leadership and staff at other facilities could leverage experience and expertise of the pilot sites. While facility staff acknowledged that each institution within the Maine DOC system is unique and adaptations to the existing policies and procedures will most likely be need to meet individual facility's needs, taking into account the perspectives and advice of the pilot sites could facilitate implementation at new sites. A Groups administrator indicated that if Maine DOC stakeholders value the outcomes of treatment, it may facilitate program continuation and expansion on a large scale: “My hope more broadly is that the rest of the country sees those outcomes and sees that work, and moves in that direction, as well. Because I think that's where you're really going to save lives.” These findings point to the continued need for education and training to normalize MAT within Maine DOC facilities, reduce stigma, and gain staff support for expansion efforts at new sites.



### 5.1.2.2 Organizational Capacity

Stakeholders expressed that moving the MAT program forward would be impacted by several factors including resources and capacity. Facility and clinical leadership indicated that monetary resources to support expansion was their primary concern. Specifically, leadership indicated that there is a need for funding to increase workforce capacity for both medical and security staff. Respondents pointed out that the staffing profile at a facility needs to be directly proportional to the number of individuals who are expected to be served by the MAT program; as the program expands there will be a need for additional security and medical staff to support referrals, screenings, medication administration, counseling and pre-release planning as well as community resources to support ongoing treatment upon release. As discussed earlier, both facility and clinical staff indicated that, in some instances, existing staff may already be overextended, especially given that staffing within the Maine DOC system is already an ongoing challenge.

*“It would take – we would have to either break it up into two different parts of the day, either have like a morning and a nighttime thing, or have, you know, another group of people that do it, because you do start to get, you know, focus fatigue. [...] And the one issue that – and it's with any correctional facility, it's staffing.”*

– Facility Security

There was an additional concern that budgeting to sustain the MAT program might impact other facility workflows or initiatives. One administrator rightfully noted: “I don't know as the pilot expands, I'm not sure where the money is going to come from to support it, because it's pretty expensive.” Others expressed concerns about overall resources to sustain the program overtime and how expansion might impact other initiatives. Despite these concerns, there was immense buy-in from both clinical and facility leadership as well as staff for expansion and most thought, with thoughtful planning, that expansion was possible.

### 5.1.2.3 Communication

All stakeholder groups emphasized that improving communication was a priority when looking to the future of the program. For example, Adult Probation felt that more timely communication about program participants and the release plans would allow them to provide better support to MAT program participants upon release. MAT program status was not readily available on their release plan, and adult probation officers needed to deliberately contact facility staff to determine relevant details about their release and future treatment plans. In order to accommodate program expansion, stakeholders emphasized changes to release plan workflows to better inform probation staff. There appears to be a need to update CORIS to include a field that specifically identifies if someone is on MAT and if probation has been notified, this would allow for greater efficiencies and more timely notification of probation staff.

*“How to lay out a plan that Probation staff get the needed information, not on day of release, but prior. And not from our IPO, but someone from a facility that says, FYI, here's the updated list. This is where they're going.....I think if I had to do this all over again, I would have – so in our database, to actually copy and paste it, the release plan. So I would have requested that they modify their release plan to specifically add MAT, yes or no. And then has Probation been contacted, yes or no.”*

– Adult Probation

Overall, improved communication was tied closely to program expansion and sustainability. A specific suggestion was to improve workflows to establish a feedback loop between facility clinicians and community-based treatment providers. Under the current program design, individuals leave the facility with enough Suboxone to sustain them until their first treatment appointment; this can be anywhere from a one day supply all the way up to a fourteen day supply. Specifically, facility based clinicians indicated that there is a need for information on community based treatment engagement among individuals who have transitioned from the facility into MAT programs in their community. One Wellpath clinician state: “we really do need some information around that, because we are giving these gentlemen and ladies a lot of medicine

*“I think for myself, it would help me to get that feedback about how they're doing in the community. Because, you know, we talked about this was implemented to save lives.”*

– Wellpath Clinician

when they leave.” Others discussed the fact that having information on how individuals are doing upon release would allow them to examine program efficacy.

