2024 Arkansas State Opioid Response (SOR) III

PROGRAM EVALUATION

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Furthermore, we would like to acknowledge with much appreciation the crucial role of our project coordinators – Angel Phillips and Miranda Greathouse – who collected, managed, and organized the data, reviewed, edited and proofread mounds of documents, and provided a myriad of other types of support needed to complete this report.

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About the Evaluators

The Wyoming Survey & Analysis Center (WYSAC) at the University of Wyoming is an objective, nonpartisan research organization that strives to provide clear, accurate, and useful information to decision-makers through applied research, scientific polling, information technology services, and rigorous program evaluation.

Our evaluators conduct studies to inform funding and policy making decisions in the areas of public health, substance abuse prevention, treatment, and recovery, education, and criminal justice. WYSAC's mission is to improve lives through the implementation of innovative, high-quality research.

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Navigating this Report

The following information will help readers navigate this report:

1) This report is divided into three sections – Prevention, Treatment, and Recovery – which are color coded for easier identification. Each section lists the names of the organizations, descriptions of the programs, tables outlining program goals, highlights, successes and challenges, and a review of administrative data.
   - Prevention
   - Treatment
   - Recovery

2) The information presented in the tables regarding program goals, highlights, successes, and challenges is derived from interviews conducted with directors, program coordinators, and other relevant staff members from each organization.

3) Qualitative studies related to these categories are embedded in each of the sections. Findings listed in these studies are specifically related to the program and population in the study and provide further context and more information regarding the particular category. Titles of these qualitative studies are listed below.

   PREVENTION
   - Results from Focus Groups with College Students on Substance Misuse, Opioids, and Naloxone Administration
   - Results from Interviews with Opioid Prevention for Aging & Longevity (OPAL) Staff in SOR III Sponsored Programs

   TREATMENT
   - Results from Focus Groups with Treatment Staff in Implementation of the Arkansas Community Corrections Medication-Assisted Treatment Program

   RECOVERY
   - Results from Interviews with Individuals Participating in Peer Recovery Support in SOR III Sponsored Programs

4) Overall program recommendations are at the end of the report and are also divided into the categories of Prevention, Treatment, and Recovery.

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Executive Summary

The State Opioid Response Grant (SOR), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), seeks to address the public health crisis arising from the increasing prevalence of opioid misuse, opioid use disorder (OUD), and opioid-related overdoses nationwide. It aims to expand access to medications for opioid use disorder (MOUD) and strengthen the continuum of care, encompassing prevention, harm reduction, treatment, and recovery support services for OUD and co-occurring substance use disorders.

WYSAC's evaluation of the Arkansas State Opioid Response III (SOR III) program incorporated both administrative and qualitative data to assess its prevention, treatment, and recovery processes and outcomes across multiple domains. Administrative data provided a comprehensive overview of key activities, including information dissemination, educational and training initiatives, community-based processes, and treatment and recovery programming. To gain a deeper understanding, focus groups and interviews were conducted with stakeholders from targeted populations. These qualitative methods offer nuanced insights into participants' perspectives and experiences with specific aspects of the program.

WYSAC's primary goals evaluating the SOR III program are twofold: (a) to leverage data for program improvement and (b) to document the program's accomplishments. Researchers from WYSAC designed the evaluation, conducted focus groups and interviews and analyzed these qualitative data, and performed in-depth reviews of administrative data.

The evaluation findings highlight both significant strengths and areas in need of attention throughout the program. While stakeholders and clients reported many shared experiences and perspectives, they also provided unique and valuable contributions. This comprehensive report from WYSAC presents the evaluation results, along with recommendations to strengthen the SOR program's successes and address identified gaps and/or opportunities for enhancement.

SOR III PREVENTION PROGRAM HIGHLIGHTS

Comprehensive Naloxone distribution and training efforts were conducted across various populations, including college students, law enforcement, older adults, and families.

- ACHI dispensed 1,320 kits to 11 hospitals to ER patients (or their caregivers) that overdosed or were at risk of overdose
- UALR SOR-C distributed 8,991 kits and conducted training sessions for 17,601 individuals (52% online, 48% in-person).
- CJI distributed 3,179 kits, including traditional, refill, and replacement kits. Kits were also integrated with AED units.
- SOR-P distributed 5,554 safe-storage contains and Dispose Rx bags to 34,800 individuals to prevent misuse.

- OPAL provided training to 1,975 individuals and distributed 23,998 educational materials.

Media campaigns played a crucial role in increasing awareness and accessibility, achieving millions of impressions statewide.

- UALR SOR-C achieved over 18 million online impressions and 25 million through television and streaming ads.
- CJI utilized Facebook, radio, billboards, and gas pump ads to promote Naloxone use and awareness.
- SOR-P television and online campaigns resulted in 6.3 million impressions, directing audiences to the PreventionAR website.
- SOR-P developed a four-part educational video series on substance use, mental health, and harm reduction.
- OPAL created billboards, bus ads, and an accessible webpage with resources tailored to older adults.

Programs tailored their approaches to target specific populations effectively, addressing the diverse needs of communities at risk of opioid overdose.

- Ninety-nine percent (99%) of ACHI's Naloxone kit recipients were patients, with an even gender distribution (52% female, 48% male).
- Recipients of SOR-C Naloxone kits were predominantly college-aged individuals, with high participation from Northwest Arkansas Community College.
- SOR-P hosted the MidSOUTH Nursing and Family Medicine Spring Review Conferences, offering CEUs and CME credits.

SOR III TREATMENT PROGRAM HIGHLIGHTS

Multi-level strategies were implemented to combat opioid use disorder through education, treatment, and community engagement.

- Nearly 4,400 people, including first responders and diverse community groups, were educated on opioid misuse and Naloxone use through the ACC MAT program.
- UAMS Emergency Department Services presented educational materials on OUD to all 63 hospitals in Arkansas to improve patient care.
- Weekly online sessions, offered through UAMS MATRIARC/Project ECHO connected healthcare providers with experts to discuss MOUD and co-morbidities, offering one CME credit per session.
- Forty-two (42) pharmacists were trained through the UAMS Justice-Involved Program in OUD prevention and recovery support, including counseling, BIRT screening, and other SUD assessments
- UAMS MAT Services provided 2,131 individuals with MOUD, 28 were provided with MUD, and 761 received both.

- UAMS MAT Services conducted 23 site visits to assess performance and outcomes for MAT providers.

SOR III RECOVERY PROGRAM HIGHLIGHTS

Peer-led services and peer training providing support for those in recovery, enhancing workforce strategy and sustainability.

- PACT delivered peer-led services to 1,657 individuals, with a focus on one-to-one counseling (49.2%), peer-led groups (26.4%), and recovery support services like housing and employment placement.
- Peer training for 535 participants was conducted through the SOR-R program across multiple specializations, with financial support provided for 48% of trainees.
- SOR-R certified 79 peers as specialists across three tiers, expanding the peer workforce.
- The Arkansas Peer Advisory Committee (APAC) or its subcommittees met 35 times to advise on peer support best practices.

Education and training offered through recovery programming was instrumental in developing skills and expanding workforce opportunities.

- Two hundred and seventy-five (275) PACT participants earned a GED or diploma, and 434 achieved family reunification through cognitive behavioral programming.
- SOR-R offered diverse training opportunities such as ethics, advanced practice, and justice-involved peer support, to enhance the capabilities of peer workers.

Introduction

The State Opioid Response (SOR) Grant, supported by SAMHSA, aims to combat the opioid crisis by enhancing access to medications for opioid use disorder (MOUD) and strengthening prevention, harm reduction, treatment, and recovery services. WYSAC evaluated Arkansas's SOR III program using administrative and qualitative data to assess its processes and outcomes across prevention, treatment, and recovery domains. The evaluation combined administrative data on program activities with insights from focus groups and interviews with stakeholders to provide a nuanced understanding of program impacts. WYSAC's goals were to inform program improvements and document accomplishments. The comprehensive findings include recommendations to build on successes and address gaps in the program.

Documenting Outcomes

Researchers face two challenges in reporting outcomes related to the SOR III project. These outcomes range from opioid overdoses to opioid-related arrests, and they reflect the problems faced by and addressed by the myriad of individuals and agencies working to abate the opioid crisis in Arkansas. First, the reporting of data takes time and is often slow. The most recent data point for many outcome measures is from years before or at the beginning of the SOR III. For example, drug overdose death rates from the Centers for Disease Control and Prevention (CDC) come from 2018 to 2022. Second, while the problem is serious numbers are often small. For example, past 30-day use of opioids/heroin among 12th graders in Arkansas has decreased from 0.3% to 0.1%, a rate only a third of what it was five years ago. However, both numbers are so small they do not reveal much about changes in behavior.

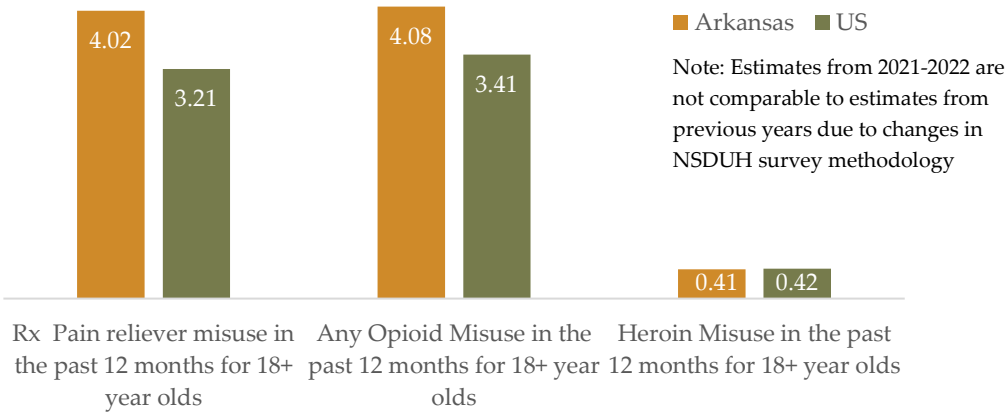
With these limitations in mind, this report presents several outcomes related to opioid use and consequences in the introduction to this report to lay a foundation for the SOR III effort, for the evaluation that follows, and for future evaluations of opioid projects in Arkansas. All data is presented at a state level, with national comparisons when available.

OPIOID CONSUMPTION

Charts 1 through 4 display trends in opioid consumption. The first is from SAMHSA's National Survey on Drug Use and Health (NSDUH) and displays past year opioid misuse, heroin misuse, and prescription drug misuse for adults. Unfortunately, the NSDUH methodology changed prior to 2019, and SAMHSA determined 2019-2020 data was not valid. For this reason, there is no trend. Chart 1 presents consumption estimates for Arkansas and the United States for the most recently available NSDUH data. While percentages are small, past-year prescription pain reliever and any opioid misuse was higher in Arkansas than in the United States, and heroin misuse was at the same level.

Chart 1. Percentage of Adults Reporting Opioid Misuse in Arkansas and the US, 2021-2022

The percentage of adults misusing pain relievers and any opioids was slightly higher in Arkansas than in the US.



Data Source: National Survey on Drug Use and Health (NSDUH)

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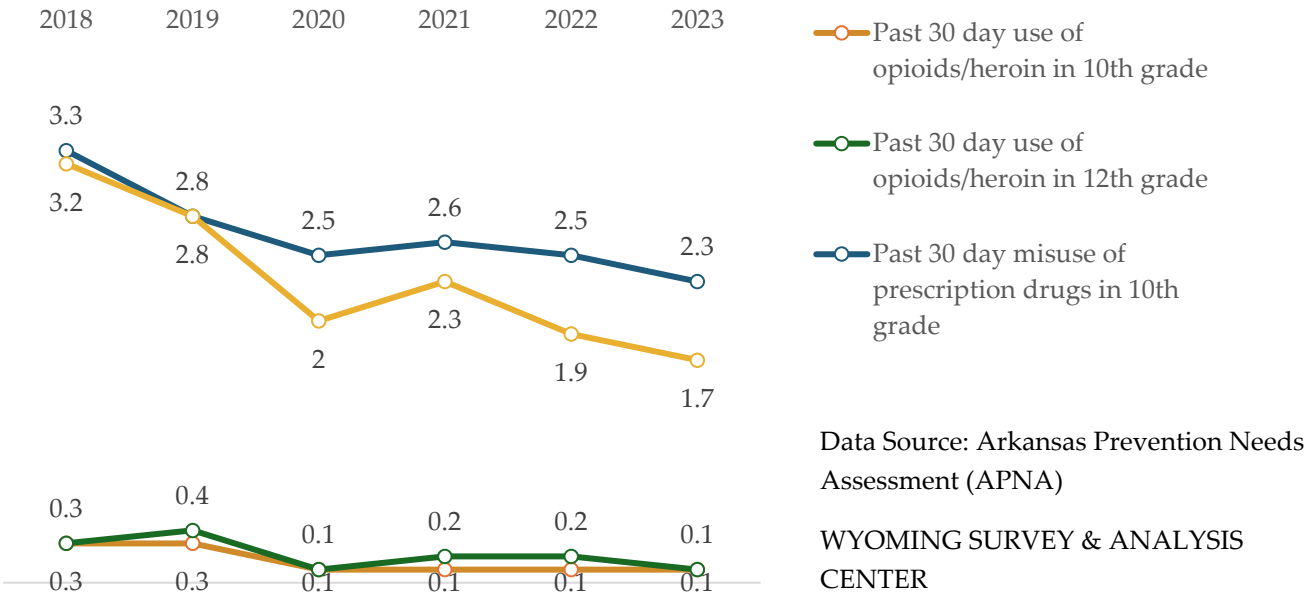
Data for youth consumption come from the Arkansas Prevention Needs Assessment (APNA) and include measures of past month opioids/heroin use and prescription drug misuse for 10th and 12th graders. As seen in Chart 2, percentages are tiny, and reported use has decreased since 2018.

Chart 2. Percentage of Opioid and Prescription Drug Misuse among 10th and 12th Graders in Arkansas, 2018-2023

Opioid/heroin use remained very low, while prescription drug misuse decreased among 10th and 12th graders in Arkansas.



Data Source: Arkansas Prevention Needs Assessment (APNA)

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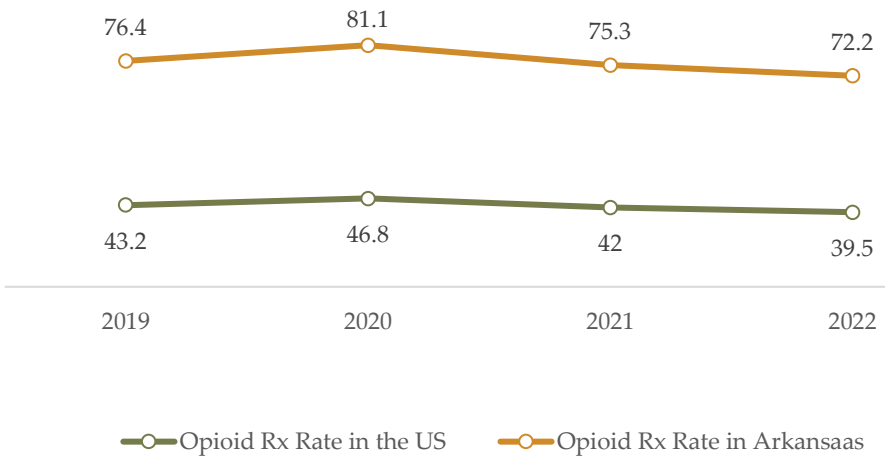
The CDC collects and reports on prescription opioid rates in each state and the United States as a whole. These data are presented in Chart 3 as rates per 100 people each year, though one person could have more than a single opioid prescription in any given year. Between 2019 and 2022, Arkansas prescribed opioids at nearly twice the national average, with a high of 81 opioid prescriptions for every 100 people in 2020. This is important because opioid prescriptions can lead to misuse, an opioid use disorder, overdose, and death.

Chart 3. Prescription Opioid Rates per 100 persons in Arkansas and the US, 2019 to 2022

Opioid prescription rates continued to decrease, but Arkansas prescribed opioids at nearly twice the national average.



Data Source: Centers for Disease Control and Prevention (CDC)

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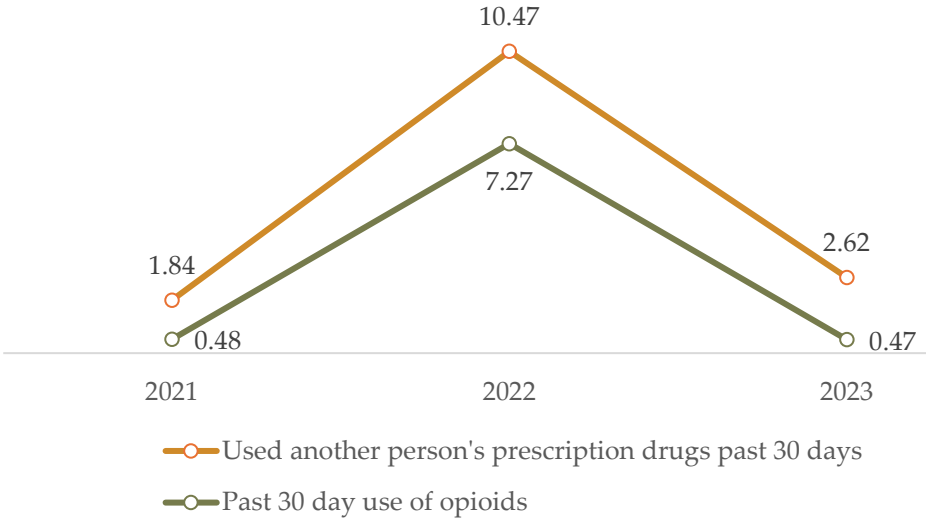
Chart 4. Percentage of Opioid and Prescription Drug Misuse among College Students in Arkansas, 2021-2023

Opioid and prescription drug misuse among Arkansas college students remained low and stable between 2021 and 2023, however 2022 data show a spike in both indicators that may be due to sample and methodological changes. Future surveys will provide a clearer picture.



Data Source: Arkansas Statewide Collegiate Substance Use Assessment (ASCSUA)

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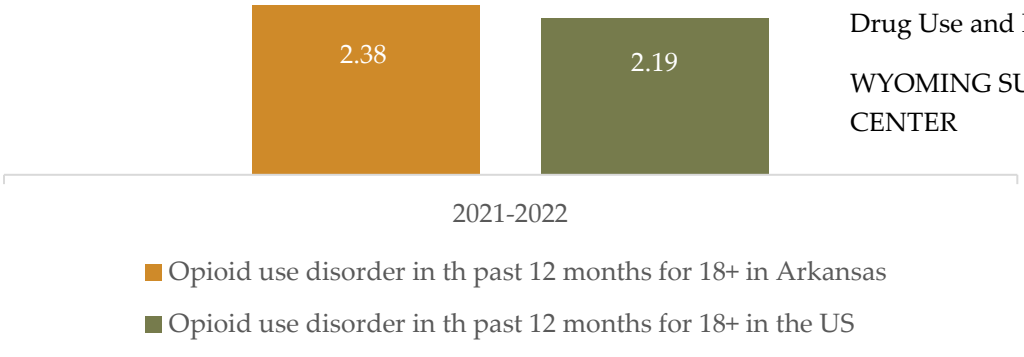
OPIOID CONSEQUENCES

Charts 5 through 9 display trends in opioid consequences. The first is again from SAMHSA's NSDUH and displays past year opioid use disorder (OUD) for adults. Unfortunately, the NSDUH methodology changed prior to 2019, and SAMHSA determined 2019-2020 data was not valid. For this reason, there is no trend. Chart 5 presents OUD estimates for Arkansas and the United States for the most recently available NSDUH data.

Chart 5. Percentage of Adults with Opioid Use Disorder in Arkansas and the US, 2021-2022

The percentage of adults reporting an opioid use disorder in Arkansas was roughly the same as those in the US.



Data Source: National Survey on Drug Use and Health (NSDUH)

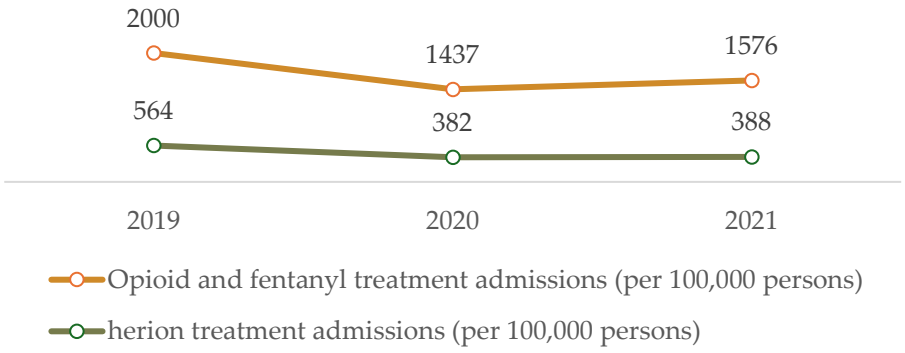
WYOMING SURVEY & ANALYSIS CENTER

Note: Estimates from 2021-2022 are not comparable to estimates from previous years due to changes in NSDUH survey methodology (https://pdas.samhsa.gov/saes/state).

Related to those reporting an OUD are individuals receiving treatment services. Arkansas collects this as part of the Alcohol/Drug Management Information System (ADMIS), and data is available for treatment admissions for 2019 through 2021. Chart 6 displays this data for admissions to state funded facilities per 100,000 persons. Over the three years presented here admissions are down, which could indicate fewer individuals needing opioid-related treatment or fewer individuals able to receive this treatment.

Chart 6. Opioid-Related Treatment Admissions per 100,000 persons in Arkansas, 2019-2021

The rate of those admitted for opioid, fentanyl, and heroin treatment decreased slightly between 2019 and 2021.