### 5.1.2.4 Community Capacity

Successful expansion is strained by the lack of available community resources for individuals with SUD post-release, including qualified MAT providers as well as robust recovery and social service support systems which are integral to promoting long-term SUD recovery. In order to adequately serve more individuals leaving the Maine DOC system, the community treatment and recovery infrastructure must steadily increase its capacity to treat individuals with complex social and medical histories. Post-release individuals emphasize that their most critical need in the community is stable work and housing. Program participants indicated that unmet social needs can be stressful and critical triggering, if left unaddressed individuals stated that these stressors will decreasing their chances of maintaining

*“You know, when I'm crashing on homeboy's couch or living in the Motel-6, I'm going to be with a pipe and a needle, absolutely.”*

– Program Participant

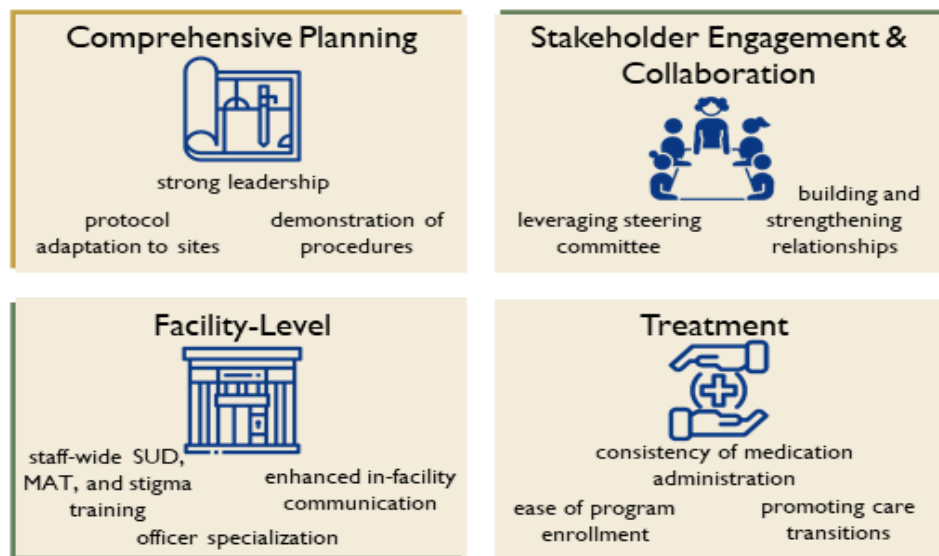
sobriety. These findings point to a need for greater collaboration with state and local officials as well as community partners to find mechanisms to expand the states existing infrastructure to meet the growing need for treatment and recovery supports throughout Maine. Cross-sector collaborations will be necessary to expand and establish recovery ready communities designed to meet the needs of individuals with SUD.

## 6. Lessons Learned and Recommendations

### 6.1 Successful Strategies

Administrative and interview data collected as part of the Maine DOC MAT Pilot Program provides key insights into the successful planning and implementation strategies used by Maine DOC to implement the MAT program. Key informants indicated that collaboration and stakeholder engagement have been critical to designing the program and establishing the partnerships necessary to implement comprehensive MAT programs in Maine correctional facilities that ensure evidence-based treatment is provided within the facility and care continuity is maintained in the community.

**Figure 4. Successful Strategies for Integrating MAT in Correctional Settings**



Below is a more detailed description of the strategies used by the Maine DOC to facilitate the successful implementation of MAT services at institutions participating in the MAT pilot program.

## Strategies for Facilitating the Implementation of MAT in Carceral Settings

### Comprehensive Planning

The comprehensive planning process for the MAT program was crucial in bringing about organizational change and successfully launching the MAT program. Literature suggests that successful organizational change must consider culture, leadership, and power.<sup>27</sup> Maine DOC effectively addressed each of these areas in their planning process. Specifically, identifying influencers, people with formal and informal power, to lead trainings and focus groups created buy-in and allowed staff to lead the change from within. Concurrently, the project had the full support of leadership. Leadership, often cited as the most important factor in affecting organizational change,<sup>28,29</sup> was crucial to the roll out of the MAT program. Maine DOC leadership was invested and committed to communication, allowing for vision clarity and creating motivation for all staff to implement the program successfully. Ultimately, the planning process also addressed culture. Literature suggests that within culture, organizations should focus on coordination, competencies, and commitment to successfully implement change.<sup>30</sup> DOC's steering committees set up a coordinated planning infrastructure, and their education and training sessions focused on required competencies such as security and medication administration. DOC's focus on inclusive education and training was well received by staff and helped to create a culture of acceptance. Additionally, regular communication amongst staff of all levels resulted in a commitment to the vision, and a high level of staff engagement created ownership of both the process and the program. Ultimately, each of the pieces within the planning process including strong leadership, structure, education and training, and staff engagement were vital precursors to program implementation. DOC should continue to address each of these components and leverage them for additional program planning and expansion.