Data Source: Alcohol/Drug Management Information System (ADMIS)

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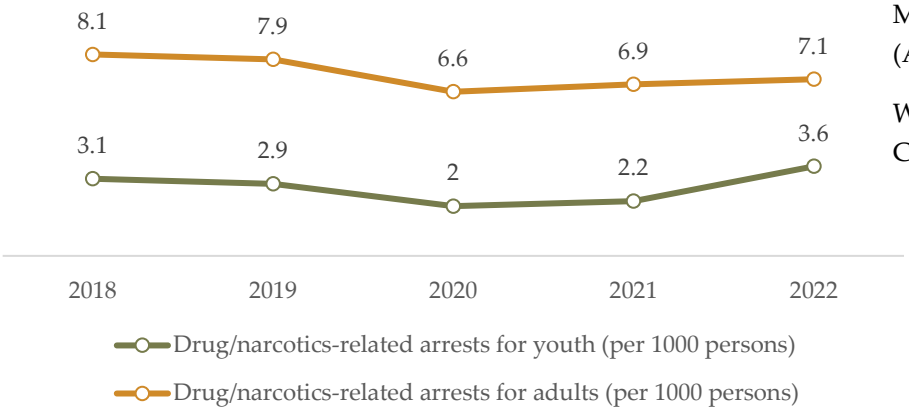
The Arkansas Crime Information Center (ACIC) collects data from law enforcement and other criminal justice agencies and provides data on two important opioid-related measures. These include drug/narcotics arrests for youth and for adults, both per 100,000 people. As seen in Chart 7, data show that these arrests in Arkansas have stayed relatively stable over the past few years.

Chart 7. Youth and Adult drug/narcotics arrests per 100,000 persons in Arkansas, 2018-2022

The rate of drug/narcotics arrests has remained relatively stable over the past few years, with adults experiencing more arrests than youth.



Data Source: Alcohol/Drug Management Information System (ADMIS)

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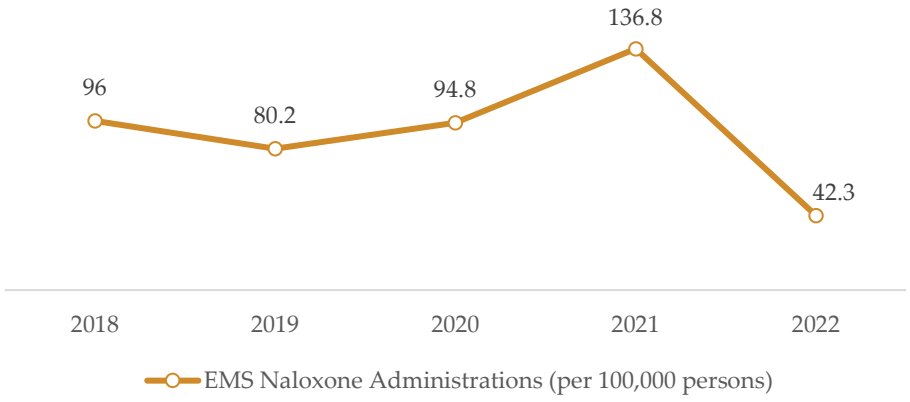
Another outcome is Emergency Medical System (EMS) administrations of Naloxone as a measure of opioid overdoses across the state. Chart 8 shows that these spiked in 2021 then dropped to a five year low in 2022.

Chart 8. Emergency Medical Services Naloxone Administrations per 100,000 persons in Arkansas, 2018-2022

The rate of EMS Naloxone administrations increased between 2018 and 2021, with a sharp decrease in 2022.



Data Source: Arkansas Department of Health

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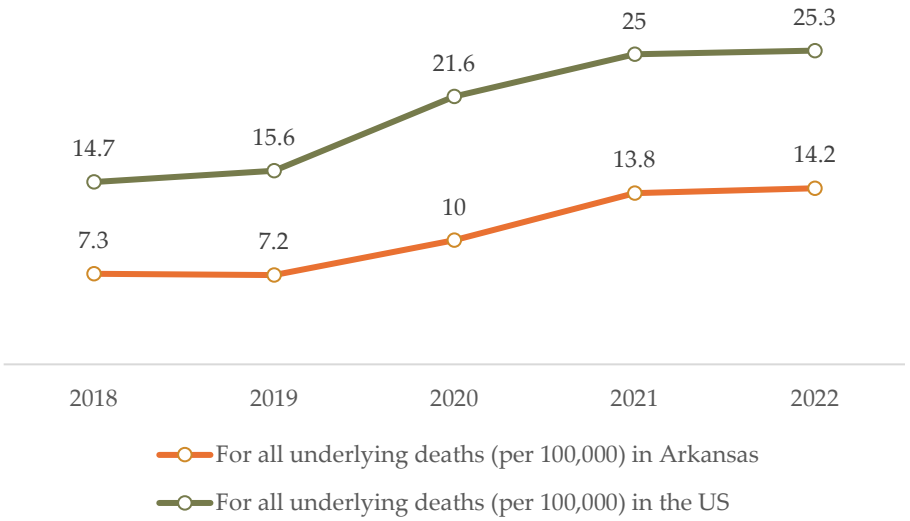
Chart 9. Opioid Related Deaths per 100,000 persons in Arkansas and the US, 2018-2022

The rate of opioid-related deaths increased over the past few years, but Arkansas rates remained below US rates.



Data Source: CDC Wonder

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Note: Estimates are age-adjusted rates for underlying causes of deaths from International Classification of Diseases (ICD) Codes that include T40.0 (Opium); T40.1

Lastly, in many ways the most crucial SOR III outcome is opioid-related drug overdose deaths. These are collected are reported in CDC Wonder per 100,000 people in Arkansas and the United States. Chart 9 shows the increasing trend for all underlying deaths related to opioids from 2018 to 2022.

SOR III Goals and Objectives

Goal 1: Reduce unmet OUD treatment needs by increasing access to Medication-Assisted Treatment (MAT).			
OBJECTIVE	**VENDOR**	**DATA COLLECTION METHOD**	**DOMAIN**
Objective 1.1: The University of Arkansas for Medical Sciences (UAMS) MAT Therapy Services and MAT Recovery Initiative for Arkansas Rural Communities (MATRIARC) programs will continue to recruit and support DATA-waived practitioners, especially in underserved rural counties and the 31 of 75 counties where the MAT Therapy program has not yet funded agencies with MAT providers.	UAMS	Administrative Data	Treatment
Objective 1.2: Arkansas Community Corrections (ACC) will continue its MAT Reentry Project, serving individuals with OUD reentering the community from incarceration with Vivitrol administered pre- and post-release, accompanied by counseling, telehealth, and wraparound support services in the community.	ACC	Administrative Data, Qualitative Study	Treatment
Objective 1.3: A new UAMS pharmacist-led program will expand access to medication for opioid use disorder (MOUD) in detainees at the Pulaski County Regional Detention Facility and promote their retention in treatment and sustained recovery upon community re-entry.	UAMS	Administrative Data	Treatment

Goal 2: Support prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders including stimulant misuse disorders involving cocaine and methamphetamine.			
OBJECTIVE	**VENDOR**	**DATA COLLECTION METHOD**	**DOMAIN**
Objective 2.1: The University of Arkansas (UA) Criminal Justice Institute (CJI) will provide its comprehensive community-based program, including Naloxone distribution and training on its administration, in the remaining unserved 18 counties.	UA-CJI	Administrative Data	Prevention
Objective 2.2: The UAMS Reynold's Institute on Aging (RIOA) will continue its current educational programs for seniors, caregivers, and physicians of elderly patients, add prescriber education about Arkansas's new Naloxone co-prescribing legislation,[1] and expand its consumer outreach and education to include Arkansas's previously unserved population of Medicare beneficiaries with disabilities.	UAMS RIOA	Administrative Data, Qualitative Study	Prevention
Objective 2.3: The Arkansas Collegiate Network (ACN) Marijuana Polydrug Project will address the increased incidence of marijuana use among the collegiate population with on-site and virtual trainings provided by the University of Arkansas at Little Rock (UALR) MidSOUTH Center for Prevention & Training and a marijuana toolkit developed by MidSOUTH. It will also expand its Naloxone distribution and training program.	UALR MidSOUTH, ACN	Administrative Data, Qualitative Data	Prevention
Objective 2.4: UALR MidSOUTH will introduce a new program on misuse of over-the-counter (OTC) drugs, collaborate with the Department of Human Services	UALR MidSOUTH, DHS-DCCEE	Administrative Data	Prevention

[1] Act 651 of 2021; An Act to Mandate the Co-prescription of an Opioid Antagonist; A.C.A. § 20-13-1805

Division of Child Care & Early Education (DHS-DCCEE) on a program about safe storage and disposal of prescription drugs, and update the ARTakeback website.[2]			
Objective 2.5: UAMS will begin a new program to educate: (1) hospital physicians about the requirements for Naloxone co-prescribing;[3] (2) nurses on Naloxone use, mechanism, and duration of action; and (3) prehospital workers (EMTs) on how and when to use Naloxone.	UAMS	Administrative Data	Prevention
Objective 2.6: The Arkansas Center for Health Improvement (ACHI) NaloxHome Program will provide free Naloxone to hospital emergency rooms to dispense to patients or families/caregivers of patients who have experienced an overdose or are at risk for an overdose, along with information about treatment and recovery resources.	ACHI	Administrative Data	Prevention
Objective 2.7: Enhancements and additions will be made to the state's Peer Specialist and Recovery Project by UALR MidSOUTH consisting of Forensic Peer Training, a new peer specialist curriculum and certification process for incarcerated individuals wishing to become a peer worker prior to release, and a variety of educational initiatives, webinars, and conferences for both PRS and the public.	UALR MidSOUTH	Administrative Data, Qualitative Data	Recovery

[2] ARTakeback.org

[3] Act 651 of 2021; A.C.A. § 20-13-1805

Goal 3: Support evidence-based prevention, harm reduction, treatment, and recovery support services to address stimulant use disorders, including for cocaine and methamphetamine.			
OBJECTIVE	**VENDOR**	**DATA COLLECTION METHOD**	**DOMAIN**
Objective 3.1: CJI will continue to provide its Advanced Methamphetamine Investigations course to law enforcement personnel.	UA-CJI	No Data	Prevention
Objective 3.2: Education about the signs, symptoms, incidence, and treatment of stimulant use disorders will be incorporated into the educational initiatives of CJI, UAMS, and ACN, as well as conferences and trainings for providers and consumers hosted by MidSOUTH.	CJI, UAMS, ACN, MidSOUTH	No Data	Prevention

SOR III Prevention Initiatives

SAMHSA promotes the use of evidence-based strategies to implement prevention, harm reduction, treatment, and recovery efforts for opioid misuse and opioid overdose. Evidence-based strategies are grounded in rigorous research and proven to be effective, thus ensuring that programs and interventions are reliable, efficient, and lead to meaningful improvements. Evidence-based prevention strategies supported by SAMHSA include targeted Naloxone distribution, training, and technical assistance to community stakeholders about opioids, opioid use disorder (OUD), and opioid overdose, and coordinated social, and environmental interventions to prevent and mitigate the broader impacts of opioid misuse and opioid overdose in the community.

Arkansas' SOR III prevention activities include:

- Widespread Naloxone distribution and training.
- Statewide public education campaigns on opioids, opioid use disorder, and opioid overdose.
- Community engagement via community roundtable presentations.
- Safe storage and disposal of prescription drugs education and training program.
- Education and training on over-the-counter medication misuse.

The following state agency and community organization programs participated in prevention efforts for Arkansas' SOR 4 Program:

- Arkansas Center for Health Improvement (ACHI) ER Discharge Naloxone Program
- UALR MidSOUTH SOR-C Collegiate Naloxone Project
- University of Arkansas (UA) Criminal Justice Institute (CJI) Community Level Project
- UALR MidSOUTH SOR-P Prescriber & Primary Prevention Training for Opioids and Over-the-counter Drugs
- UAMS/Opioid Prevention for Aging and Longevity (OPAL) Narcan Project

PREVENTION

Arkansas Center for Health Improvement (ACHI) ER Discharge Naloxone Program

The Arkansas Center for Health Improvement (ACHI) Emergency Room Discharge Naloxone Program partnered with hospitals across Arkansas to offer Naloxone free of charge to patients and/or their caregivers who had either experienced an overdose or were at risk of one. The program included providing educational materials on recognizing overdose symptoms and administering Naloxone correctly, training pharmacists, emergency department physicians, and hospital staff on Naloxone use, and promoting peer specialist interventions to help individuals identify substance misuse and access treatment resources. A multi-media campaign supported ongoing education initiatives.

Program Goals	Program Highlights
▪ To distribute Naloxone to the community via hospital emergency rooms.	▪ When the program ended, ACHI helped hospitals connect with community organizations to distribute the rest of the Naloxone.
Program Successes	**Program Challenges**
▪ The program surpassed deliverables and placed Naloxone in 52 hospitals with SABG and SOR III funding. ▪ The program has distributed over 1800 boxes to individuals outside of hospitals.	▪ The program was a grassroots effort and received little support from higher up hospital staff. ▪ The program struggled to reach people in rural areas. ▪ It was difficult to get rural area hospitals to engage with the program.

ACHI ER Discharge Naloxone Program Administrative Data

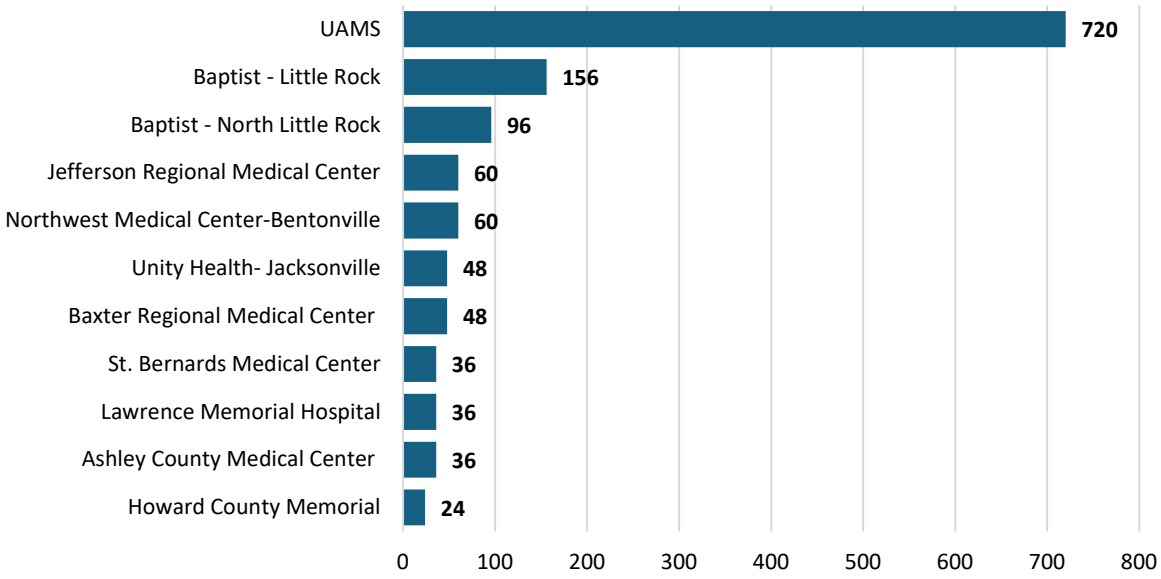
ACHI
1,320
Naloxone
Kits
Distributed

In 2021, ACHI was awarded supplemental funding through the Substance Abuse Block Grant (SABG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support individuals at risk of opioid overdose by providing Naloxone kits to various hospitals statewide. Starting on December 1, 2023 the program's funding transitioned to the SOR III grant, continuing until August 2, 2024, when the program concluded. WYSAC evaluators analyzed administrative data from ACHI during SOR III. The data in this report therefore reflect program data from December 1, 2023 through August 2, 2024.

NALOXONE DISTRIBUTION

Kits Dispensed by Participating Hospitals: Over the course of seven months, ACHI distributed 1,320 Naloxone kits to eleven hospitals throughout the state using SOR III funds, which were then dispensed to ER discharge patients and/or their caregivers.

Fig 1: Hospitals that Received Naloxone from ACHI



Reason for Dispensing: ACHI collected data on the reason for dispensing kits as either a) patient presenting in a participating Emergency Department (ED) at possible risk for overdose, or b) patient experiencing an overdose.

Table 1: Reason for Dispensing

Overdose Risk	490
Presented with Overdose	119
Missing Data	481
Total	**1,090**

Naloxone Recipient by Type: According to ACHI data, 99% (619) of Naloxone kit recipients were patients, and 1% (9) were caregivers (family or friends).

Naloxone Recipients by Gender: Gender of Naloxone patient recipients during this time period was broken down into two categories: Female and male. Three hundred and twenty-one (52%) recipients identified as female, and 298 (48%) identified as male.

Fig.2: Naloxone Recipient by Gender

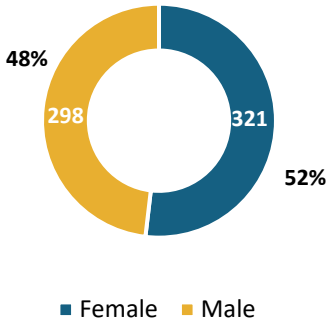
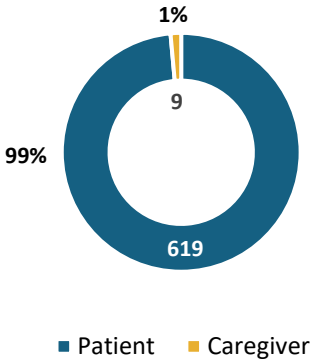


Fig.3: Naloxone Recipient by Type



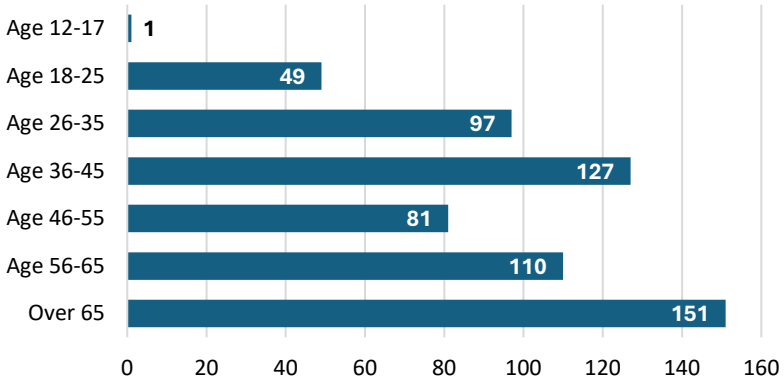
Naloxone Recipients by Race and Ethnicity: Race of Naloxone recipients was broken down into six categories: White, Black, Asian/Pacific Islander, Other, Multiracial, and Unknown. The two racial categories with the greatest number of recipients were White and AA/Black. Three hundred and seventy-nine (67%) of 566 recipients self-identified as White, and 121 (21%) self-identified as Black. Thirty-eight (7%) recipients identified as Other, seven (1%) identified as multi-racial, four (1%) identified as Asian, Pacific Islander, or Native American. Seventeen (3%) of recipients' race was Unknown.

Table 2: Naloxone Recipients by Race

Race	Count	Percent
White	398	67%
AA/Black	125	21%
Other	39	7%
Multiracial	7	1%
Asian/PI/NA	4	1%
Unknown	18	3%

Naloxone Recipient by Age: Age of Naloxone recipients was broken down into groups from 12 years of age to 66 years of age and older. The age range of Naloxone recipients that received the greatest number of kits (151) from December 1,2023 through August 2, 2024 was 65 years of age and older.

Fig. 4: Naloxone Recipient by Age Group



UALR SOR-C Collegiate Project

The UALR SOR-C Collegiate Project focuses on preventing overdose through the Arkansas Collegiate Network (ACN), which addresses substance misuse in higher education institutions. The ACN has grown its coalition by developing long-term goals and recruiting more institutions. The SOR Collegiate Polydrug Use Project specifically targets opioid and polydrug use among college students by updating and creating new training resources, both in-person and online, for use on campuses and in residential housing. This includes a fentanyl prevention toolkit for higher education institutions and a statewide media campaign to raise awareness of opioid overdose response kits on campuses.

The project builds on existing efforts like the state's Rise Above Alcohol & Drugs (RAAD), Me Over Meth, and Faith-Based substance misuse prevention campaigns. It also supports Naloxone training and distribution on college campuses. Many institutions have joined the ACN since its inception and have participated in virtual Naloxone training and recruitment efforts for the Arkansas Statewide Collegiate Substance Use Assessment (ASCSUA). The project continues to supply Naloxone to campuses and promote virtual Naloxone training in both English and Spanish, specifically aimed at the college population.

Program Goals	Program Highlights
▪ To get all 37 of publicly funded colleges and universities compliant with Act 811. ▪ To make Naloxone available to other individuals residing in or frequenting collegiate areas in Arkansas, including hotspots for drinking and potential drug use.	▪ The program is designed to serve the existing collegiate student population as well as incoming students. ▪ The program has created video and online trainings which have been made available to all colleges. ▪ Though private schools are not served by Act 811, the program distributes supplies and education materials if requested. ▪ This program hosts events to encourage student involvement and interest.
Program Successes	**Program Challenges**
▪ All colleges now provide online training. ▪ NaloxBox distribution was successful in aiding at least one overdose reversal. ▪ Active collegiate community events have been successful for reaching students who do not attend trainings. ▪ The program has provided strong support for collegiate prevention.	▪ The program is meant to be a student coalition, but getting students and faculty involved was difficult. ▪ There is high coalition turnover every 2-4 years which negatively affects coalition cohesion. ▪ Some colleges are reluctant to participate in the program. ▪ The program has no dedicated team or staff. ▪ The program struggles to reflect needs and schedules of students.