### Stakeholder Engagement and Collaboration

As part of the planning process, Maine DOC engaged a range of key stakeholders with different perspectives; this strategy proved to be instrumental in building both internal and external buy-in and support for the program. Giving a variety of stakeholders input into the design of the program help to strengthen the model, served as a catalyst to facilitate implementation, and was the primary mechanism through which critical collaborative partnership were formed. Comprehensive cross-sector partnerships between correctional institutions, law enforcement, health care providers, peer recovery and social service agencies, are essential to increasing clinical-community linkages, expanding low barrier access to treatment, reducing stigma, and creating recovery ready communities. The collaborations established as part of the Maine DOC MAT pilot program have played a critical role in creating the infrastructure necessary to successfully implement the MAT program at the participating pilot sites. Creating sustainable, effective linkages between Maine DOC, clinical providers and community organizations can improve individuals' access to prevention, treatment and chronic care.<sup>31</sup> Sustaining and expanding these partnerships, particularly those with organizations who can provide social service and recovery supports within the community, are essential to supporting MAT programs in correctional settings and will be pivotal to supporting efforts to expand MAT programs in carceral settings throughout Maine. Program expansion and sustainability will require the engagement and support of other state agencies and community-based services.

### Facility-Level

Stakeholders indicated that staff training greatly benefitted the MAT pilot's implementation and could be modified to train more staff. In addition, having officers specialized in the MAT program protocol was a strength of implementation, and that

officer specialization should be maintained. The success of the pilot was also largely due to the ability of facilities to work with the larger planning committee and sub-committees to make facility-level adaptations that ensured the program was implemented safely and efficiently. Effective leadership and strong staff engagement at pilot sites were also integral to supporting the overarching goals of the pilot while at the same time allowing facility-level adaptations to meet. Maine DOC facilities were able to adapt to unforeseen circumstances, including creative diversion attempts or dosage difficulties, allowed them to make real-time adjustments to the program that benefitted both staff and inmates.

**Treatment** Overall, feedback from individuals overseeing and implementing the program as well as inmates receiving MAT services indicates that the treatment program is filling a much needed gap in SUD treatment services with Maine DOC facilities. Inmates who participated in the pilot reported a great benefit from receiving MAT including reduced cravings and anxiety. Many of them felt that for the first time in their lives they had hope that they could sustain their recovery upon reentry into the community. In addition, administrative and clinical staff reported that employers, treatment providers and other community stakeholders have provided feedback that the individuals participating in the MAT program seem much better equipped to sustain recovery and successfully reintegrate into the community. While it is still too early to know the full benefits of the program, early findings point to the fact that providing MAT in carceral settings and supporting care transitions has had a measured impact on the lives of program participants.

## 6.2 Challenges and Opportunities for Change

The Maine DOC MAT Pilot Program is being implemented at a time when there is considerable interest in developing strategies to expand the state's treatment infrastructure to address the opioid epidemic. However, despite support at of the state government and the Maine DOC, substantial barriers to increasing access to MAT in correctional settings remain. Over the course of the first year of the Maine DOC MAT Pilot Program, key stakeholders and program participants have identified a number of opportunities to overcome existing challenges and enhance the Maine DOC MAT program. Below is a brief summary of the primary obstacles identified during the program planning and implementation phases of the Maine DOC MAT Pilot Program.

### Organizational Challenges

**Staffing** Interviewees mentioned limited staffing as a hurdle to program implementation and sustainability. As mentioned, stakeholders reflected on the demands and stress to existing staff resulting from limited capacity, including a low tolerance for inmates that took longer to dissolve the medication. Limited staff and competing priorities also impacted the frequency of counseling sessions—if staff were not available to supervise a session, it would not take place. While limited resources is a pervasive challenge throughout correctional environments, there is an opportunity to address the specific challenge of the MAT program by exploring alternative medication administration models.

Addressing limited staff is a comprehensive challenge that relies on larger systems and resources. However, one potential avenue to reduce stress on staff is to look into alternative medication administration models. Though having a separate medication line was mentioned as a positive aspect of the program, it requires additional time and resources beyond administering the medication within the existing med line. The balance between security and efficiency is an ongoing challenge that deserves attention throughout implementation and expansion. Maine DOC could continue to utilize the focus groups set up in the planning stage to work with staff to collect feedback on the program process in addition to collectively gathering strategies and suggestions on how to tackle the challenges presented by limited resources.

Due to its popularity, Maine DOC has already expanded this pilot initiative to other facilities. As it contemplates whether to open this initiative up to additional participants and expand eligibility criteria, it will need to consider how to staff the program. Expansion of the program within the current pilot sites would probably necessitate additional medication lines and the need for more security staff at a time when many facilities are somewhat short staffed in terms of security. As mentioned, earlier in this report, security staff have been “pushed to the max” by this pilot. Unless more staff are added, expansion would further compound this situation.

**Stigma** The stigma associated with opioid use is a major barrier for providers of MAT as well as patients in treatment and recovery. Health-related stigma is often described as a socio-cultural process in which social groups are devalued, rejected and excluded on the basis of a socially discredited health condition.<sup>32</sup> While Maine DOC made substantial efforts to reduce stigma throughout the program, it remains an issue that necessitates ongoing attention and training. Inmates both pre and post release, specifically in the male facilities, reported experiencing a high level of stigma from staff in the form of sometimes inappropriate language, targeted shake-downs and assumptions of diversion leading to placement in segregation. To combat the persistent stigma that exists in any MAT program, organizations such as SAMHSA have developed and compiled resources available online.<sup>33</sup> These resources range from books on the evidence for stigma change to studies on how language choice affects those with substance use disorder. Additional resources include trainings curriculums such as those developed by the Harm Reduction Coalition.<sup>34</sup> Maine DOC should continue to focus on stigma reduction and utilize available training resources to not only ensure ongoing education and understanding, but also to maintain the momentum started in the planning process.

**Communication** The communication difficulties between the different organizations described earlier in this report deserve attention. Stakeholders such as adult probation shared that they were not often aware of inmates’ participation in the pilot program and that communication felt limited. Groups also shared that more frequent communication would have aided them in learning about updates and what was happening in the program. Interviewees also mentioned that communication challenges are not unique to the pilot program but are an ongoing challenge with multiple stakeholders involved in the system. While communication within the facilities was reported to be positive and frequent, increased communication among all stakeholders and organizations would improve the efficiency of the program. DOC could draw upon the structure of the communication utilized during the planning phase and build in systems for regular programmatic updates including e-mails and in-person meetings. Standardized operating procedures for identifying inmates as participants in the pilot and ensuring that all relevant parties have access to that information would also aid in the transitions. These findings also point to the need to establish more mechanisms for ongoing communication between facility caseworkers and adult probation well in advance of release would help this situation. This could come in the form of monthly phone meetings with facility staff and the Director of Adult Community Corrections and three regional correctional administrators. This would help align treatment efforts with case planning. Further, it would help Adult Probation know about the unique needs that each participants may need.

**Program Logistics** Accessing patient records is integral to providing appropriate treatment and not having this access delays effective treatment. Key informants frequently mentioned that coordinating care and operating within Maine DOC was difficult for contracted staff. As documented earlier in this report, external contracting staff need better access to

meeting/work space and the internet while working in the facility in order to execute their programmatic responsibilities. While we recognize there are some security concerns, it appears there is a need for Maine DOC and Wellpath to further explore additional options for external partners that provide services that are critical to ensuring continuity of care including pre-release planning and scheduling of post-release treatment services.

### **Clinical Care Coordination**

As mentioned earlier, this pilot initiative involved a considerable number of planning meetings prior to the launch of the pilot. Groups staff were part of this planning process. However, once the pilot started in July, the planning meetings ceased and communication between the parties became far less frequent. Clinical leadership and staff, as well as Adult Probation leadership express a need for improved communication between key stakeholder groups pertaining to the MAT program. Considering that a primary motivation for implementing the MAT program in Maine DOC was to improve post-release outcomes for individuals with SUD, it is important that there is an ongoing feedback loop between clinical staff in the community and Groups staff who can provide information on patients' engagement in treatment in the community. Adult probation stakeholders expressed that the program status of released individuals was not readily available to them. The clinical, medically necessary nature of the program demands more development of formal communication channels that are streamlined and accessible despite the stringent demands of Maine DOC culture. Because of the success of the steering committee during the planning portion of the pilot, steering committee members might be leveraged to develop new workflows and communication protocols. The evaluation team would suggest that if the pilot was to continue that Groups (or any other community-based treatment provider) and DOC meet regularly (e.g., monthly at first) to discuss implementation issues and ways to resolve issues in a productive and up-front manner.