UALR SOR-C Collegiate Project Administrative Data

SOR-C
8,991
Naloxone
Kits
Distributed

NALOXONE DISTRIBUTION

SOR-C is a collegiate coalition committed to providing prevention education, with a particular emphasis on the distribution of Naloxone kits and training to college communities across Arkansas. The coalition offers virtual training through the Arkansas Prevention website and distributes Naloxone kits along with educational materials at college events and popular student venues. To date, SOR-C has successfully distributed 8,991 Naloxone kits and delivered 17,601 training sessions, including 9,185 conducted online and 7,876 held in-person.

MEDIA

The SOR-C program conducted an advertising campaign directing viewers to training and information about Naloxone and opioid overdose. Online advertising included video display, static image ads, social media, and a website for a total of 18,184,811 impressions, while television advertising totaled 25,985,000 impressions and streaming audio advertising totaled 76,304.

ONLINE ADVERTISING

Ad Type	Impressions
Video Display	15,505,539
Static Image Ads	1,380,980
Social Media/website	1,298,292
TOTAL	18,184,811

STREAMING AUDIO ADVERTISING

76,304

Impressions

TELEVISION ADVERTISING

25,985,000

Impressions

TRAININGS

During the reporting period, SOR-C conducted Naloxone training sessions at various colleges and universities across Arkansas, both in-person and online. The program successfully trained a total of 17,061 individuals in Naloxone administration, with 9,185 participants attending in-person sessions and 7,876 completing online training. Northwest Arkansas Community College accounted for the highest number of attendees, making up 38% of the total, followed by the University of Arkansas at Monticello, which contributed 19% of the participants.

Table 3: Number of SOR-C Naloxone Trainings by College/University

College/University	In-Person	Online	Total
Arkansas Northeastern College	0	2,912	**2,912**
Arkansas State University	51	0	**51**
Arkansas Tech University	954	0	**954**
Baptist Health College Little Rock	15	0	**15**
Harding College of Pharmacy	48	0	**48**
Henderson State University	325	0	**325**
National Park College	22	74	**96**
Northwest Arkansas Community College	6,537	0	**6,537**
Ozark College	99	0	**99**
Philander Smith University	20	0	**20**
Shorter College	5	0	**5**
Southeast Arkansas College	204	0	**204**
University of Arkansas at Little Rock	133	0	**133**
University of Arkansas at Monticello	460	2737	**3,197**
University of Arkansas Community College at Morrilton	25	0	**25**
University of Arkansas for Medical Sciences	0	2153	**2,153**
University of Central Arkansas	287	0	**287**
Total	**9,185**	**7,876**	**17,061**

Four thousand four hundred and eighty-nine (4,489) in-person trainees identified as female, 3,574 identified as male, and 1,122 did not report their gender. 5,118 online trainees identified as female, 2,645 identified as male, and 113 (less than 1%) did not report their gender.

Fig. 5: SOR-C In-Person Trainings by Gender

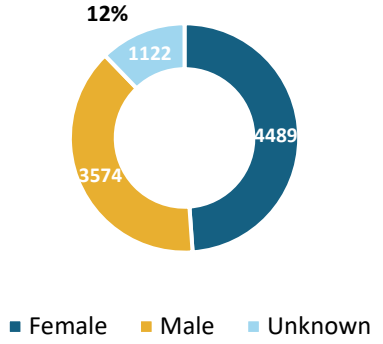
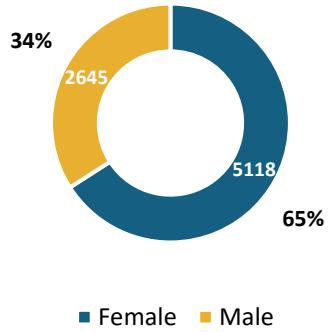
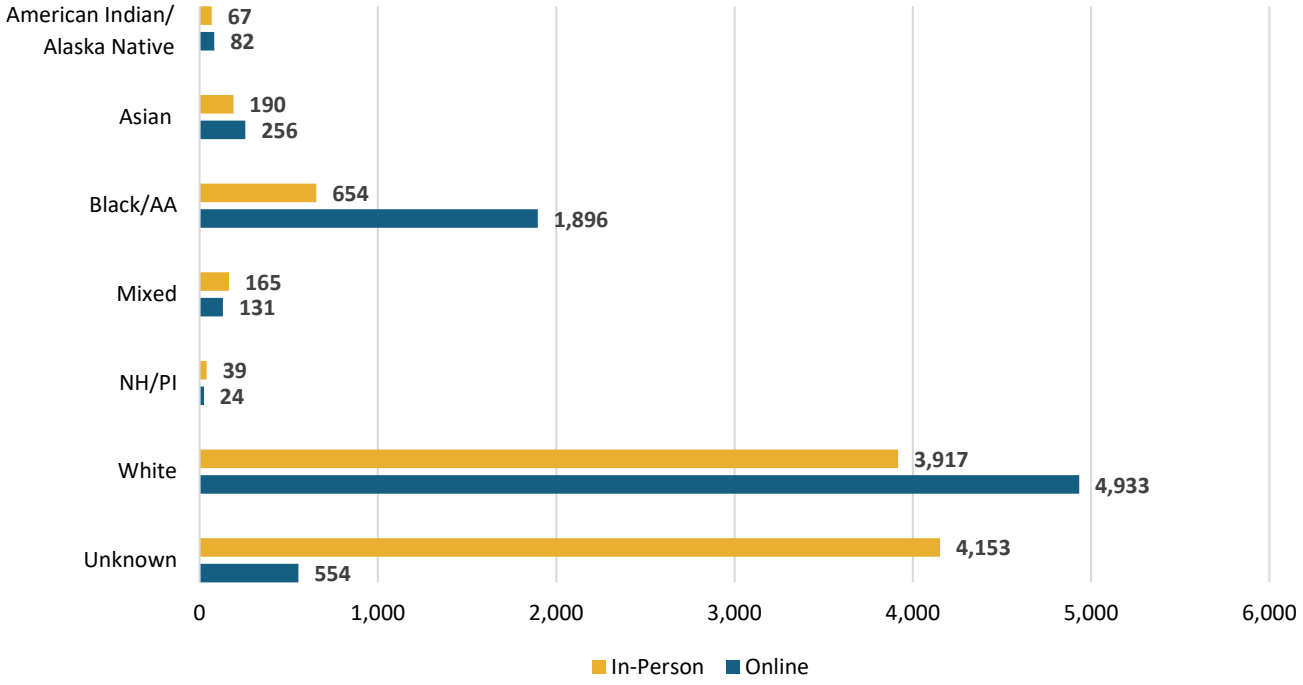


Fig. 6: SOR-C Online Trainings by Gender



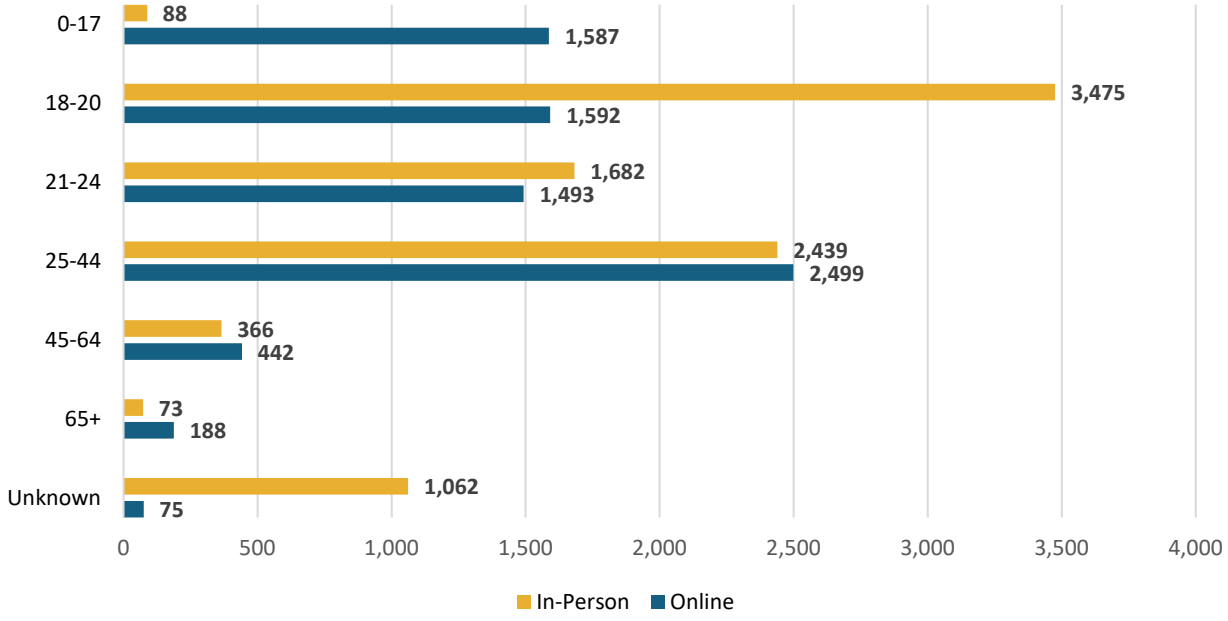
Four thousand one hundred and fifty (4,150) in-person trainees did not self-report their race. Of those that did, 3,917 (78%) identified as White, and 654 (13%) identified as Black or African American. Five hundred and fifty-four online (554) trainees did not self-report their race. Of those who did, 4,933 (67%) identified as White and 1,896 (26%) as Black or African American.

Fig. 7: SOR-C Trainings by Race



One thousand and sixty-two in-person (1,062) trainees did not report their age. Of those that did, 3,475 were between 18-20 (43%) years of age, and 2,439 (30%) were between 25-44 years of age. Seventy-five online trainees did not report their age. Of those that did, 2,499 (32%) identified as between 25-44 years of age, and 1592 (20%) identified as between 18-20 years of age.

Fig. 8: SOR-C Trainings by Age



Qualitative Study #1

Results from Focus Groups with College Students on Substance Misuse, Opioids, and Naloxone Administration

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Executive Summary

The SOR III UALR/MidSOUTH SOR-C Collegiate program evaluation focuses on Naloxone education and administration training of college students, and the distribution of Naloxone kits at Arkansas Collegiate Network (ACN) affiliated college campuses. Wyoming Survey & Analysis Center researchers held a total of five focus groups with students at one private and one public institution of learning to assess the knowledge, opinions, and experiences of college students concerning marijuana, opioids, opioid misuse, and Naloxone.

The two primary goals of the SOR-C Collegiate program evaluation are 1) to use data to enhance or improve the SOR-C Collegiate program as part of the SOR III program, and 2) to document successful program components within the overall SOR III program. Researchers from WYSAC designed the evaluation and facilitated five focus group sessions with the help of the ACN Project Director, visiting the two focus group sites in October of 2023 and January of 2024.

The results of the evaluation identified both effective components of the program and areas in which gaps in students' knowledge were evident. Findings indicate that, overall, students had limited knowledge concerning opioids and Naloxone. However, students enrolled in a health-related field appeared to have more information and understanding about opioids, substance use disorder, and Naloxone. In this report, WYSAC presents the findings of the evaluation, our recommendations for sustaining and enhancing the program's strengths, and areas in which the program could be improved.

Background

The ACN works to promote student wellbeing through substance misuse prevention initiatives in college campuses throughout the state of Arkansas. The overarching goal of the ACN is to empower campus leaders to create greater inter-collegiate cohesion among students to address substance misuse in college communities. The SOR-C program provides substance misuse prevention training and disseminates Naloxone and opioid overdose kits. In addition, SOR-C directed funds support a public information campaign about overdose awareness and statewide opioid/substance use as a current healthcare issue for college-aged individuals. The SOR-C program is part of the State Opioid Response III (SOR III) grant program managed by the Arkansas Department of Human Services (DHS) and The Office of Substance Abuse and Mental Health (OSAMH) and is supported through funding by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT).

In September of 2022, DHS/OSAMH contracted with the University of Wyoming, Survey & Analysis Center (WYSAC) to evaluate the SOR III program. The evaluation of this portion of the UALR/MidSOUTH SOR-C Collegiate program, funded by SOR III, is part of the overall evaluation. The University of Wyoming granted WYSAC researchers an IRB exemption, determining that individuals would experience less than minimal risk for participating in the research.

Methods

Data Collection Process

WYSAC evaluators developed focus group research instruments (Appendices A and B) containing prompts to help guide group discussion of substance misuse, opioids, Naloxone, and related topics. All focus group participants were informed of their rights, and each signed a consent form (Appendix C) explaining the goals of the study and the focus group format prior to participation. Researchers provided each focus group faculty representative with a copy of the consent form which included 1) contact information if they had any later concerns or wanted additional information, and 2) consent for the session to be digitally recorded. Contact information of a virtual counseling organization was also provided for participants if they experienced feelings of discomfort or distress resulting from discussing issues related to the focus group sessions. All participation was voluntary, and participants could refrain from answering any or all questions and could leave the focus group at any time.

Focus groups were implemented in two separate sessions. During October 2023, two focus groups were administered, each with a short training module presented by the ACN Project Director. Naloxone kits were distributed to student participants for inspection but returned to the ACN Project Director at the end of each focus group session. A $15 incentive was given to each student for participating. This incentive was funded through the SOR III grant. During January 2024, the ACN Project Director received approval to implement enhanced training sessions with data-driven PowerPoint presentations and free Naloxone kits to be distributed to each student participant. A $25 incentive was given to each student participant by the faculty representative during these sessions. This incentive was not part of SOR III but was funded through a private grant awarded to the college. All focus group discussions lasted between 60-90 minutes and were held at two colleges in semi-private conference rooms.

Demographics of Participants

A total of 44 students, 25 women and 19 men, took part in the focus group sessions to discuss their experiences, opinions, and recommendations for program improvement. The majority of focus group participants were undergraduate students between 18 and 24 years of age. However, several older graduate students also participated. The following table lists gender and session of focus group participants. Demographic variables such as race, age, and location were not collected to help preserve confidentiality.

Session	Female Students	Male Students	Total
October 2023 Sessions	9	7	16
January 2024 Sessions	16	12	28
Total	**25**	**19**	**44**

Analysis

WYSAC researchers and support staff transcribed the digitally recorded interviews verbatim. All personally identifying markers were removed from the documents during the transcription process to preserve confidentiality. Consent forms are stored in a locked file cabinet and digital files of transcripts have been uploaded to WYSAC's password protected secure server. QDA Miner 6, a qualitative data analysis software, was used to code the transcripts into notable categories of significance that describe the experiences, opinions, thoughts, and recommendations of the focus group participants.

Findings

What are your thoughts on marijuana use? Should it be legalized? Why or why not?

The majority of focus group participants (students) felt that marijuana should be legalized in Arkansas, with most leaning towards supporting its legality primarily for medical reasons rather than recreational use. A few students felt that legalizing marijuana for recreational use was a better alternative to using alcohol. Others felt that legalizing marijuana was warranted to protect users from unsafe interactions with dealers and/or products laced with dangerous drugs. One student stated that they were against marijuana being legalized.

Most students felt that marijuana should be included in the arsenal of drugs used to address pain, depression, and anxiety. Some referenced specific research whose findings indicated that side effects from marijuana use for certain ailments were less than those of medically accepted treatments. Others pointed to the exorbitant cost of prescription drugs and how medical marijuana might be a less expensive alternative.

- "I think it should be legalized with stipulations. There's a lot of drugs that we're giving to people right now to treat things that have way worse side effects."
- "I mean, it's kind of been proven to help people with pain and sleep and stuff. So, it has obvious medical uses, and I think criminalizing it just makes it harder for people to get that kind of help."

Several students spoke of the high rates of student alcohol abuse on college campuses and how they felt that, if legalized and regulated, marijuana might be a safer choice.

- "I think that if it's safe and approved and gone about in the correct avenue, I mean, I think there's a lot more like alcohol related problems that we're seeing right now, especially in like the age range like 21 to like 25, and deaths related to that, than we're seeing recreational marijuana use."

Others felt that legalization and regulation would provide some protection from risky interactions and/or inadvertently overdosing on marijuana laced with some other harmful drug.

- "You need a license in order to distribute or, like, practically bring stuff like that to the community, whether it's with a doctor's note, or purely recreational. Because like we were saying earlier, people drink anyways, people smoke anyways, people use marijuana, regardless of whether it's legal or not. And then stuff like that opens up a lot more chances of being unsafe, or going to unsafe places to procure it, or meeting unsafe people to get or having stuff that's not strictly marijuana. But if it was administered in the same way as other substances, it could remove some of the risks."

One student was against the legalization of marijuana, stating that it might lead a person to experiment with other substances that may be more harmful and addictive.

- "I feel like marijuana is the gateway drug. I come from a family history of people that started off with marijuana and ended up on crack."

How prevalent is marijuana on campus? What about the surrounding community?

All students stated that they have either directly witnessed or have known of marijuana use on their campus. Students also stated that marijuana use was common in their communities. However, they also felt that other illicit drugs including methamphetamine and heroin were even more prevalent in some areas.

The majority of focus group participants described the prevalence of marijuana being used on campus as "very prevalent." Focus group participants stated that it was common to see or at least smell marijuana being used in many areas on campus.

- "I'm a resident assistant. So, I work in the dorms, and it's kind of my job to like, make sure people aren't doing this kind of thing. And it's always weed or alcohol. I don't think I've ever found anything stronger."
- "I was actually driving into campus at 12:30 at night and I saw some people smoking on campus. It was actually kind of crazy."

Several students discussed the prevalence of marijuana as well as other drugs in their communities. These discussions described marijuana as well as other illicit drugs as common, but also geographically based, with specific drugs more prevalent in some areas than in others.

- "It's more of a like…rural places, anywhere in the south, specifically in Arkansas, the more rural you get. So, like [unclear] County is a massive hotbed for meth. Garland County down south is really bad with meth. But once you get into Faulkner like near Conway or down, like up in Washington, or towards where Little Rock is, there's just less prevalence with meth and it's more other drugs like heroin and stuff like that. So, meth is like a poor rural person's drug."
- "The impoverished thing [in rural areas] specifically was about...like meth as opposed to cocaine, or some of the drugs like heroin, that's still more up North in bigger cities."

Have you talked about drugs with your parents or guardians?

Students were equally divided into two distinct categories for this question. Responses were either, "Yes, we talked about it," or "No way."

Approximately half of the students who participated in focus groups stated that they have had conversations about drugs and other sensitive topics with their parents or guardians.

- "I grew up in a house with no alcohol, no nothing. I also have family in law enforcement, so it was present, you know like dinner table talk about stuff like that. But I don't think it's awkward talking to people about it."
- "For me, whenever my family would have a conversation, it was more like 'Don't do drugs'. It was one of those types of conversations. So, it was just not a very informative thing."

Although roughly half of the students attending focus group sessions stated they had talked with their parents or guardians about drugs, half of the students had not. Some students stated they felt uncomfortable discussing drugs and related topics with their parents or guardians and found the information elsewhere. Some voiced their frustration with not being able to have an informed discussion with their parents or guardians to help them navigate their feelings and make better choices.

- "We didn't talk about it, we just couldn't."
- "I feel like, just be straightforward about it and just, you know, really being clear and not be weird about it with the drug talk. Get straight to the point . . . Because when you're so weird about it, it's kind of like, I don't really know how to feel about it. You know, when you really get to the point and like, it's bad, don't do it, you know?"

Have you talked about drugs with your peers?

Notably, most students stated they were also not comfortable talking about drugs with their peers. When asked where they got their information from, the majority of students cited their main information came from when they attended elementary or high school. However, most students felt that much of the information they received at that time was either vague or superficial.

- "For me, they only talked about it in elementary school. You get to junior high, it's like they just don't do it. Like don't do drugs. And that's it. Like, I feel like in high school for me in elementary school, you sat down, PowerPoint, da-da-da. Teachers knew in high school that kids . . . marijuana was very [popular] . . . the school would smell like it, and the teachers kind of just ignored it. And our principal

knew it was a big problem, but she didn't like to have to talk with us about it. I feel like if they talked about it, it might keep people away from it."

- "I think it's good to also talk about it a lot in schools. I feel like at my school, we talked about it but then they didn't."
- "We talked almost exclusively about meth. In elementary school and stuff, we talked about drugs. Whenever we got to junior high, we never talked about cocaine or heroin or pot. It was just meth. Granted, where we were situated, there was a lot of meth. We watched the 'Chasing the Dragon' movie. And like, all that stuff. That was the only thing we talked about."
- "I remember in elementary school, I went to a school that had the DARE stuff, [unclear]. But once you got to junior high and high school, it kind of went away, like oh, don't do this."

Have you talked about drugs with your younger siblings?

However, most students stated they <u>had</u> talked to their younger siblings about drugs. Many of them worried about their siblings making poor choices, understood the social pressures of wanting to belong and/or wanting to be "cool" or popular, and hoped their siblings would come to them with questions before experimenting with drugs or alcohol.

- "I have had a talk with my siblings about, like, drugs and stuff like that. For the most part, you know how kids are, 'I'm not going to do that.' I know they're going to say that, but I just pray they don't actually try to do anything."
- "I tell them to call me. I also feel like it helps to try to steer them away from it, but I feel like I would give them that thing of, 'Hey, if you do it, I won't be mad at you'."
- "I'm really worried about my brother just taking them, just but like getting laced and stuff. You know, you never know who you're buying from or what you're buying. And there's a lot of crazy people out there that prey on younger children. So that's why I worry about drugs. And drugs are becoming more normalized in our society, even just like marijuana and stuff. So, one day someone might say, 'Oh, this is cool,' and then you know, peer pressure and all that can just change someone's perspective quickly."

Have any of you heard of the drug called fentanyl?

The majority of students had heard of fentanyl. Those students that had heard of it were divided into two groups: a small number that were fairly knowledgeable about the drug, and the rest that had a rudimentary knowledge based on vague memories of news, billboards, or conversations.

Those students that were fairly knowledgeable received their information from a formal presentation at their university, class discussion, or through a family health crisis.

- "We had a speaker from the FBI come, the [unclear] coordinator, and he was talking about it."

- "I'm a biology major. So, I know a bit of the pain relief, like if you go into labor, sometimes they use that drug fentanyl."
- "My granddad while he was going through cancer treatments, they had him on fentanyl patches."

Other students that had only a cursory knowledge of fentanyl stated that they were not sure what it (fentanyl) was, but knew it was dangerous.

- "I don't know what it is, I've just heard of it."
- "[I only know] just how extremely dangerous it is. That's about it."
- "I remember seeing a billboard one time about fentanyl."

Have any of you heard of the drug called Naloxone?

Roughly half the students that participated in focus groups had heard of Naloxone. Most of those that had heard of it had a limited knowledge of what it was or what its function was in reversing an overdose.

Those students that had heard of Naloxone had seen it on campus or had heard about it through the internet or on television.

- "I have seen it on campus. There's these opioid abuse kits hanging up. It's in there."
- "I saw it on a friend of mine's shelf."
- "I saw it on TV, but I vividly remember them having a box of it on campus somewhere."

Do you think access to Naloxone on campus is important?

When asked if having access to Naloxone on college campuses was important, the majority of students said, "Yes," however, some questioned whether people would understand its importance.

- "Probably having a lack of knowledge on what Narcan is and how it works it might not even register [that it' important]. Because if you're like, 'Yeah, I've got Narcan in my bag,' and somebody doesn't know what Narcan is, they're like, 'Why do you have Narcan? What's it for?'"

Would you be comfortable carrying Naloxone?

After the Naloxone training, students were asked if they would be comfortable carrying Naloxone. Their answers indicated varied degrees of comfort. Some said an unequivocal "Yes," while others were more hesitant due to fear of pushback.

Discomfort in having their choices or knowledge questioned by parents or adult authority figures was the primary reason for being hesitant in carrying Naloxone.

- "My parents would be like, 'Why is this in your backpack? What's going on?'"
- "I moved here from Portland, Oregon. So, I had some friends visiting me this summer and they got pulled over by the police and they carry Narcan. And then the police were like, 'Why do you have this?' They're suspicious."
- "You feel like the older people are going to accuse you. 'Like are you doing drugs? Are you associating with people who do drugs? Are your friends doing drugs? Are you going to do drugs?' Like it comes from a place of genuine worry, I think. When it was like, 'Why are you even carrying that? You shouldn't have to be carrying that because you're not going to do drugs.'"

However, one individual did not feel the need to carry Naloxone because she/he didn't know anyone that might need it.

- "I don't know if I would take one because I don't know anybody around me that does that type of activity, so I would probably say no. You know what I'm saying?"

Do you think there's stigma about carrying and/or using Naloxone? If so, how do we address it?

Most students felt that there is at least <u>some</u> stigma concerning Naloxone distribution on campus. Many blamed it on a lack of awareness of opioids and the opioid crisis. Others felt that while people may know about the crisis, there is a still a lack of education about Naloxone and how individuals could easily administer it as an antidote for an opioid overdose.

Students gave thoughtful responses to addressing stigma, including the need for more education; however, the majority of students felt that personal stories that they could readily identify with were the most effective in getting the information concerning Naloxone and opioids across to the public.

- "I feel like one of those personal stories like the one you gave of the freshman at Hendricks."
- "Really more than just the information and the statistics and the facts, and those are very legit within themselves, but just like appealing to people, like just emotionally, like that said a lot despite the other facts."

Do you have any questions?

Students asked a variety of questions about drug related issues during focus group sessions. Below is a list of student questions categorized by topic.

Addiction Questions
• How much of addiction is hereditary?
Marijuana Questions
• Is marijuana a rich person drug?
Fentanyl Questions
• Is that the drug that's been on money and stuff?
• So, it can affect you just by touching it?
• Does fentanyl kill you instantly?
• Can you be addicted to it, because it's such a, like, intense drug?
• Where are people getting it from and who keeps making it if it's so dangerous?
Overdose Questions
• What does a fentanyl overdose look like?
• Don't we (AR) have the highest amount of fentanyl overdose or something like that?
Naloxone Questions
• How effective is Naloxone when you overdose on fentanyl?
• Can you become immune to Naloxone if you've used it so many times?
• Do they [Naloxone administration methods] work the same? Injection versus up your nose?
• How long does it [Naloxone] stay active in your body?
• Where do they make Naloxone?
• So, if you see somebody on the street, like, how you gonna know if they need Naloxone to save them?
• How do you know it's [Naloxone] working if you do the chest rub and then CPR?
• So. like, now, okay, now you said that it might take more than one [Naloxone administration] so like, would it just add up or would it still stay in the body for the same amount of time?
• I know this is for overdoses, but you know if you take fentanyl, you don't automatically overdose, but if you were taking something laced with it, would that still be useful to get it out of your system?

Evaluator Observations and Recommendations

1. **Provide more "live" Naloxone trainings for students, administrators, and staff.** We recommend either face-to-face or "live" video conference training sessions that include a question-and-answer period to help students, administrators, and staff better understand opioids, opioid overdose, and Naloxone. Students asked numerous questions during focus

group sessions that went beyond the basic training that was presented. A live question and answer period and hands-on demonstration would help address most concerns about opioids, opioid overdose, and Naloxone. These sessions could be part of the annual student onboarding process and an annual completion certificate for administrators and staff to confirm that all necessary individuals get the required training they need to be fully informed.

2. **Consider adding interactive workshops and seminars led by experts in addiction, law enforcement, and healthcare professionals:** Focus group comments suggest that adding interactive workshops and seminars that combined awareness, prevention, support, and engagement would help to bridge the gap in information among students concerning the illicit use of drugs. Topics could include the effects of drug use, legal consequences, and healthy coping mechanisms.

Concluding Thoughts

Focus group sessions indicated that more prevention programs are needed at the middle and high school level. Students described prevention programming and access to information about the dangers inherent in illicit drug use dropped off precipitously toward the end of middle school. It is evident by the questions and comments during focus group sessions that prevention programming is needed at all grade levels; however, the gap seems greatest during adolescence during grades 9-12. Prevention programming during this critical time in development could help mitigate risks inherent during adolescence and beyond by providing information and support to equip students with the knowledge and skills they need to make healthy choices, reduce the prevalence of substance abuse, and foster a supportive and safe learning environment.

- "I remember in elementary school; I went to a school that had the DARE stuff. But once you got to junior high and high school, it kind of went away, like. 'Oh, don't do this.'"
- "I feel like once you get to high school, they kind of see us and [unclear] oh, they're adults, they know what they're doing. It's fine."
- "I also feel that they think it's just wasting time. As for me, where I grew up, anytime they talked to us, they think we don't care. Sometimes I feel like teachers just don't care. I've had just teachers, like, I'm just here to get paid like, so I feel like they just don't care."

Appendices

Appendix A

COLLEGE STUDENT FOLLOW-UP FOCUS GROUP QUESTIONS

We've invited you here today because you are all students attending a university in Arkansas, and because of that, many of you share some common experiences and interests.

We would like to talk to you about your attitudes towards marijuana use and your knowledge of some drugs called fentanyl and Naloxone. **We are not asking about your individual marijuana use (if any), but about your feelings and opinions concerning the use of marijuana in general.** We are also interested in your knowledge of fentanyl and Naloxone. Each of you has somewhat different backgrounds and experiences and so your attitudes and familiarities with these topics will be slightly different. That's why it's important that each of you tell us about your ideas and opinions – even if it's different from what everyone else has to say. We don't expect everyone to have the same perspective, so if you disagree with something, don't be afraid to speak up. Often, we learn the most when people have different ideas about something.

Process Introduction

My name is _____. I will be the moderator. I will introduce topics and try to keep the discussion on track and make sure everyone gets a chance to talk. I will be taking notes during the discussion because I will be meeting with several groups of students from around the state, and I want to be able to keep track of what the different groups say. If it's okay with everyone, I will also be recording the discussion so that I don't miss any of your comments. We will be using each other's first names only during our discussion; but when I write up our summaries, no names will be used. I will keep all of the information you share with us confidential, and I ask that all of you do too.

Are there any questions before we begin?

Introduction

To get started, why don't we go around the room and have everyone introduce themselves using first names only. Please state what class standing you are in: freshman, sophomore, junior, senior, or graduate student.

Prompts for Discussion

- *First, I want to discuss a bit about your attitudes towards marijuana use.* ***Remember, I am not asking about your individual marijuana use (if any), but about your feelings and opinions concerning the use of marijuana in general.***

    - Where do you stand on marijuana use? Should it be legalized or not? Why or why not?
- *Next, I want to discuss your thoughts on using marijuana and other drugs.*
    - How prevalent (how much or how often) do you think using marijuana is?
    - How prevalent (how much or how often) do you think using marijuana plus something else (like other drugs or alcohol) is?
- *Now, I'm going to ask about two particular drugs: fentanyl and Naloxone.*
    - How many of you have heard of the drug called fentanyl?
        - What have you heard about it?
        - Where did your information come from?
    - Have you heard about Naloxone?
        - What have you heard about it?
        - Where did your information come from?
- *Finally, I want to discuss your thoughts on Naloxone and its use.*
    - Do you think access to Naloxone on college campuses is important? Why or why not?
    - If someone were to offer you a free Naloxone kit, would you take it? Why or why not?
    - Would you be willing to use it on someone that was experiencing an overdose? Why or why not?
    - Would you be willing to take a short class, watch a video, or read a pamphlet on Naloxone and when and how to use it?

Conclusion

The moderator provides a short overview of the purpose of the study (10 minutes before end of focus group).

The goal of this focus group is to gather college students' attitudes towards marijuana use and their knowledge of fentanyl and Naloxone. The information that you provide will help the Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) gain a better understanding of community attitudes toward recreational use of marijuana and knowledge of opioids and emergency treatment. This focus group is one data collection method we are using to gather information.

- Is there anything anyone would like to add that we haven't covered?

Thank you for participating in the focus group. I appreciate you taking the time out of your day to be part of our study.

Appendix B

COLLEGE STUDENT FOLLOW-UP FOCUS GROUP QUESTIONS

We've invited you here today because you are all students attending a university in Arkansas, and because of that, many of you share some common experiences and interests.

We would like to talk to you about your knowledge of some drugs called fentanyl and Naloxone. Each of you has somewhat different backgrounds and experiences and so your attitudes and familiarities with these two topics will be slightly different. That's why it's important that each of you tell us about your ideas and opinions – even if it's different from what everyone else has to say. We don't expect everyone to have the same perspective, so if you disagree with something, don't be afraid to speak up. Often, we learn the most when people have different ideas about something.

Process Introduction

My name is _____. I will be the moderator. I will introduce topics and try to keep the discussion on track and make sure everyone gets a chance to talk. I will be taking notes during the discussion because I will be meeting with several groups of students from around the state, and I want to be able to keep track of what the different groups say. If it's okay with everyone, I will also be recording the discussion so that I don't miss any of your comments. We will be using each other's first names only during our discussion; but when I write up our summaries, no names will be used. I will keep all of the information you share with us confidential, and I ask that all of you do too.

Are there any questions before we begin?

Pre-Training Introduction

To get started, why don't we go around the room and have everyone introduce themselves using first names only. Please state what class standing you are in: freshman, sophomore, junior, senior, or graduate student.

Prompts for Discussion

- *First, I'm going to ask about two particular drugs: fentanyl and Naloxone.*
    - How many of you have heard of the drug called fentanyl?
        - What have you heard about it?
        - Where did your information come from?
    - Have you heard about Naloxone?
        - What have you heard about it?
        - Where did your information come from?
- *Next, I want to discuss your thoughts on Naloxone and its use.*
    - Do you think access to Naloxone on college campuses is important? Why or why not?

- If someone were to offer you a free Naloxone kit, would you take it? Why or why not?
- Would you be willing to take a short class, watch a video, or read a pamphlet on Naloxone and when and how to use it?
- Would you be willing to use it on someone that was experiencing an overdose? Why or why not?

Post-Training Prompts for Discussion

- *Now that you've received training on administrating Naloxone, I have a few questions:*
  - Do you think access to Naloxone on college campuses is important? Why or why not?
  - If someone were to offer you a free Naloxone kit, would you take it? Why or why not?
  - Now that you've received training, would you be willing to use it on someone that was experiencing an overdose? Why or why not?
  - Would you be willing to talk to other students about fentanyl and Naloxone?

Conclusion

The moderator provides a short overview of the purpose of the study (10 minutes before end of focus group).

The goal of this focus group is to gather college students' knowledge of fentanyl and Naloxone. The information that you provide will help the Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) gain a better understanding of community knowledge of opioids and emergency treatment. This focus group is one data collection method we are using to gather information.

- Is there anything anyone would like to add that we haven't covered?

Thank you for participating in the focus group. I appreciate you taking the time out of your day to be part of our study.

Appendix C

COLLEGE STUDENT FOLLOW-UP FOCUS GROUP
INFORMED CONSENT

Thank you for agreeing to participate in this focus group. The purpose of this focus group is to find out about college students' attitudes towards marijuana use and knowledge of and your knowledge of some drugs called fentanyl and Naloxone. **We are not asking about your individual use, but about your feelings and opinions concerning the use of marijuana in general.** The Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) is collecting data in this area to gain a better understanding of community attitudes toward use of marijuana, knowledge of fentanyl and Naloxone, and emergency treatment. This focus group is one data collection method we are using to gather information.

This focus group will take approximately 1 to 1 ½ hours. Your participation is entirely voluntary. Your answers to questions will be kept confidential, and at no time will your name be attached to your answers or to any of the data collected through this discussion. You will receive a $15 gift card for your participation. You do not have to answer any question that makes you feel uncomfortable, and you may choose to leave the focus group at any time. You will receive your $15 gift card whether you complete the focus group session or not.

We will be reporting the results of this focus group in aggregate. While we may capture some meaningful quotes, they will not be connected to any individual. In order to protect confidentiality and to make everyone comfortable here today, we ask that you do not discuss specific things that any particular person said here after we leave. We are interested in both majority and minority viewpoints. We will not be upset by critical commentary, nor will that count as a strike against you, so please do not hold back even if you feel your comments may be discouraging or unpopular. During or after the focus group, if you have any feelings of discomfort or distress resulting from discussing this topic, please call UAMS at (501) 526-3563 to connect to a free virtual mental health clinic.

During the focus group, we will ask you questions, and will listen to what you have to say. We will not participate in the discussion. Please feel free to respond to each other and speak directly to others in the group during the discussion. We want to hear from all of you. We may sometimes ask someone to speak who has been quiet or ask someone to hold their thought for a few minutes. If you have questions about your rights as a research subject, please contact the University of Wyoming IRB Administrator, at 307-766-5320. You may also contact Dr. Andria Blackwood, at (734) 678-5428 for general questions about this project.

"My participation is voluntary and my refusal to participate will not involve penalty or loss of benefits to which I am otherwise entitled, and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled."

_____ Date

_____ Participant name (please print)

_____ Participant signature

I consent to be recorded during this focus group: □ YES □ NO

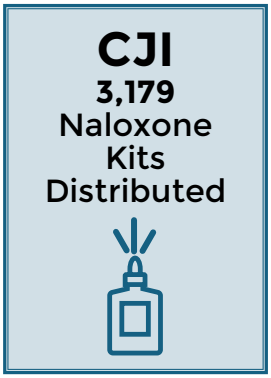
PREVENTION

UA Criminal Justice Institute (CJI) Community Level Project

The University of Arkansas Criminal Justice Institute (CJI) Community Level Project provided training and distributed Naloxone kits to first responder agencies, treatment center staff, families in recovery, domestic violence shelters, and veterans' associations within Arkansas. CJI prevention efforts included pre-release peer support training for incarcerated individuals, prevention materials and technical assistance to providers, and health literacy and awareness in at-risk communities for opioid misuse. Other community prevention initiatives included a media campaign utilizing billboards, social media posts, print ads, news stories and broadcast presentations, and community roundtable events that provided information about opioids, OUD, and the Good Samaritan Law to targeted communities. Ten counties – Calhoun, Clark, Dallas, Fulton, Lafayette, Nevada, Newton, Perry, Sevier, and Yell – were included in CJI's SOR III targeted community initiative.

Program Goals	Program Highlights
▪ To provide Naloxone training to firefighters, librarians, families in recovery, school nurses, school resource officers, and law enforcement. ▪ To lead a prevention education campaign within the community. ▪ To provide refills and replacements for Naloxone that has been administered or expired.	▪ This program works to train the community in Naloxone and to bring awareness about Good Samaritan Laws. ▪ This program provides an Advanced Overdose Investigation course which educates investigators in methods of tracing drugs overdoses back to the dealer. ▪ In addition to training, the program provides the organizations they train with Naloxone refills and replacements.
Program Successes	**Program Challenges**
▪ Program staff feel that deliverables are being met. ▪ Program staff feel that media campaigns have been successful.	▪ The program has experienced changing staff and have been understaffed. ▪ The program is getting requests from organizations and businesses outside of their deliverables and are unable to grant requests. ▪ Law enforcement and rural librarians are less receptive to the program. ▪ Difficult to cover the entire state post-COVID.

UA Criminal Justice Institute (CJI) Community Level Project Administrative Data



CJI Naloxone Purchase and Distribution: During the reporting period from October 2023 – September 2024, CJI successfully distributed 3,179 Naloxone kits. CJI project staff maintained comprehensive records of Naloxone purchases and distribution details. An inventory and distribution list tracked each Naloxone kit. Boxes were individually numbered and labeled to include their distribution date, agency name, total number of kits, and the staff member responsible for the request. Traditional kits contained the following items: two doses of 4mg Naloxone nasal spray, two pairs nitrile gloves, one CPR mask, one treatment referral card, two towelettes, one administration instruction card, one grant code sticker, and one QR scan code for reporting administration.

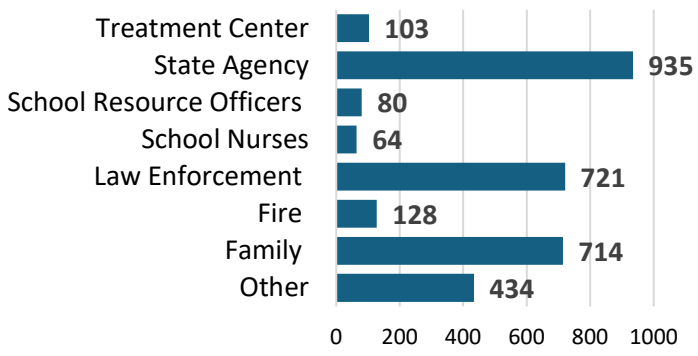
Most of the kits distributed were new, particularly to individuals who completed the initial Naloxone training course (1,606). Additionally, kits were integrated into Automated External Defibrillator (AED) units statewide (1,122). Refill kits were provided to replace Naloxone that had been administered and documented (28), while replacement kits addressed expired Naloxone (55). Reserve kits (198) consisted of two Naloxone doses sent to first responders for scenarios where traditional two-dose administrations were insufficient. Other kits included those that were not specified in the data reporting.

Table 4: Type of Kit Distributed by CJI

Type of Kit	Kits Distributed
New Kit	1,606
Refill Kit	28
Replacement Kit	55
Reserve Kit	198
AED Kit	1,122
Other	170
Total	**3,179**

Project staff have implemented a procedure for refilling and replacing Naloxone for agencies that had previously participated and met program requirements. Agencies that had not received training in over two years were required to attend a refresher training session. Furthermore, refill doses of Naloxone were only provided to agencies that reported the Naloxone administration through the program's Naloxone administration portal.

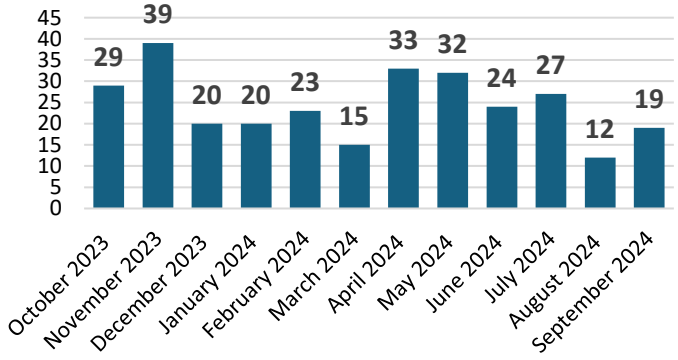
Fig. 9: CJI Naloxone Kit Distribution by Type of Individual



State agencies received the highest number of Naloxone kits, totaling 935. Law enforcement agencies followed with 721 kits, and family members or friends of individuals at risk of overdose received 714 kits. The Other category included community events (155), coroners (3), faith-based communities (9), library staff (38), first responders (42), schools and school districts (109), and unidentified (78).

Overdose Reversals: Overdose reversals can be reported through the Naloxone Reporting Tool which captures information about the individual administering the Naloxone, the recipient, and where the Naloxone was obtained. The reporting tool is available on the NARCANsas website and app, and by using the QR code on the kit. CJI reported 293 overdose reversals from October 2023 through September 2024.