### **Data Tracking**

Since the inception of the pilot, Maine DOC and their clinical partners have not developed an extensive list of metrics that can be used to track programmatic milestones and patient outcomes. These outcomes should include process measures (e.g., number of participants enrolled, number of counseling sessions attended, etc.) to more long term outcomes (e.g., # of relapses, treatment retentions at 3, 6 and 12 months). The timely collection and reporting of key metrics will not only allow the Maine DOC to make data informed decisions on how to refine the program but, can serve as a key mechanism to improve communication between Maine DOC and their partners. Creating an ongoing feedback loop between Maine DOC and their clinical as well as community partners will not only improve communication but is essential for supporting care coordination and transitions. These outcomes should be readily share among pilot organizations and included in progress/annual reports that are shared with a broader group of key stakeholders.

### **Addressing Diversion**

Diversion training should be also be provided to all nursing and security staff. Some inmates will think up ingenious ways to divert the medication. DOC staff should receive semi-annual or annual training on common misuse or diversion techniques.<sup>35</sup> While recognizing diversion does exist, pilot participants should be treated respectfully and not further stigmatized. Understanding addiction should be a topic that staff receive on a regular basis.

## Programmatic Challenges

**Program Design** While the implementation of the Maine DOC MAT Pilot Program has largely been successful, feedback suggests that there are additional opportunities to refine and expand the program. Many interviews discussed the importance of expanding the program to meet the high need among individuals residing in Maine DOC facilities. In addition, program participants frequently discussed the need to initiate the program earlier in their incarceration with the majority believing that it would be beneficial to be induced upon intake into the facility. While this is a costly endeavor, Maine DOC has implemented MAT to address SUD which is a chronic disease characterized by reoccurrence. Induction upon entry would ensure continuity of care for individuals who are already receiving MAT; has the potential to reduce illicit use of substances within facilities; and would provide an opportunity for individuals to have a prolonged period of recovery prior to reentry into the community which increases the likelihood of sustaining recovery.

In addition to considering changes in the size and scope of the program, findings suggest that there is an opportunity to refine treatment protocols and policies to be more patient-centered and include interventions specific to the tasks and challenges faced by program participants at each stage of treatment, maintenance and recovery. Our findings indicate a need for MAT programmatic policies that facilitate engagement and the achievement of treatment goals. Many program participants reported issues with medication administration and dosing patients such as feeling stigmatized for participating in the program and not having adequate input into their treatment planning and medication dosage. While we acknowledge there is a need to balance facility security, the administration of clinical care, Maine DOC facility and clinical staff may benefit from routinely assessing policies, and procedures to ensure the program security concerns are not hindering the effectiveness of the clinical care team to actively engage patients in treatment. It will be important for Maine DOC to regularly assess patient feedback and utilize that information to refine programmatic policies and procedures.

**Medication Administration** As mentioned earlier in the report, stakeholders described medication administration and dosing levels as initial challenges for the pilot program. Several participants initially received a dose that was too high for them, though DOC made adjustments after noticing the difficult side effects of such a high dose. DOC also uncovered initial attempts at diversion and adjusted their monitoring to a high level of strict oversight, sometimes at the cost of the integrity of some inmates. When asked about the medication administration, one inmate expressed a desire for having the medication administered twice in a day as opposed to all in one dose. However, staff time is limited and two administration times presented a challenge. DOC should continue the exploration of medication administration with the available resources and best practices.

If DOC continues to use Suboxone in film strip form, the Cutler team recommends security and nursing staff continue to receive yearly training on how to detect if Suboxone is being administered incorrectly or diverted. The medication must be taken sublingually and some inmates may struggle with this type of administration. Some inmates complained that the medication has a very unpalatable taste. Some inmates struggle with dissolving it in their mouth much to the chagrin of security staff. Maine Quality Counts has some training options that are more tailored to medical providers.<sup>36</sup> That said, perhaps they could tailor their training to a correctional setting.

Another area to consider as the program continues and expands is alternate forms of medication. While it is initially more expensive, Vivitrol<sup>37</sup> could help with some of the staffing issues with administering Suboxone film strips. Vivitrol is an extended release

form of naltrexone, one of the components found in Suboxone, and is a once-monthly injectable medication. While Vivitrol is not for everyone and does have some side effects it would not require daily medication lines and tying up security staff. It would also greatly eliminate diversion possibilities and reduce the problems with medication administration. The elimination of medication lines would lessen the tension the strain that has arisen between some MAT participants and staff.

**Counseling** At the time of the pilot interviews some counseling sessions were being cancelled. While inmates attributed some of these cancellations to staffing shortages and holidays, the sessions were not rescheduled. Some inmates interviewed for this study had not attended the requisite number of weekly counseling sessions that are integral to MAT. What this means is that some inmates are not getting the “whole-patient” approach to treatment. The counseling sessions should provide tools and skills that alter behaviors, thoughts, emotions and teach patients how to respond to certain triggering situation.<sup>38</sup> Just as important these sessions should be held at least weekly and at times that are convenient for both pre-release and post-release participants. Counseling sessions should be at a convenient time and location to assist participants with their work schedules and their ongoing recovery efforts.

**Pre-Release Planning** While scheduling medical appointments and counseling sessions for the period immediately after release is critical, many of the participants the interview team spoke with were far more concerned about other factors. A handful of male participants were very concerned about their housing, transportation and employment opportunities once they left the facility. The interview team spoke to two-three participants who were less than two weeks from release and did not having housing lined up. Some individuals understandably did not want to return to the communities they lived in prior to their incarceration. Others wanted to find a sober house, but did not know a lot about them, specifically the quality of these establishments. These individuals were incredibly stressed about this situation and it did not seem out of the realm of possibility that this might lead to some type of relapse upon release. Findings indicate that this group might greatly benefit from some advanced pre-release planning. Also, if DOC could assess the quality of some of these programs it might help some participants know where to move to upon release. At a minimum, it would certainly allay some of the concerns voiced by some in this group.

**Recovery Supports** According to SAMHSA, recovery support systems help people with SUD to successfully manage their condition.<sup>39</sup> Auxiliary recovery supports include safe housing, food security, employment, and transportation all of which are crucial to supporting long-term recovery. Most of the program participants we spoke with expressed concerns about having these basic needs met upon release to the community and for many, this was a great source of anxiety. While the Maine DOC program is making efforts to address housing, transportation and employment needs during the pre-release planning phase of the program, several key informants noted difficulties in assisting patients with the recovery supports because many communities lack a comprehensive recovery support infrastructure. In order to increase treatment engagement and aid in the recovery process the Maine DOC could explore additional linkages to help inmates address these needs. While some of these elements are out of the purview and control of DOC, all of them deserve consideration. DOC stakeholders such as adult probation could work more closely with pre-release patients to understand their status in the program in addition to referring patients to available support networks.



## 7. Summary

Maine is among the states hardest hit by a national trend of non-medical uses of opioid prescription drugs and illicit opioids, with subsequent increases in opioid-related morbidity and mortality. While there are significant state and local efforts underway in Maine to improve access to treatment and recovery support services for individuals with OUD, rates of opioid related overdoses and deaths continue to remain high, particularly among individuals who have interacted with the criminal justice system. The Maine DOC MAT Pilot Program is uniquely situated to provide critical treatment services to individuals who are at significantly higher risk for the negative consequences associated with SUD. Using a comprehensive planning process which included broad stakeholder engagement; collaboration across organizations and sites; training and education for facility staff; and the development of policies and procedures that address the specific needs of participating facilities, the Maine DOC, has been able to significantly expand their capacity to deliver MAT to individuals in carceral settings throughout Maine. Findings indicate that, while there are opportunities to continue to refine the program, overall the implementation of the Maine DOC MAT Pilot Program has been successful. Feedback from participants indicates that the program is meeting their treatment needs and has helped them to maintain access to care as well as sustain their recovery post-incarceration.

*“If it can save one person, it's worth it. Because I – while I was there, the last six months I think I counted five people who within three days were dead upon release, so if it helped one person”*

**-Program Participant**

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