Fig. 10: CJI Reported Overdose Reversals by Month



CJI Naloxone Trainings: During the reporting period, CJI trained 1,593 individuals. CJI conducted both online and in-person Naloxone trainings. Whenever possible, CJI collected demographic information from the attendees. To participate in the program, first responder agencies were required to fulfill all approval criteria established by the Director of the Criminal Justice Institute. Each agency needed to successfully complete the online Naloxone administration training course before receiving Naloxone kits. Following this, agency heads were required to sign a Letter of Agreement and contact the Director to obtain the model policy for the program. Additionally, each agency was expected to submit a model Naloxone program policy for approval.

Table 5: CJI Trainings by Type

Training Type	Number Trained
Online	1011
In-Person	582
Total	**1,593**

Three hundred and twenty-three (323; 32%) of online trainees identified as female, and 686 (68%) identified as male. Less than 1% did not indicate their gender (3) . For in-person trainings, the participation was more equally distributed, with 291 (50%) in-person trainees identifying as female, 265 (46%) identifying as male, and 26 (4%) people did not report their gender.

Fig. 11: CJI Online Trainings by Gender

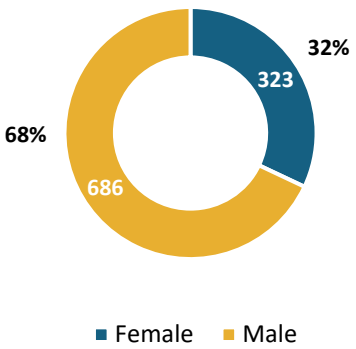
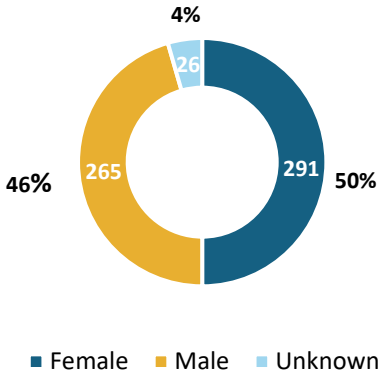
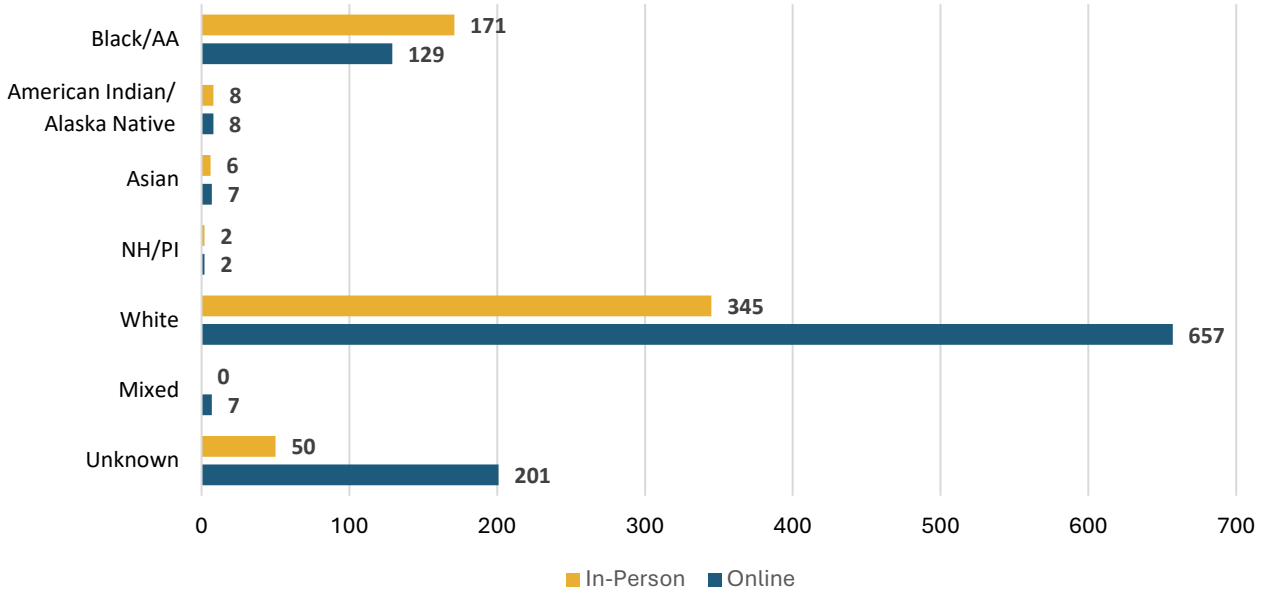


Fig. 12: CJI In-Person Trainings by Gender



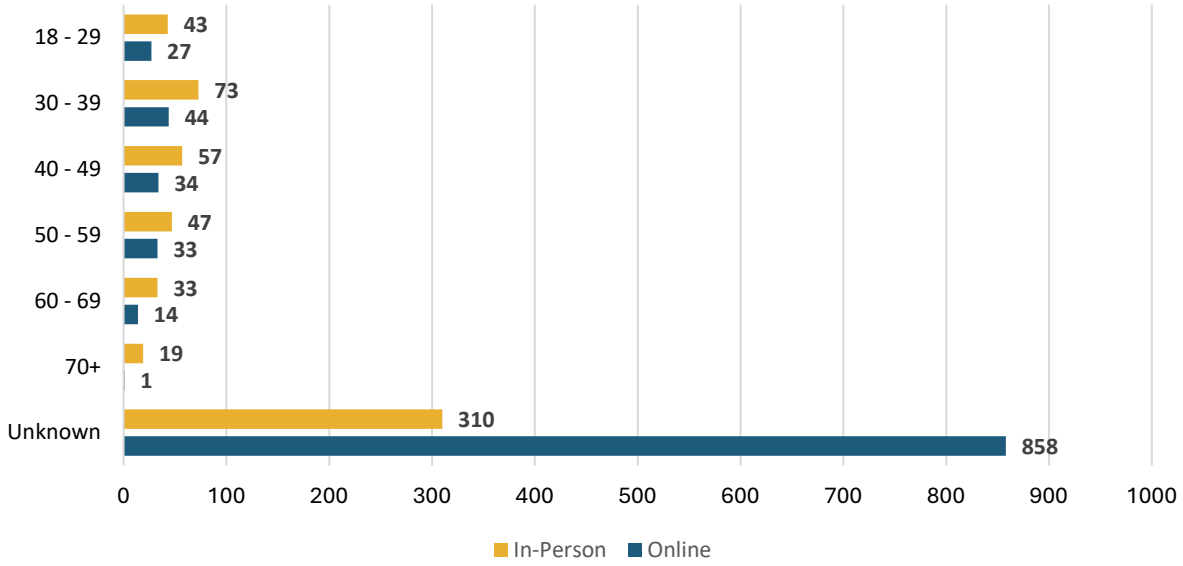
Two hundred-and-one (201) online trainees did not self-report their race. Of those that did, 657 (81%) were White, and 129 (16%) were Black or African American. For in-person trainees, 50 individuals did not self-report their race, 345 (65%) were White, and 171 (32%) were Black or African American (32%).

Fig. 13: CJI Trainings by Race



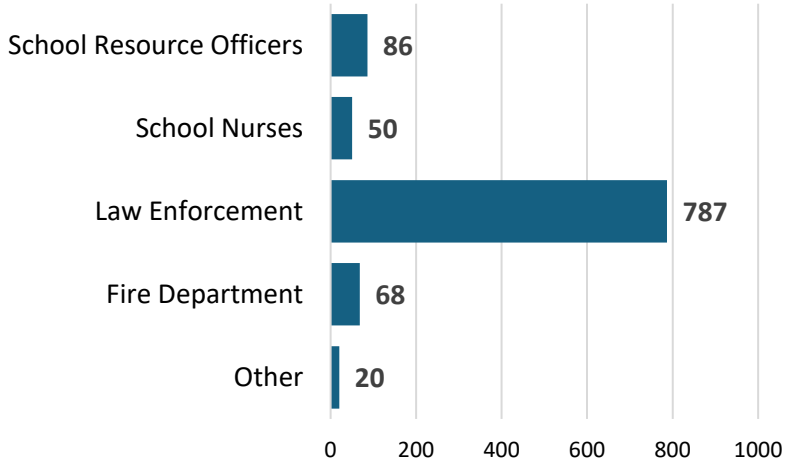
The majority of trainees did not report their age. Of those that attended online that did report, 44 (29%) were between 30-39 years of age, and 34 (22%) 40 – 49 years of age. For those that attended in-person, the majority (70 attendees; 27%) that reported their age were between 30 and 39 years of age.

Fig. 14: CJI Trainings by Age



Most of the 1,011 online trainees were law enforcement (787 attendees; 78%). Individuals included in the Other (20 trainees; 2%) category were first responders (15), library staff (4), and coroner (1). The vast majority of online trainees (997 trainees; 99%; 7 did not report) reported feeling somewhat to extremely confident in administering Naloxone, while 98% (986 trainees; 22 did not report) reported that accurately recognizing opioid overdose symptoms is somewhat to very useful.

Fig. 15: CJI Online Trainings by Occupation

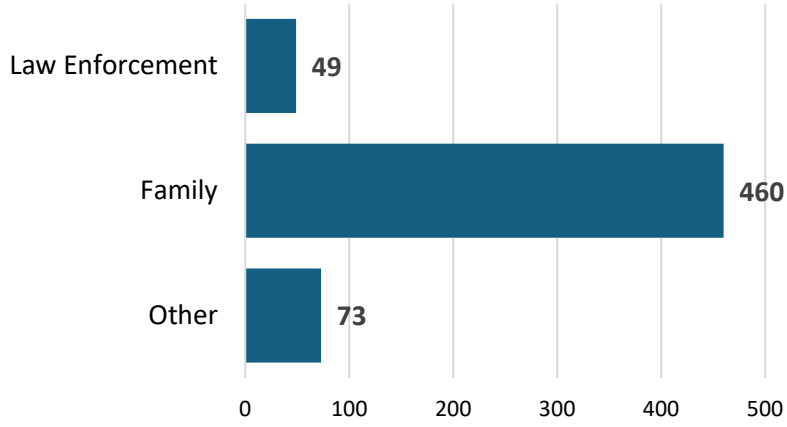


CJI
98% of online trainees reported that recognizing overdose symptoms is useful

CJI
99% of online trainees reported feeling confident in administering Naloxone

Five hundred eighty-two (582) people attended in-person training. The majority of in-person trainees were family or friends of people at risk for an overdose (460 trainees; 79%), Eight percent (49 trainees) were law enforcement. Individuals in the Other category (73 trainees) were first responders (40) and library staff (33), making up 13% of in-person training. The overwhelming majority of online trainees (546 trainees; 94%; 36 did not report) expressed feeling somewhat to extremely confident in administering Naloxone. Additionally, 96% (558 trainees; 24 did not report) indicated that accurately recognizing opioid overdose symptoms is somewhat to very useful.

Fig. 16: CJI In-Person Trainings by Type of Individual



CJI
96% of in-person trainees reported that recognizing overdose symptoms is useful

CJI
94% of in-person trainees reported feeling confident in administering Naloxone

Quotes from Trainees: Naloxone trainees were very satisfied with the Naloxone training, and several gave feedback about their experiences.

Technical Assistance: CJI provided technical assistance to a variety of organizations including law enforcement departments, schools and school districts, fire departments, libraries, government and health agencies, and churches. The technical assistance was most often about Naloxone replacements, refills, and/or training registration.

TECHNICAL ASSISTANCE

164

Assisted

MEDIA

Facebook: CJI used SOR III funds to boost Facebook posts. These posts included messaging about events such as the Rx and Illicit Drug Summit, Striking Out Opioid Abuse Day, Drug Takeback Day, and community roundtables. They also included messaging about drug disposal sites, Naloxone, signs of overdose, the dangers of fentanyl, and stopping the stigma of addiction. Eight roundtable events were livestreamed from the Facebook page.

FACEBOOK BOOSTED POSTS

Post Impressions	1,218,600
Clicks	18,982
Livestream Views	2,615

Radio: Radio advertising was used to announce events such as the community roundtables.

RADIO ADS

193,400

Impressions

Newspaper: CJI ran several newspaper ads in Sevier, Fulton, Clark, Nevada, Newton, Yell, and Lafayette, as announcements for events such as the roundtables.

NEWSPAPER ADS

18,850

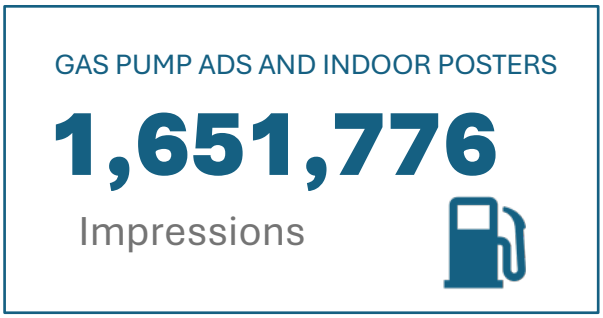
Impressions

Billboards: CJI funded several billboards in counties throughout the state, resulting in over 15 million impressions during the reporting period. The billboards included messaging about the NARCANsas website and "Save a Life From Opioid Overdose. Carry Naloxone."

Table 6: CJI Number of Billboard Impressions

Billboard Location	Impressions
Searcy County	1,098,000
Conway County	5,102,300
Grant County	736,542
Columbia County	1,494,312
Howard County	779,056
Little River County	2,650,600
Polk County	2,002,160
Fulton County	159,393
Dallas County	791,658
Yell County	662,739
Total	**15,476,760**

Gas Pump Ads and Indoor Posters: Gas pump ads and indoor posters with messaging about Naloxone resources and the dangers of fentanyl were also part of CJI's media campaign. The ads were on display in Monroe, Bradley, Phillips, and Prairie Counties from April through July of 2024.



EDUCATIONAL ACTIVITIES

Pharmacies: Pharmacies in targeted counties were identified by CJI to distribute health literacy materials regarding opioid use and misuse, Naloxone, fentanyl, and more. Since January 2024, a total of 20 pharmacies were visited by CJI personnel.

Table 7: CJI Pharmacies Visited by County

County	Pharmacies Visited
Sevier	2
Fulton	4
Yell	5
Lafayette	1
Dallas	2
Newton	1
Clark	3
Perry	1
Nevada	1
Total	**20**

Community Roundtables: CJI facilitated community-level prevention activities by organizing regional roundtable events. These events aimed to present the grant's strategic plan to citizens and key stakeholders, including existing coalitions, Regional Prevention Representatives, faith-based organizations, and community leaders. During the discussions, participants examined the impact of opioid misuse and overdose in their communities. Livestream videos are still available to watch after the original live airing.

Table 8: CJI Community Roundtable Presentations

County	Month	Attendees	Views
Fulton	February	21	115
Perry	March	448	322
Clark	March	8	593
Nevada	May	18	125
Newton	June	38	234
Yell	July	22	490
Lafayette	July	21	122
Sevier	August	28	635
Total		**604**	**2636**

PREVENTION

UALR SOR-P Prescriber & Primary Prevention Training for Opioids and Over-the-Counter (OTC) Drugs

The UALR SOR-P project addressed the issue of opioid over-prescription and its consequences through education, training, and targeted interventions. These efforts engaged both the broader community and specific groups such as prescribers, healthcare professionals, early childhood staff, and parents. A key focus was expanding access to safe-storage materials for early childhood programs and Kinship and Resource families caring for foster youth. Additionally, the project addressed the misuse of over-the-counter (OTC) medications, which have received less attention than prescription drugs and may be perceived differently by users. Funds for this program also supported education to healthcare providers regarding information on opioid risks and best-practices.

Program Goals	Program Highlights
▪ To provide education to prescribers and the aftereffects of over-prescription. ▪ To train medical professionals, organizations working with children, and in-home service providers on safe storage and safe storage boxes. ▪ To focus on neonatal/infant care for opioid withdrawal syndrome.	▪ In-home providers have been contacted and have been receptive to program. ▪ The virtual platform for the nursing conference increased attendance by 100-150%.
Program Successes	**Program Challenges**
▪ Proud of the relationship with Division of Child and Family Services (DCFS) – organization can now have Naloxone. ▪ Virtual component of nursing conference was successful.	▪ Staff changes were a challenge. ▪ Lost a partner and had to reallocate funding to other contractors ▪ Some funding could not be utilized and direction on implementing portions of the program were unclear.

UALR SOR-P Prescriber & Primary Prevention Training for Opioids and OTC Drugs Administrative Data

MEDIA

The SOR-P program funded television and online media campaigns from October 2023 to September 2024. These advertisements directed audiences to the PreventionAR website, which offers numerous resources, including prevention information, a directory of prevention providers and partner agencies, training on various substances, data resources related to prevention, and opioid education specifically tailored for college students, including Naloxone training and overdose recognition. Collectively, the ads generated a total of 6,299,575 impressions.

TELEVISION ADVERTISING

4,789,200

Impressions

ONLINE ADVERTISING

1,510,375

Impressions

Television Advertising: During the campaign period, prevention-related television advertisements achieved 4,789,200 impressions.

Online Advertising: In addition, the SOR-P program launched online ads in September 2024, which garnered 1,510,375 impressions.

EDUCATIONAL VIDEO SERIES

The SOR-P program, in collaboration with the Department of Family and Preventative Medicine developed a four-part video series focused on screening, counseling, and treating adults and youth with mental health and substance use concerns, as well as addressing the opioid epidemic and alcohol misuse harm reduction. The series also covered the effects of the COVID-19 pandemic, the use of substances as coping mechanisms, and behavioral communication.

Table 9: Department of Family and Preventative Medicine Videos

Video Title	Views
Detecting and Addressing Youth Substance Use Concerns	54
Mental Health and Substance Use	55
Harm Reduction for Opioid Use Disorders	80
Understanding and Addressing Alcohol Misuse: Harm Reduction Strategies	67
Total	**256**

The videos, hosted on the Department of Family and Preventative Medicine website, offer viewers the opportunity to earn two CME credit hours (0.5 hours per video). Posted in August 2024, the series has garnered a total of 256 views as of October 2024, with "Harm Reduction for Opioid Use Disorders" receiving the highest number of views.

2024 MidSOUTH NURSING CONFERENCE

NURSING CONFERENCE

301

Attendees

The SOR-P program organized the 2024 MidSOUTH Nursing Conference, which took place on June 21, 2024. As part of the event, a custom-branded MidSOUTH app was launched, developed using EventMobi software, and made available for free download on both the Apple App Store and Google Play Store. Attendees utilized the app to engage with the conference and were provided access codes for the Skyscape Medical Library, as well as a digital copy of "Chronic Pain: The Patient and Family Journey" by Alaa Abd-Elsayed.

Continuing Education Units (CEUs) for the conference were approved by the National Association of Social Workers, and the Arkansas State Nursing Licensing Board confirmed their acceptance of these CEUs for Arkansas nurses. Key session topics included Neonatal Opioid Withdrawal Syndrome (NOWS), Substance Use Disorders and Childhood Adversity: A Cycle of Trauma, Garrett's Law, and Implicit Bias.

FAMILY MEDICINE SPRING REVIEW CONFERENCE

The SOR-P program hosted the Family Medicine Spring Review Conference, offering attendees up to 2.5 hours of Continuing Medical Education (CME) focused on opioid use disorder (OUD). The conference attracted a total of 599 attendees over the course of two days. Sessions covered essential topics, including the integration of care in recovery settings, safe opioid prescribing practices, and strategies for reducing the potential for misuse.

Table 10: Family Medicine Spring Review Conference

Session Title	Date	Number Registered
Integrated Care: The Weave of Addiction Recovery	April 24, 2024	302
Opioid Stewardship	April 25, 2024	297

SAFE-STORAGE CONTAINERS

The SOR-P program distributed 5,554 safe-storage containers of differing sizes to daycares, HeadStart programs, and other agencies throughout the state of Arkansas.

SAFE-STORAGE CONTAINERS

Large Boxes	4651
Small Boxes	319
Bags	584
Total	**5,554**

DISPOSE Rx BAGS

The SOR-P program collaborated with the Department of Family and Preventative Medicine to distribute "Dispose Rx Bags" with drug-neutralizing agents and informative leaflets to Arkansas pharmacies. Each case contains 1200 units of the drug-neutralizing agent. Twenty-nine cases (34,800 units) were distributed to 28 pharmacies throughout the state.

DRUG-NEUTRALIZING AGENTS

34,800

Units

PREVENTION

Opioid Prevention for Aging and Longevity (OPAL) Narcan Project

The Opioid Prevention for Aging and Longevity (OPAL) Narcan Project, initiated by the UAMS Donald W. Reynolds Institute on Aging (RIOA), aimed to educate seniors, caregivers, healthcare professionals, and at-risk populations across Arkansas. The program provided Naloxone kits and comprehensive education on Naloxone use, safe prescription opioid practices, potential side effects, and non-opioid alternatives for pain management. Educational outreach was conducted through individual contacts via in-person meetings, phone calls, and emails, as well as group training sessions held onsite or virtually at health centers, churches, and community organizations. OPAL also engaged with the community through health conferences and events to disseminate current information regarding opioids and Naloxone for individuals aged 65 and older. To further its mission, the program employed a media campaign that promoted alternative pain management strategies and raises awareness about opioid use disorder and overdose. This campaign included webinars, billboards, bus advertisements, newsletters, posters, and an active presence on social media platforms such as Facebook.

Program Goals	Program Highlights
▪ To educate the older adult public about adverse effects of opioids and safely treat pain. ▪ To educate providers about prescribing opioids to older adults and alternative pain treatments.	▪ The clinic is the largest outpatient geriatric clinic in the country and the program has had a nationwide impact on geriatrics. ▪ The program has distributed educational materials in every single county in Arkansas. ▪ The program employs an outreach coordinator who travels across the state to perform statewide education.
Program Successes	**Program Challenges**
▪ Materials have been distributed in ERs across Arkansas. ▪ Program directors feel that program's outreach has been fairly effective. ▪ Stigma toward opioids and Naloxone has been somewhat reduced (as seen in qualitative study).	▪ Unable to effectively reach older adults with visual and auditory disabilities. ▪ Since the pandemic, the program has been unable to offer classes for alternative pain management methods such as yoga classes and acupuncture. ▪ Rural areas are hard to reach. ▪ Difficult to reach Marshallese, Vietnamese, and homeless population.

Opioid Prevention for Aging and Longevity (OPAL) Narcan Project Administrative Data

OPAL
3,487
Naloxone Kits Distributed

OPAL implemented a targeted distribution initiative for Naloxone, aimed at older adults, caregivers, and the communities and healthcare providers that support them. The program promoted accessible Naloxone kits by distributing them at health fairs, community events, churches, senior centers, and healthcare facilities.

Naloxone Training: OPAL facilitated Naloxone training sessions both in-person and virtually. In-person trainings were held at various locations, including senior centers, health clinics, home health agencies, churches, health fairs, and conferences. Additionally, OPAL provided one hour of continuing education credit for healthcare professionals attending either virtual or in-person training sessions, upon request.

Table 11: OPAL Types of Training

Type of Training	Total Trainings	Number Trained
In-Person Presentation	19	443
Onsite Visit	46	48
Vendor Booth/Conference	3	202
Vendor Booth/Health or Community Event	29	1132
Virtual Presentation	6	72
Other Type of Training	5	78
Total	**108**	**1975**

Whenever feasible, OPAL collected demographic information from participants to enhance program effectiveness; however, time constraints and varied levels of engagement among elderly participants often made collection challenging. Six hundred and twenty-two individuals (31%) out of 1975 trainees did not report their gender, 51% identified as female, and 18% identified as male. While nearly one third of trainees did not report their race (29%), the majority of those who did were Black or African American (51%) or White (43%).

Fig. 17: OPAL Naloxone Training by Gender

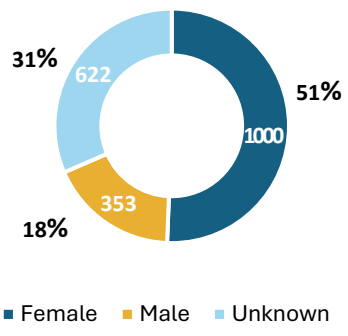
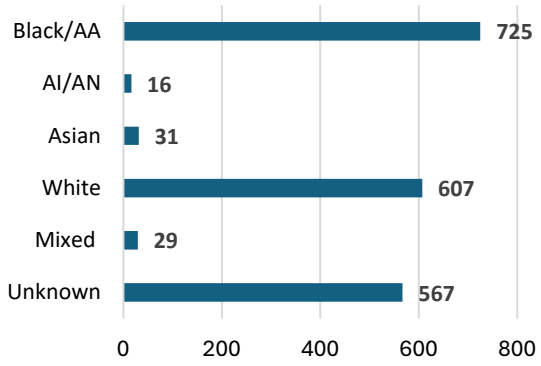
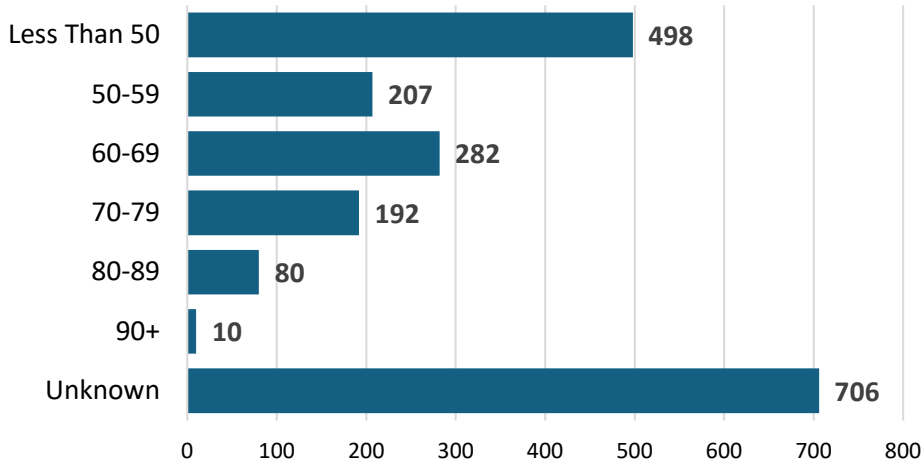


Fig. 18: OPAL Nalxone Trainings by Race



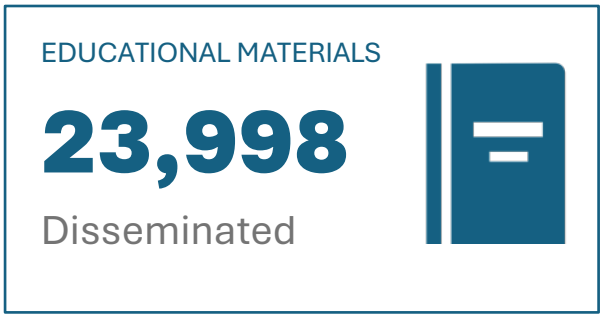
Because OPAL focused on older adults, their age categories began at less than 50 up to 90+. About one third of the trainees' ages were unknown. Of those that did report, the most frequent age was less than 50 (39%), the next most frequent age was age 60-69 (22%).

Fig. 19: OPAL Naloxone Training by Age



Quotes from Trainees: Naloxone trainees were very satisfied with the educational and training materials provided by OPAL. A number of trainees gave feedback.

Educational Materials: OPAL actively disseminated educational materials at every available opportunity, including events, Naloxone training sessions, and upon request via mail. The materials covered a range of topics, including the effects of opioids on older adults, the risks and side effects associated with opioid use, and information about opioid use disorder (OUD). Between October 2023 and August 2024, OPAL distributed a total of 23,998 educational materials. Additionally, these materials were translated into Spanish and Marshallese to ensure broader accessibility



MEDIA

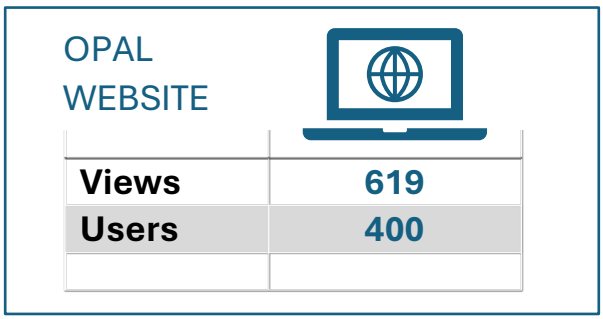
Billboard and Bus Advertisements: During the reporting period, OPAL funded media in both billboard and bus advertisements, resulting in millions of impressions each month. Messaging was targeted at older adults and included information about careful management and monitoring of opioid use are essential to prevent harmful outcomes.

Table 12: OPAL Media Impressions by Month and Type

Month	Billboard	Bus Ad
December 2023	6,785,258	2,223,511
January 2024	18,888,533	2,223,511
February 2024	38,144,509	2,181,432
March 2024	55,444,604	2,183,766
April 2024	67,829,401	2,255,806
May 2024	0	2,130,978
June 2024	0	2,150,336
July 2024	0	2,130,422
August 2024	62,683,341	2,237,018
September 2024	70,052,156	2,189,681
Total	**319,827,802**	**21,906,461**

Web Page and Facebook: OPAL created a page on the UAMS Institute on Aging website in English and Spanish (https://aging.uams.edu/outreach/o-p-a-l/), with information about opioids and aging, including side effects, risks, and alternatives to opioid medication. OPAL's webpage had 619 views with 400 users from October 2023 through September 2024.

During this same time period, OPAL created a facebook page with posts directed at older adults describing the risks and side effects of opioid use.



June 12, 2024

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

Qualitative Study #2

Results from Interviews with Opioid Prevention for Aging & Longevity (OPAL) Staff in SOR III Sponsored Programs

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UNIVERSITY OF WYOMING

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Executive Summary

The SOR III Opioid Prevention for Aging & Longevity (OPAL) program evaluation assessed the experiences of educators and caregivers to older adults about opioid pain medication, opioid misuse, along with alternative strategies for managing pain (e.g., music or yoga).

The OPAL evaluation has two primary goals: first, to use data to enhance or improve OPAL program services as they relate to SOR III, and second, to document OPAL program challenges and successes. Researchers from the Wyoming Survey & Analysis Center (WYSAC) designed the evaluation and facilitated the interview sessions, visiting OPAL offices in Little Rock, Arkansas, in February and May 2024.

WYSAC researchers found consistent patterns in respondent answers. Interview participants suggested that due to the physical and cognitive challenges often encountered by older adults, information needs to be communicated to them differently compared to younger audiences. Moreover, while a strong stigma surrounding opioid use exists, most interview participants found older adults to be curious and receptive to opioid education and Naloxone use. All interview participants stated they felt that the OPAL program is a successful component of SOR III, and that Naloxone plays an important role in addressing problematic opioid use and opioid overdose. However, many participants indicated that Naloxone is not a "miracle drug" but only part of a broader set of tools needed to mitigate opioid misuse in Arkansas.

Background

The OPAL education and awareness program provides education and awareness training on the use and potential for misuse of opioids to adults aged 65 and older. Education and training includes suggestions for alternatives to opioids for pain management. Interview participants' interactions with older adults occur in clinical settings, large groups at a health clinic, and one-on-one at health fairs across Arkansas. OPAL provides and distributes educational materials related to opioid use state-wide, not just to likely patients, but medical professionals and community members as well.

OPAL program training for staff involves courses on addiction, stigma, and symptoms and treatment for opioid overdose from the Arkansas Criminal Justice Institute. This is in addition to ongoing continuing education courses on the use, administration, and importance of Naloxone, and workshops with experts on effective instructional strategies for teaching healthcare concepts to older adults. Staff members include both gerontologists, and specialists in geriatric medicine with prior training and experience with prescription misuse of opioids and signs of opioid

overdose before joining OPAL. Some respondents also see patients in a clinic that specializes in geriatric medicine and is affiliated with OPAL and the University of Arkansas for Medical Sciences (UAMS).

In September of 2022, DHS/OSAMH contracted with the University of Wyoming, Wyoming Survey & Analysis Center (WYSAC) to evaluate the SOR III program. The evaluation of the Opioid Prevention for Aging & Longevity (OPAL) program in various SOR III sponsored programs is part of the overall evaluation process. The University of Wyoming granted WYSAC researchers an IRB exemption, determining that individuals would experience less than minimal risk for participating in this research.

Methods

Structured interviews were used to collect qualitative data. WYSAC evaluators developed an interview instrument (Appendix A) containing prompts to help guide discussion about opioids and related topics. All interview participants were informed of their rights, and each signed a consent form (Appendix B) explaining the goals of the study and the interview format prior to participation. Contact information of a virtual counseling organization was also provided for participants if they experienced feelings of discomfort or distress resulting from discussing issues related to opioid use, opioid use disorders, and opioid overdose. All participation was voluntary, and participants could refrain from answering any or all questions and could end the interview at any time.

The interview research instrument listed questions asking for the opinions and experiences of individuals involved with opioid-related education of older adults. Interview prompts asked participants about their experiences and interactions with older adults and their caregivers at health fairs throughout Arkansas, their thoughts and experiences surrounding the use of opioids, the challenges and barriers related to teaching older adults about the potential for opioid misuse, perceived stigma surrounding opioid use and opioid use disorder and OPAL, notable successes, and their recommendations for improvement. Interviews lasted approximately 30 minutes and were held at OPAL offices in Little Rock, Arkansas, in a semi-private conference room.

Demographics of Participants

Demographics of interview participants are described in Table 1 below. There were seven interview participants: four women and three men. Five self-identified as White, one as Black,

and one as Asian. The youngest interview participant was 22, and the oldest was 72 years of age. The average age was 55.

Table 1: Demographics of Interview Participants (*n* = 7)

	Response Frequency	Percent	Mean	Range
Age	7	100%	55	22 - 72
Race				
White	5	71.4%		
Black	1	14.2%		
Asian	1	14.2%		
Ethnicity				
Hispanic/Latino	0	0%		
Non-Hispanic/Latino	7	100%		
Gender				
Female	4	57.1%		
Male	3	42.9%		

Analysis

WYSAC researchers and support staff transcribed the digitally recorded interviews verbatim. All personally identifying markers were removed from the documents during the transcription process to preserve confidentiality. Digital consent forms are stored in a password protected secure server. Paper consent forms are stored within a locked file cabinet at WYSAC offices. Content and thematic analysis using QDA Miner were used to determine patterns of responses that describe the experiences, opinions, thoughts, and recommendations of the interview participants.

Findings

How are teaching methods catered to older adults?

Many interview participants find that having shared experiences with older individuals is an effective teaching strategy. They also carefully consider the increased potential for cognitive impairment, sight and hearing impairment, and other age-related health issues. For instance, when teaching older adults interview participants may use visual aids, easy-to-read flyers, charts and figures, personal stories and stories about celebrities, and physical demonstrations of Naloxone kits.

- “I try to find common ground. And that's where my background as a home health nurse always came into play. If I'm talking to an electrician about the heart, I might talk about electricity. But if I'm talking to a plumber about the heart, I'm going to talk about pipes. So, when I'm talking to older adults, whether it's in training or at a conference where they're stopping by the table, I try to find some common ground. I'm a storyteller.”
- “I try to use simple, clear language and avoid medical jargon as much as possible. Visual aids are incredibly helpful – things like charts, diagrams, and demonstration kits for Naloxone. I also make sure to speak slowly and clearly, and I repeat important points several times. It’s also important to be patient and give them time to ask questions and process the information. Sometimes, I use stories and analogies that they can relate to, which makes the information more relatable and easier to understand.”
- “I think being in the senior population myself, but I've had the advantage of being a healthcare provider, I obviously understand it from a different perspective. But when we go out to teach it to the lay public and to seniors particularly, you just have to meet them where they're at and understand that in the lay public community of seniors, you can't give them medical terminology because it's just going to go over their heads and they're not going to understand it. So, you have to use plain language wording that they can understand, present it slowly, methodically, don't overstimulate them with too much information about it, but hit home on the point that Naloxone, Narcan is the only true antidote that we know of for opiate overuse and overdose.”
- “Teaching older adults requires patience and clarity. I use simple, straightforward language and avoid medical jargon. Visual aids are very helpful, so I often use diagrams or written materials that they can take home and review later. It’s also important to ensure they understand the information, so I always ask them to repeat back what I’ve told them or demonstrate how to use something, like a Naloxone nasal spray. Building a relationship of trust is crucial, so I take the time to listen to their concerns and answer any questions they may have.”

What differs about this process than when teaching other age groups?

Most interview participants had different teaching methods when teaching older adults versus younger adults. For instance, younger audiences understand technology more than older adults.

Younger Adults

- “Younger patients often have more familiarity with technology and are used to looking up information online. With them, I might direct them to websites or apps where they can learn more.”
- “With younger groups, you can often use more technical language and move at a faster pace. They might also be more comfortable with digital resources and interactive elements like quizzes or apps.”

- “I think we incorporate the same ultimate message, but the method is different. The method's a little bit different for seniors because you have to be a little bit more intentional with them. And again, bring it to their level.”

Older Adults

- “Well, I think with older adults, I'm an older adult myself, and I know some of the things that—older adults are more thoughtful. They're more likely to ask questions, pay attention, [and] read the materials. But they also may be like me; I have a hearing impairment. When I'm talking to older adults, I try to be cognizant of how loud I'm speaking. I do an approach I call ‘tell, show, and ask for a repeat back.’ That's the same method I always used when teaching people as a home health nurse. When we are at vendor fairs, people come up to the table. I take out our kit, I take the Narcan out of the kit, I show it to them, and I talk about why they need it. We have a little laminated card inside our kit that shows them what it's for and then how to get it …I go over it. We also do a survey that asks them some true or false questions. I find that's the easiest way to get people to respond.”
- “With older adults, I find that a more traditional approach works better – face-to-face communication, printed materials, and hands-on demonstrations.”
- “For older adults, face-to-face interaction is more effective. They appreciate the personal touch and the opportunity to ask questions directly.”

What are the advantages, disadvantages, barriers, and opportunities of teaching older adults?

Older adults are more likely to follow healthcare advice, listen to providers, and are generally curious, receptive, and appreciative of information and medical devices once they understand the importance of the information. Moreover, those in rural areas of Arkansas may require more patience when addressing stigma and pushback, and where a more extensive problem might be access to healthcare and prevention resources.

Advantages

- “Seniors, it takes a little bit of verbal massaging to get the message home to them. But once they get it, they get it, and they're very, very grateful. That's what I really find and for me is very rewarding.”

Disadvantages

- “One of the drawbacks with older adults is that people are often set in their ways. You want to provide a different perspective and give them the time and space to think about it without being pushy. Sometimes I see people multiple times at events. People who weren't interested last year are now because they've had more time to think about it. People who stop by the table are generally very curious and excited about having a new tool.”

Barriers

- "One barrier is the initial resistance or denial that there is a problem. Some older adults are set in their ways and reluctant to change their medication routines. There's also the issue of accessibility – not all pharmacies carry Naloxone, and not all patients can easily get to a pharmacy."
- "In rural areas, people are reluctant because they don't know you. You're an outsider. So, people would listen, but nobody would take a kit initially. Then one person sticks up a thumb, and the minute that happened, it was like an evangelism conference. Everybody wants a kit then."
- "One of the biggest barriers in Arkansas is that it's a rural state. When we first started talking about opioids, particularly to providers, everyone said, 'Hey, this is a problem in our area,' but they weren't connecting the fact that it's a problem for older adults. Occasionally, you'd run across an APRN who'd say, 'I inherited this patient who's been taking opioids and benzos for years,' and they're trying to get them off of them. But a lot of times, they don't immediately think of that."

Opportunities

- "On the other hand, there are opportunities in that many older adults are very receptive once they understand the risks and the benefits. They tend to follow medical advice closely, so once they are convinced of the importance, they are likely to adhere to recommendations."
- "The opportunities are plentiful. You know, I think we're really targeting a population that is very fertile ground. You know, there's nobody else out there that I know of that is delivering the message to seniors like we are through UAMS. …They are very receptive."

What common opinions have you found that older adults have about opioids?

Many older adults do not appear to understand the interactions that opioids may have with other medications, or the risks associated with their use. They assume because their opioid prescriptions are not obtained illicitly and are prescribed by their physician that they are safe to use.

- "Many older adults I've spoken with don't realize that they're taking opioids or that these medications can be dangerous. They often associate opioid misuse with illegal drugs or younger people. There's also a belief that if a doctor prescribed it, it must be safe. They don't always understand the risk of dependency or overdose, especially if they've been taking the medication for a long time."
- "It's easy for people to think that if the doctor prescribed it, they can't be harmed by it. 'If one pill will do me good, two will do me better.' I joke that older adults, especially in the rural South, are known for passing on their medicines. Their husband dies, they take it to the church potluck and pass it out to whoever might need it. People grew up in an environment of deprivation and don't want to throw anything away."
- "Many older adults don't realize they are taking opioids, or they don't understand the risks. They often believe that because a medication is prescribed by their doctor, it is completely safe. There's

also a stigma associated with opioids; some feel that admitting they use opioids or need Naloxone is an admission of weakness or addiction."

What about misconceptions?

There is significant stigma surrounding opioid use. Older adults associate it with illicit drugs and criminal behavior. Because they do not take opioids and are not a "druggy," an overdose will not happen to them or anyone in their family, and education about opioids and Naloxone is unnecessary. Older people also might believe discussing opioid misuse and Naloxone is akin to admitting weakness. Although, there is anecdotal evidence this stigma is slowly changing. There is also a lack of awareness concerning the potential for misuse of opioids even when prescribed by a physician.

> **"I'm not on any opioids, so I don't need this."**

Stigma

- "Some still associate opioids with 'street drugs.' There's a concern when they hear 'opioid,' unlike with other medications."
- "Generally, most people know someone who's overdosed. When I first started doing this, there was this reluctance. People would come by the table and say, 'Not my family. I don't take any opioids.' In fact, my husband is 77 years old. When he found out I was doing this job, he said, 'Opioids? Isn't that like street drugs? What does that have to do with older adults?' So, what I try to do is find common ground. Either they know someone, or you start talking about it in relation to the three potential people to be harmed. One is the older adult themselves, who may accidentally misuse their medications. Maybe they're taking medicines their physician doesn't give them. Maybe they're taking medications in combination that can increase their risk for overdose. Maybe they have liver or renal impairment which can affect that. So, their own risk for overdose. I have lots of stories about people I've known who have gotten into this situation. The second person at risk is the five-year-old child that grandma may be babysitting. As a home health nurse, I saw this all the time. People have their medicines out on the coffee table, bottles open, pill boxes open, and they're babysitting a small child. The third person is someone they may know who's shopping in their medicine cabinet."
- "Well, I think one of the misconceptions that they have out there is that 'Oh, I'm not a druggy. It's not going to happen to me.' When they don't understand that 'Hey, look at your medications. Let's take a look at what you're taking so that you understand if you are as an individual at risk or somebody in your household is at risk.'"
- "I like to address the stigma right away. As a nurse and educator, this isn't about calling you a drug abuser. It's about providing tools that could save a life. If you care for a grandchild, you'll need this tool. It's about talking to people where they are. When I first started, they didn't think about it, but now they are. You can see that change in mindset."

- "I tell them about the program and every once in a while, you'll get some that are, 'Oh, I'm not interested. I'm not on this medication,' or, and I don't know if it's their misperception that because of the fact that this particular drug class is a topic of abuse, sometimes they may associate it with drug addiction."

A Lack of Education or Awareness

- "Based on the surveys we give out with Naloxone kits; some misunderstandings include not knowing they don't need a prescription to buy Naloxone. Also, some are unaware of certain symptoms that could be side effects of the drug, whether abused or not."
- "Many older adults don't want to admit they're taking opioids, or they're ashamed to ask for help. It's important to create a non-judgmental environment where they feel safe to ask questions and share their concerns. On the flip side, there's a great opportunity to make a real difference in their lives. When they understand the risks and how to manage their medications safely, it can prevent a lot of problems."
- "One major misconception is that they can't get addicted because they are using the medication as prescribed. They also might not understand the potential for interactions with other medications they are taking, or the risks associated with long-term use."
- "One major misconception is that they think opioid misuse won't happen to them because they don't see themselves as drug users. They don't realize that taking more of their prescription than recommended or mixing it with other medications can be very dangerous. There's also a lack of awareness about the signs of an overdose and how Naloxone can help."
- "They think that it's not going to happen to me. But that's why we try to also deliver them the message that, yeah, it could happen to you. And having a kit readily available that someone might need to use on you is there, but it's that they think that overdosing is, you know, it's a subpopulation of drug users and abusers that are out there using it, and I'm never going to encounter something like that. But yet we encounter so many seniors at our events where we have first contact with them. And they say, and I had a lady this weekend at the Black Expo that said, you know, she came to our table, and she says, 'Opiates destroyed my family.' She says, 'My daughter and my son, their lives have been ruined because of it.'"

How do you address these misconceptions?

Many interview participants use education and awareness, including visual aids and hands-on demonstrations, to illustrate how opioid use and misuse can occur within the older adult population. One example is that Naloxone, much like a fire extinguisher, is useful for themselves and friends and family in a life-or-death crisis. This is true even if they personally do not take opioids.

- "I tell them that you don't need to be addicted for this to impact you. It's about education and awareness. Having information and a Naloxone kit can be useful in emergencies."

- “Education is key. I spend a lot of time explaining how opioids work, why they can be dangerous, and the importance of following the doctor’s instructions exactly. I also provide information about the signs of overdose and demonstrate how to use Naloxone. I use a lot of real-life examples and stories to illustrate these points, which helps to make the information more concrete.”
- “I explain that anyone taking opioids can be at risk of overdose, not just people who are addicted. I also clarify that Naloxone is a safety measure, like having a fire extinguisher, and demonstrate how simple it is to use. Providing printed materials, they can take home and discuss with their family also helps to reinforce the information.”
- “Again, it's finding common ground. Once they realize you're not just talking about them individually but about family members they know or friends, they begin to see that you're not calling them a drug abuser. It just takes persistence.”
- “I will tell them, you know, you don’t necessarily have to be in a situation where you’re addicted for this to impact you in some way…I kind of tell them, even if you don’t have a prescription for an opioid and you don’t take opioids, aside from that, having the information and having a Naloxone kit, it can turn out to be useful because you never know when you may need to help somebody, whether it’s an intentional or unintentional overdose.”
- “It literally is a first aid for somebody that you suspect that they might suspect is overdosing, and that they're not going to hurt anybody by using Naloxone. And that's really kind of the message I try to get out to them. And even if they aren't users of opiates and narcotics themselves, there might be family members that they might have to use it on or a neighbor that may come to them in a panic, and they could save a life.”

Do you get pushback when addressing these misconceptions? How do you address that?

There is some pushback especially surrounding the stigma related to opioid use. However, most interview participants feel that it is minimal.

- “A few people just don’t want to hear it, which could be due to time constraints or stigmatization, but it’s rare. Usually, when I explain further, they’re receptive.”
- I had one lady this weekend that was walking past our table, our booth. I shouldn't say never [get pushback] because there's always that little fraction of 1%. I invited her to the table, ‘Can I interest you in a free Naloxone rescue kit?’ And she said, ‘My husband and I don't take those kinds of things.’ And she was very polite about it. And on she walked. And you know that just happens, but that's such a small fraction, and that's the reason I can remember that stuff because it happens so rarely it stands out.”
- “The only pushback is ‘I don't take opioids; I take what's prescribed,’ not realizing their prescriptions could have opioids.”

- "Uh, I haven't noticed, not really, no. I mean, there's been a few that just don't want it. Just, you know, and I don't know if that's because maybe they don't have time to hear it, or it could just be they're not interested. Or it could be they're still stigmatizing it with addiction….So I, you know, I can't tell. But it's not often. Usually when I explain to those few who kind of, you know, shrug off the information, you know, I go into details and they're receptive to it after that. Only a few that are not."

How do you discuss opioid misuse?

Interview participants discussed opioid misuse by individuals associated with patients and other older adults, for instance other family members. Older adults often do not understand the risks and consequences associated with opioid use. For instance, older adults often do not realize the strength of their current opioid prescription. They also may forget when opioids were last taken and mistakenly overmedicate. Some interview participants discuss the use of daily pill containers, to prevent inadvertent misuse.

- "I think the best way to discuss it is in the context of either my personal stories or the stories of people I've come into contact with. When I was a home health nurse, I saw how people took care of their medicines and their kids. I saw different situations that could arise. Relating those stories to people is important. People are more apt to listen and take something in if they realize you've had personal experience with it. With opioid misuse, it's such a hot topic right now. It's on everybody's mind, but they may not realize how it affects them or their family members personally. When you tell them a story, they think, 'That could happen to me.' That's the best way to approach it."
- "Well, with our target group, I mean, we don't see so many people who are addicted, I guess I could say. I'm sure there are cases where there's addiction without knowing they're addicted. But in most cases, I think, you know, I just, like I said before, I talk about this and about forgetting medications and things that can happen….You know, maybe someone is babysitting, and they leave the medication out and a two or three-year-old gets into the medication somehow if they left it open or whatever."
- "With our target group, we don't see many people who are addicted, but I talk about forgetting medications and potential dangers, like leaving medication out where children can get it."

How do you introduce Naloxone?

A demonstration on how the device to administer Naloxone works is common. Interview participants explain to their clients how the risks are low (i.e., someone cannot overdose on Naloxone or Narcan) and show that instructions in the kit are easy to understand. They introduce it as a useful tool in an emergency, explaining that opioid overdoses can occur unexpectedly, and that Naloxone could possibly save a friend or family member's life.

- "I'm just very blunt with it. I just tell them Naloxone is an antidote for opiate overdose. It's the best thing we've got going. If somebody that you suspect is in an overdose situation, it's easy to use. It's a nasal spray now and we're going to give it to you. This is something that you can give someone and it's not going to hurt them a bit. If they're not in an overdose situation, you're not going to hurt them by giving it to them. So that's how I kind of just bring it to their attention."
- "It's really just a matter of showing them the kit and telling them how easy it is to use. We show them the kit, show them how easy it is to use, and tell them it's just a nasal spray, not an injection anymore. We have a little card that shows them step-by-step how to use it. I think that really helps. It's just a matter of persistence and talking to people over and over again until they understand it."
- "I ask them first of all if they've heard of Naloxone or Narcan, if they understand what it is, how it works, and what it's for. Um, and then I go into explaining what it's for if they don't know and kind of explain about how to use it and when to use it. And I will show them the kit that we make and we have a card, a laminated card that has the instructions inside of the kit."
- "I usually start by explaining what Naloxone is and how it works. I emphasize that it's a life-saving medication that can reverse an opioid overdose. Then, I demonstrate how to use it, step by step, with a trainer kit. I also provide written instructions and make sure they understand that they can't hurt someone by using Naloxone – it's safe to use even if they're not sure whether the person is overdosing."

Have you found that older adults have heard about Naloxone?

Interview participants reported mixed results. Some older adults have not heard of Naloxone, while others have heard of it, but do not have hands-on experience. Some ask for Naloxone at health fairs and conferences.

- "Some have, but many have not. Those who have often have a limited understanding of what it is and how it works. Increasing awareness is a big part of my job."
- "With the epidemic, some may have heard of it but not know what it is. Many haven't heard of it yet."
- "Yes, there's a lot more awareness out there. Even in the past year, I've noticed in contacting seniors, you know, when we first were rolling this out, a lot of people didn't know. They haven't heard of that. They didn't know what it was. Now we go to conferences and events and expositions and they're like, 'Oh yeah, you're going to give one to me? You're going to give me a kit?' Absolutely. So yeah."

  "It seems no, they've heard of it, but they don't really know how to use it. I think that's a big thing. Um, and that they, you know, it seems probably, um, if I had to guess, I would say maybe 70 or 80 percent have heard of it. Um, this is just a guesstimation, but of those people that have heard of it, not too many of them really know how to administer it. And so, and that's going to be, I have to explain to them how it works and how they administer the drug."

Are older adults receptive to Naloxone?

Yes, most are receptive, although initially they might be hesitant, because of the stigma associated with opioid use, or unclear about its purpose. However, once interview participants understand how it works, and why it is important to have it case of emergency, they are open to its in use.

"One of the stories I like to tell…an 80-year-old patient who saved her granddaughter's life with a Narcan kit…."

- "I think they are becoming more receptive. At first, there was a lot of resistance because they didn't understand it or why they needed it. Now, they are starting to see that it is a necessary tool that can save lives. The more we talk about it, the more receptive they become. It's just a matter of education and getting the word out there."
- "Initially, there's often some hesitation. They might think they don't need it or that it's only for drug addicts. But once I explain that anyone taking opioids is at risk of overdose and that Naloxone could save a loved one's life, they usually become more open to it. Hearing stories about other older adults who have used Naloxone successfully can also be very persuasive."
- "Generally, they are receptive once they understand the importance of it. At first, there might be some hesitation, especially due to the stigma associated with opioid use. However, once I explain that it's a precautionary measure and show them how easy it is to use, most are willing to have it on hand. They often appreciate the peace of mind it brings, knowing they have a way to respond in an emergency."
- "Most are receptive. They take it seriously because of the opioid problem in the country. They know older people often take opioids for chronic pain."
- "Yes. Yes, they are receptive to it. And why? Because I think so many seniors have in their lives been touched by an overdose situation. They have kids. They have grandkids that have been involved in drug use and so they understand the importance of it."

How do they respond to administering Naloxone?

Older adults are comfortable with Naloxone use, or quickly become comfortable with using it and respond positively. Many older individuals at health fairs are surprised at how easy it is to use and appreciate the clear instructions on a laminated card.

- "They respond very well. Once they see how easy it is to use, they are very receptive. The more we talk about it, the more they understand it, and the more willing they are to use it. It's just a matter of education and getting the word out there."

- "Generally, they're very responsive. They appreciate the hands-on training and the opportunity to ask questions. Once they see how easy it is to use, their confidence grows. I've had many older adults tell me they feel empowered knowing they have the knowledge and tools to save a life."
- "They're responsive but sometimes afraid they might give too much of the medication. We have to explain that it's safe and they can't harm anyone by administering it."
- "They are usually quite responsive. I take the time to ensure they are comfortable with the process. Hands-on demonstrations are very effective, and I always encourage them to ask questions. Providing them with the opportunity to practice with a demo kit helps build their confidence."
- "I think they're really comfortable with it. When they understand how easy it really is to use now that it's in a nasal spray formulation. You know, when I first got into medicine, and this is going back, you know, 40 plus years, you could give it as an injection. That's how it was. It was only in the ER. So, we've come a long way. People are obviously, an 83-year-old woman did it for her granddaughter. So, making it available, and not only, you know, so there for a while it was by prescription and then it was non-prescription, but they had to pay for it. But now they don't even have to pay for it. I mean, it's just, it's just amazing. It's sad on the one hand that we've come to that, but it's also great because now I tell people you can save a life. And I think the data is proving that the statistics are showing that, at least for Arkansas."

What is the overall opinion that Naloxone can play in reducing problematic opioid use, opioid use disorder (OUD), and potential opioid overdose in older adults?

Every interview participant felt that Naloxone could play an important role in reducing opioid misuse. However, interview participants also believed that it was only part of the solution, and that it is most useful in conjunction with education and awareness about the potential consequences related to opioid use.

- "I think it can play a very significant role. It can save lives and prevent many of the issues we see with opioid use in older adults. The more we talk about it, the more we educate people, and the more we get the word out there, the more lives we can save. It's just a matter of persistence and continuing to talk about it and educate people."
- "Well, I think it can definitely prevent deaths. Um, now that's probably the biggest thing. Um, it could probably also, I assume, it could probably, perhaps, um, for someone that has an opioid use disorder, it could wake them up, perhaps if they were to overdose and have that administered, and then it may make them aware that they have a problem. Um, and I think it could, in that sense, it could, um, it's useful."
- "I think Naloxone is an incredibly important tool. It's not a solution to the opioid crisis on its own, but it's a crucial part of the overall strategy. By providing Naloxone and educating older adults about its

use, we can prevent overdoses and save lives. It also opens up a conversation about opioid use and safety, which is essential for reducing stigma and encouraging safe practices."

- "Naloxone is a crucial tool in reducing opioid-related harm. It provides a life-saving intervention that can prevent fatal overdoses. In older adults, who may be at higher risk due to multiple medications and potential for misuse, Naloxone adds an extra layer of safety. It's an important part of the broader effort to manage opioid use and prevent misuse and overdose."

Do you feel that the OPAL program is successful in educating older adults on opioid misuse?

Every interview participant strongly felt the program was successful. Several participants gave empirical evidence to support their opinions (e.g., the number of Naloxone kits distributed). Others noted the positive feedback they have received from community members.

- "I do. I think it is working. We are making a difference, saving lives, and changing minds. The more we talk about it, the more we educate people, and the more we get the word out there, the more we can make a difference. It's just a matter of persistence and continuing to talk about it and educate people."

- "Yes, I do. The feedback we receive is overwhelmingly positive. Older adults often tell us that they feel more informed and better prepared to manage their medications safely. We've also seen a noticeable increase in the number of Naloxone kits being distributed and used effectively. It's a continuous effort, but I believe we're making a significant impact."

- "I think it's working in raising awareness and education about the situation. People may have heard about it in the news, but we provide detailed information that can reduce anxiety and misunderstanding. Understanding is the first step in solving a problem."

- "Yes, because of the feedback we get in presentations. People interact and share experiences, and clinicians see the potential benefit. The older they get, the more medications they might be on, and Naloxone helps mitigate the risk of overdose."

- "I think that it's working in that more people are becoming aware and educated about the situation. They've probably heard so much about it in the news, but, you know, a lot of times the news, after you're aware of it and it just continues, you hear the same thing every day, it just generates a lot of anxiety, I think. So, it doesn't really get into how can we fix this? So I think in that sense, I feel like we're doing that. We're kind of, perhaps people have more understanding which could maybe relieve some of their worries or anxieties if they have any misunderstandings. And in that sense, I think it will help. Because understanding something is the first part of solving a problem."

- "Yes, I do feel it's working. I've seen a lot of positive responses from patients and their families. Education and awareness are increasing, and more people are carrying Naloxone. The feedback I

receive indicates that patients feel more informed and empowered to manage their medications safely. There's always more work to be done, but I believe we are making a significant impact."

Conclusions

Many older adults encounter unique challenges that impede their ability to communicate effectively compared to their younger counterparts. Interview participants noted they employed different teaching strategies when engaging with older adults, including the utilization of visual aids, hands-on demonstrations, storytelling, and minimizing medical jargon. Conversely, technology proves more effective in communicating ideas to younger audiences. However, interviewees also observed that older adults tend to pose more questions and exhibit a greater inclination to adhere to medical advice than their younger counterparts.

There exists a significant stigma surrounding opioid and Naloxone usage, necessitating early intervention. Individuals harboring strong negative sentiments towards opioids often perceive Naloxone as unnecessary. Interview participants noted that multiple outreach attempts are frequently needed, particularly in rural areas of Arkansas, before individuals become receptive to educational messages and Naloxone usage. While some have been exposed to information about Naloxone, others remain uninformed. Respondents interviewed said most older adults have no direct experience with Naloxone usage.

After understanding that minimal risk is associated with Naloxone and its user-friendliness, most older adults displayed receptiveness or curiosity towards it. Some individuals have been personally impacted by opioids, leading them to inquire about Naloxone kits at conferences and health fairs. All interview participants felt the OPAL program was successful, viewing Naloxone or Narcan, coupled with educational initiatives and training programs, as effective tools for combating opioid misuse and overdose.

Observations and Recommendations

- **Continue to develop a stronger presence in rural Arkansas, particularly engagement with community health centers.** A continued presence in rural parts of Arkansas would benefit patients who lack access to resources and medical support.
- **Create a "train-the-trainer" program that includes older adults willing to educate others in their cohort about opioids, opioid misuse, and Naloxone.** Numerous research has shown

that peer-to-peer teaching is often the best method for learning and retention. Forming an older adult training program also has another potential benefit of promoting and enhancing social interaction among this cohort.

- **Continue to research effective teaching strategies for adult and senior populations.** Older adults may be experiencing cognitive, physical, and psychological changes that negatively impact their ability to learn and/or retain information. Identifying age-appropriate teaching strategies can help address the challenges inherent in communicating with and teaching this population.

Appendices

Appendix A

UAMS REGIONAL CLINIC MEDICAL PERSONNEL AND STAFF
INTERVIEW INSTRUMENT

Hi, my name is _____, and I will be your interviewer for this DHS/OSAMH research project.

We would like to talk to you about your experiences teaching older adults about opioid misuse, the appropriate use of Naloxone, and prescribing Naloxone to this demographic. We've invited you for an interview because you are either a *clinician or staff member* at a UAMS regional clinic. Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) aims to reduce unmet treatment needs and opioid-related overdose deaths by gathering information concerning the knowledge and use of Naloxone by older adults in the state of Arkansas. Everyone has somewhat different backgrounds and experiences and so your attitudes and familiarities with this topic will be slightly different. That's why it's important you tell us about your ideas and opinions – even if you might feel it may be different from what you think everyone else has to say. We don't expect everyone to have the same perspective, so if you disagree with something, don't be afraid to speak up. Often, we learn the most when people have different ideas about something.

Do you have any questions before we begin?

Introduction
To get started, why don't you tell me a little bit about your job and any training you received to teach older adults about opioid misuse and Naloxone?

Prompts for discussion
- How do you cater your teaching methods to older adults?
- Can you tell me about the process? What differs about this process than when teaching other age groups?
- Are there advantages? Disadvantages? Barriers? Opportunities?
- Since you started teaching, what common opinions have you found that older adults have about opioids? What about misconceptions?
- How do you go about addressing these misconceptions?
- Do you get pushback when addressing these misconceptions? How do you deal with that?
- How do you discuss opioid misuse?
- How do you introduce Naloxone?
- Have you found that older adults have heard about Naloxone?
- Are older adults receptive to Naloxone? Why or why not?
- How do they respond to training about administering Naloxone?

- What is your overall opinion of the role that Naloxone can play in reducing problematic opioid use, opioid use disorder (OUD), and potential opioid overdose in older adults?
- Do you feel that what you're doing is working? Why or why not?

Conclusion

The interviewer provides a short overview of the purpose of the study.

The goal of this interview is to gather clinicians and other trained professionals' experiences teaching older adults about opioid misuse, the appropriate use of Naloxone, and prescribing Naloxone to this demographic. The information that you provide will help the Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/ OSAMH) gain a better understanding of how to reduce unmet treatment needs and opioid-related overdose deaths in the state of Arkansas. This interview is one data collection method we are using to gather information.

Is there anything anyone would like to add that we haven't covered?

Thank you for participating in the interview. We appreciate you taking the time out of your day to be part of our study.

Appendix B

CLINICIANS AND STAFF INTERVIEW INFORMED CONSENT

Thank you for agreeing to participate in this interview. We are speaking with you because of your role as a clinician or staff member of a UAMS regional clinic. The purpose of this interview is to find out about your experiences teaching older adults about the appropriate use of Naloxone and prescribing Naloxone to this demographic. The Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) aims to reduce unmet treatment needs and opioid-related overdose deaths by gathering information concerning the knowledge and use of Naloxone by older adults in the state of Arkansas. Interviews are one data collection method we are using to assess to gather this information. This interview will take approximately 30-60 minutes. Your participation in this interview is entirely voluntary. You may choose not to answer any or all of the questions, and you may choose to end the interview at any time. Your answers will be kept confidential, and at no time will your name be attached to your answers or to any of the data collected through this discussion.

We will be reporting the results of the interviews in aggregate. While I may capture some meaningful quotes, they will not be connected to any individual. I am interested in both majority and minority viewpoints, as well as common and uncommon experiences. I will not be upset by critical commentary, nor will that count as a strike against you, so please do not hold back even if you feel your comments may be discouraging. I am interested in your experiences and opinions concerning opioid use and the distribution and use of Naloxone by older adults. After the interview, if you have feelings of discomfort or distress resulting from discussing this topic, a free virtual clinic is available through UAMS. If interested, please contact (501) 526 – 3563.

If you have questions about your rights as a research subject, please contact the University of Wyoming IRB Administrator, at (307) 766-5320. You may also contact Dr. Andria Blackwood at the Wyoming Survey & Analysis Center, at (734) 678-5428 for general questions about this project.

"My participation is voluntary and my refusal to participate will not involve penalty or loss of benefits to which I am otherwise entitled, and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled. I authorize the interviewer to use my verbal acknowledgement of this document as consent to be interviewed. I understand that a copy of this document will be emailed to me for my records."

_____ Participant name

I consent to be recorded during this interview: □ YES □ NO

_____ Date

SOR III Treatment Initiatives

SAMHSA endorses evidence-based intervention methods for treating opioid use disorder (OUD). Strategies may include pharmacological, behavioral, or psychosocial approaches, as well as specific forms of therapy. SAMHSA promotes different forms of care and acknowledges that many care plans may require more than one form of treatment. Comorbidity of opioid misuse and mental health disorders occurs frequently, making an integrated approach combining MAT with behavioral therapy an important feature of treatment strategies. SAMHSA highlights the role of harm reduction for individuals at a high risk, which can include counseling and encouragement from support groups in addition to medication and psychiatric care. Evidence-based practices for OUD treatment include the use of MAT alone and in combination with therapy and counseling, and participation in long-term therapeutic groups such as sober living communities and support programs.

Arkansas' SOR III treatment activities include:

- Medication-Assisted Treatment (MAT)/pharmacy-led interventions
- Behavioral modification therapy
- Counseling
- Access to comprehensive wrap around services including housing, transportation, and education
- In-patient and out-patient treatment services
- Access to addiction psychiatric services

The following state agency and community organization programs participated in treatment efforts for Arkansas' SOR III Program:

- UAMS SOR Grant Emergency Department Services
- UAMS MATRIARC/Project Echo
- Arkansas Community Corrections (ACC) MAT Program
- UAMS MAT Justice Involved Program
- UAMS MAT Services

UAMS Emergency Department (ED) Services

The UAMS SOR Grant Emergency Department Services supported Arkansas hospital emergency department physicians and staff by providing education and training on Naloxone to reverse an opioid overdose. The program helped Emergency Departments establish protocols for pre-hospital use of Naloxone, management of OUD in the Emergency Department, and best practices for treating patients who have experienced an opioid overdose. Training consisted of four videos and is eligible for CME credits.

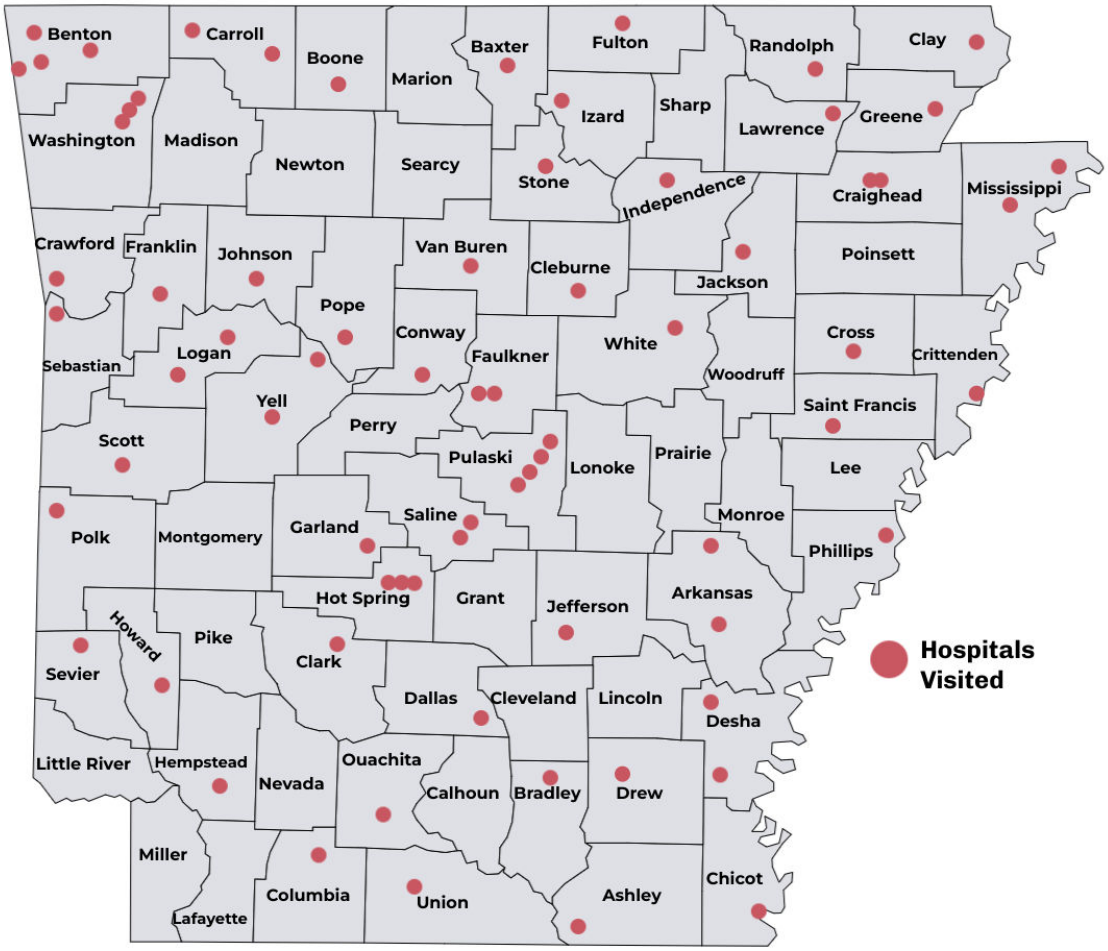
Program Goals	Program Highlights
▪ To assist hospital emergency rooms in treating opioid use disorder (OUD). ▪ To provide naltrexone and buprenorphine to agencies throughout the state.	▪ Educational videos are available on the websites of certain providers.
Program Successes	**Program Challenges**
▪ The program is successfully educating residents on integrating treatment for OUD into their practices. ▪ Communication and education between emergency room doctors has improved OUD treatment in participating agencies.	▪ The program struggles to help patients to remain in treatment without the cost of treatment being funded.

UAMS Emergency Department (ED) Services Administrative Data

Educational services provided by the UAMS ED Services program included video content to be distributed throughout the state. The Continuing Medical Education (CME) application has received provisional approval, and UAMS has worked to develop a dedicated webpage for access. The video content received a thorough peer review by River Valley Medical to ensure accuracy and quality.

To maximize outreach, Dr. Martin and the peer staff initiated direct contact with every Emergency Department (ED) across Arkansas. This effort included reaching out to all 63 hospitals statewide, involved follow-up communications with previously non-responsive Eds, and new engagement with non-ED hospital sites. The goal of the UAMS ED Services program was to secure opportunities for presenting this educational material, enhancing provider knowledge on opioid use disorder, and Naloxone, and supporting improved patient care throughout the state.

Fig. 20: Hospitals Visited by UAMS ED Services Representative



UAMS MATRIARC/Project ECHO

Project ECHO, a part of the MATRIARC (Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities), provided weekly video conferences to community health centers needing assistance in opioid addiction treatment. Medical practitioners accessed in-person telemedicine consultations with an addiction psychiatrist from the UAMS Psychiatric Institute's Center for Addiction Services and Treatment.

Program Goals	Program Highlights
▪ To educate medical practitioners about accommodating co-occurring conditions. ▪ To increase the number of providers able to prescribe Buprenorphine.	▪ This program has worked to increase the number of physicians providing MOUD. ▪ Stigma among physicians about MAT has been lessened. ▪ Physicians have been able to address comorbidities by having 24/7 access to psychiatrists for consultations.
rogram Successes	**Program Challenges**
▪ MATRIARC was successful in reaching its goal of increasing providers able to prescribe Buprenorphine as there are now over 500 prescribers who can do so. ▪ Medical providers and practitioners have built a strong network through weekly ECHO webinars. ▪ The program has been very successful in providing access to care.	▪ Lag in grants every year impact the ability to continuously administer MAT services to individuals in recovery.

UAMS MATRIARC/Project ECHO Administrative Data

Project ECHO facilitated connection between healthcare providers treating patients with Medication for Opioid Use Disorder (MOUD) and subject matter experts through weekly online sessions. These interactive sessions, offered one (1) Continuing Medical Education (CME) credit for eligible participants, aimed to enhance support for providers managing Opioid Use Disorder (OUD) and related co-morbid conditions. Providers, including physicians, pharmacists, nurses, and other healthcare professionals, were encouraged to present their cases to receive expert feedback and guidance.

PROJECT ECHO TELEVIDEO	Sessions	Attendees*
Quarter 1	8	115
Quarter 2	11	118
Quarter 3	8	125
Quarter 4	8	124
Total	**35**	**482**

*These data were compiled from the quarterly and final reports. Some data may not match between reports.

During the reporting period, Project ECHO held 35 sessions, attracting 561 attendees, many of whom participated in multiple sessions throughout each quarter. Across the first three quarters, over 1,500 CMEs were awarded. This initiative not only offered valuable educational opportunities but also fostered a collaborative community, enabling providers to share insights and best practices in MOUD treatment.

Table 13: Project ECHO Attendees by Type and Quarter Attended

Type	1st	2nd	3rd	4th	Total
Physicians	17	21	24	17	**79**
PharmD/PD	5	4	5	7	**21**
PA-C	3	3	3	2	**11**
PhD	0	0	0	1	**1**
APRN/FNP	18	16	21	20	**75**
RN/LPN	3	5	7	6	**21**
LCSW	15	14	9	10	**48**
MHP	13	17	12	17	**59**
Peer	29	23	20	17	**89**
Other	12	15	24	27	**78**
Total	**115**	**118**	**125**	**124**	**482**

The MATRIARC program was designed to support physicians in the treatment of OUD. Additionally, MATRIARC offered a dedicated assistance hotline for physicians seeking guidance in the treatment of patients. During the reporting period, MATRIARC took on 601 assistance and advice calls. Callers inquired about a variety of topics, including questions about treating patients, referrals, and questions about Project ECHO.

Table 14: MATRIARC Advice and Assistance Interactions by Quarter and Type

Quarter	Email	Call	Meeting	Combined/ Unknown	Total
Q1	221	5	21	36	**283**
Q2	124	0	0	7	**131**
Q3	97	4	1	18	**120**
Q4*	63	0	1	10	**74**
Total	**505**	**9**	**23**	**71**	**608**

*Note Combined are when one form of contact was not sufficient and an additional type of contact, such as a phone call or meeting was required. Unknown are blank entries in the reports.

TREATMENT

Arkansas Community Corrections (ACC) MAT Program

The Arkansas Community Corrections (ACC) Medication Assisted Treatment (MAT) Program offers treatment for OUD to probationers and parolees throughout six residential centers in Arkansas. ACC collaborates with the healthcare provider WellPath to assess participants for Vivitrol eligibility. Treatment, alongside Vivitrol injections, included counseling services, access to Peer Workers, and comprehensive wraparound services such as transportation, housing assistance, family unification services, and telehealth. ACC participants had access to community services that provide bus passes and resources for participants seeking employment. Upon successful completion of counseling and the Vivitrol regimen, participants were enrolled into the Continuing Care program for six months to support sustained recovery. Throughout this period, participants continued access to Vivitrol injections and counseling services. ACC is affiliated with seventy-five community providers statewide to aid in the continuity of care post-completion. Naloxone is provided to participants and their families to mitigate overdose risk.

Program Goals

- To engage individuals in treatment for substance use disorder immediately upon release from incarceration.
- To get participants covered through health insurance as soon as possible to prevent lapse in MAT and other health related services.

Program Highlights

- This program has optimized the process of getting individuals insured as close to release as possible, working to close the gap between release and the start of treatment.
- The program will cover the first dose of Vivitrol if insurance is not active in time.
- This program offers effective counseling.
- Individuals are actively engaged in treatment while in the program.
- Treatment can be extended past the end of the program up to 9 months.

Program Successes

- Participants are enrolled in insurance and able to receive services (peer support, connecting with provider) right away.
- Over 900 have initiated the program from inside and almost 600 have started the program post-release.
- At the end of the program, participants can extend insurance with Medicaid, Blue Cross, and Blue shield for 9 months post-release.

Program Challenges

- Closing the gap between release and getting insured is difficult.
- They need to be able to offer injectable suboxone to catch everyone.
- Pinpointing patients specific to their program.
- Data and organization issues.

Arkansas Community Corrections (ACC) MAT Program Administrative Data

The ACC MAT program provides a six-month medication-assisted treatment (MAT) program for individuals diagnosed with opioid use disorder (OUD) who are currently in residential treatment. The program begins with treatment groups focused on substance use and addiction. As participants approach their release date, they receive an initial Vivitrol injection.

ACC
319
Naloxone Kits Distributed

Following release, participants are required to continue attending treatment groups, receive their medication, and complete ACC's three-month Continuing Care Program to fulfill program requirements.

During the reporting period, 96 participants were released, 34 successfully completed the program, 23 were discharged as unsuccessful, and 8 withdrew voluntarily or due to medical issues.

SUCCESSFUL COMPLETION OF THE ACC MAT PROGRAM

34
Participants

REACHED THROUGH EDUCATION

4,400
People including First Responders, Community Members, and Targeted Diverse Populations

The ACC MAT program educated first responders, community members, and targeted diverse populations on the subjects of opioid misuse and the use of Naloxone. During the reporting period they reached nearly 4400 people.

Upon release from a residential treatment center, participants were given the opportunity to talk about their experience during a reentry interview. Overall, participants felt that the program and Vivitrol injections helped them succeed in recovery.

"For me, the counseling and support group made the biggest difference because it helped me know that I'm not alone"

"I like Vivitrol because I don't have control of using more or less of it like I did with Suboxone"

"I have always struggled with drugs and the shot has helped me with not getting high the most "

Qualitative Study #3

Results from Focus Groups with Treatment Staff in Implementation of the Arkansas Community Corrections Medication-Assisted Treatment Program

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Executive Summary

The Arkansas Community Corrections (ACC) Medication-Assisted Treatment (MAT) program evaluation assessed the experiences of treatment staff and program administrators at six different program sites: five Community Correction Centers (CCCs) located throughout the state, and the ACC main headquarters based in Little Rock, Arkansas.

The ACCMAT evaluation has two primary goals. First, to use data to enhance or improve the SOR III program, and second, to document program success. Researchers from the Wyoming Survey & Analysis Center (WYSAC) designed the evaluation and facilitated the focus group sessions, visiting all six focus group sites in September of 2023.

The results of the evaluation identified both key strengths and areas in need of improvement within the overall program. Findings indicate that many staff and administrators hold similar opinions; however, there were a few notable areas where opinions diverged. These differences were important as they revealed areas within the program that may need further attention in terms of education, training, and/or implementation. In this report, WYSAC presents the findings of the evaluation and our recommendations for sustaining the program's strengths and areas in which the program could be improved.

Background

The Arkansas Community Corrections (ACC) Medication-Assisted Treatment (MAT) Program using Vivitrol, was implemented in 2018 with probationers and parolees in five residential centers and their surrounding communities. MAT is an evidence-based approach that is made possible for substance use treatment through prescribing and monitoring medications such as Vivitrol to prevent reoccurrence to opioid dependence after opioid detoxification. The ACCMAT program is part of the State Opioid Response III (SOR III) grant program managed by the Arkansas Department of Human services (DHS) Division of Aging, Adult, and Behavioral Health Services (OSAMH), and is supported through funding by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT).

The purpose of ACCMAT program is to provide for the initiation of MAT for eligible offenders prior to release once they receive appropriate education about the administration, use, and effects of Vivitrol. All treatment staff and medical staff providing services through the ACCMAT program are trained to educate residents on eligibility criteria, the opioid epidemic, opioid dependency, the type of medications such as Vivitrol used in MAT to treat opioid dependency, and the program’s rules, procedures, and overall curriculum.

The MAT program is voluntary and requires written consent from the applicant to participate. Upon admission, residents are first screened for opioid dependency using an approved substance use disorder assessment tool by treatment personnel, and then for

eligibility into the program by medical staff. Mental and physical health evaluations are conducted to determine if there are any contraindications that would cause the resident applicant to be unable to be considered for participation. If contraindications are identified, a medical professional makes appropriate treatment recommendations or referrals. Disqualified residents may be reconsidered for the program once their health conditions have stabilized.

If accepted into the ACCMAT program, participants are required to complete a substance use disorder program which includes education about the program, counseling, cognitive behavioral therapy, and random drug testing for a minimum of 45 days before being eligible to receive MAT. Once completed, participants are given a "3-day challenge," a small dose of oral naltrexone, to monitor for signs of adverse reactions. If no adverse reactions are indicated, the participant is given an injection of Vivitrol within seven (7) days of release.

Once released, MAT participants are required to report to their assigned Parole/Probation officer as scheduled and are connected with MAT treatment professionals for approximately six months. During this time, participants receive a Vivitrol injection once per month. After receiving their last dose of Vivitrol, participants are referred to the Continuing Care Program. Participation in the Continuing Care Program is required for a minimum of six months. After completion of the Continuing Care Program, participants are discharged from the ACCMAT program, but must continue to report to their Parole/Probation officer for the remainder of their supervision sentence and continue participation in community recovery programs such as Narcotics Anonymous (NA) as needed.

The MAT program aims to achieve the following goals:

- Increase and improve substance abuse treatment response among offenders prior to release
- Reduce reoccurrence related to future substance abuse
- Reduce recidivism related to future substance abuse

In September of 2022, OSAMH contracted with the University of Wyoming, Survey & Analysis Center (WYSAC) to evaluate the SOR III program. The evaluation of the ACCMAT program is part of the overall SOR III program. The University of Wyoming granted WYSAC researchers an IRB exemption, determining that individuals would experience less than minimal risk for participating in the research.

Methods

Data Collection Process

WYSAC evaluators developed a focus group research instrument (Appendix A) containing prompts to help guide group discussion of ACCMAT programming and related topics. All focus group participants were informed of their rights, and each signed a consent form (Appendix B) explaining the goals of the study and the focus group format prior to participation. Researchers provided each focus group participant with a copy of the consent form which included 1) contact information if they had any later concerns or wanted additional information, and 2) consent for the session to be digitally recorded. Contact information of a virtual counseling organization was also provided for participants if they experienced feelings of discomfort or distress resulting from discussing issues related to the ACCMAT programming. All participation was voluntary, and participants could refrain from answering any or all questions and could leave the focus group at any time.

The focus group research instrument listed questions asking for the opinions and experiences of staff and administrators involved in the ACCMAT program. Focus group prompts asked participants about their history working in treatment, working as part of the ACCMAT program, their thoughts and experiences about their MAT training, the challenges and barriers related to the ACCMAT program, perceived stigma surrounding opioid use disorder and the use of MAT, notable programming successes, and their recommendations for program improvement. Focus group discussions lasted between 60-90 minutes and were held at each of the 6 community corrections sites in a semi-private conference room.

Demographics of Participants

A total of 29 administrators and staff, 25 women and 4 men, took part in the focus group sessions to discuss their experiences, opinions, and recommendations for program improvement. The following table lists the self-reported titles, the range of years in the profession, and range of years at the current position of all participants in aggregate. Demographic variables such as age, race, and location were not collected to help preserve confidentiality. Years in Profession and Years in Current Position were suppressed in some positions to preserve confidentiality.

Title	Range of Months/Years in Profession	Range of Months/Years at Current Position
Assistant Director	20 years	3 years
Assistant Treatment Manager*		
Health Services Administrator	6 months – 4 years, 5 months	1 week – 4 years, 6 months
MAT Advisor	7 months – 24 years	1 year, 5 months

MAT Coordinator*		
MAT Counselor	7 months – 6 years	7 months – 1 year
Nurse	1 year, 2 months – 9 years	5 months – 3 years
Substance Use Program Leader	4 – 10 years	2 – 10 years
Supervisor	25 years	3 years
Telehealth Advisor	8 months	8 months
Treatment Coordinator	6 years, 6 months – 23 years	4 – 24 years
Treatment Supervisor	7 – 24 years	7 – 24 years
Warden	20 years	3 years

*Suppressed data

Analysis

WYSAC researchers and support staff transcribed the digitally recorded interviews verbatim. All personally identifying markers were removed from the documents during the transcription process to preserve confidentiality. Consent forms are stored in a locked file cabinet and digital files of transcripts have been uploaded to WYSAC's password protected secure server. QDA Miner 6, a qualitative data analysis software, was used to code the transcripts into notable categories of significance that describe the experiences, opinions, thoughts, and recommendations of the focus group participants.

Findings

What are your thoughts on the MAT training you received?

The majority of focus group participants said they received some kind of formal training, either virtual or in-person about MAT. Those few that did not were relatively new to their position and were waiting for the next scheduled training to occur. The training that was described during focus group sessions included an educational component for administrators, staff, and nurses to learn about the ACCMAT program, and to teach clients about MAT and Vivitrol in particular.

All administrators and staff stated that they appreciated the training sessions, and many said they learned something new each time they occurred.

- "I've done pretty much the same computer-based training and person training [every year]. I feel like each time I learn something new. There's so much information. It's kind of hard to just go to one training and feel like you have it all. So, each time it's something new and more enlightening."

Several administrators commented that there should be more opportunities for training either virtually or in-person.

- "I think there should be more opportunities for training. We need refresher trainings for staff. That would be very helpful in general, but especially for new hires. There is a lot of staff turnover and not everyone is up to speed like they should be."
- "I'm able to explain to them [residents] about what MAT is and opiate use disorder. But I do think that we need more hands-on training. We do a lot of Zoom trainings that go over MAT or go over Vivitrol or different types of MAT that are used. You know, Suboxone and methadone. But at the same time, we don't have any old hands, old trainings. We're just learning from each other how to do this or call this person and get the answer. But I think hands on training is what's needed."

Nurses said that along with the educational component, they also received training about Vivitrol and how to administer it. Not all of them received this training in person. A few said the training occurred "on-the-fly," with the person they were replacing. The majority of nurses that participated in the focus group sessions stated that more hands-on and face-to-face training in administering MAT would have been helpful.

- "I would have liked to have observed more, like how MAT is stored and to see some people [clients] getting injections."

Some nurses had some specific requests listed below:

- "I would like more education on the why of addiction."
- "I would like more training on substance use disorder in general and other options for recovery."

How do you feel about the MAT program?

All focus group participants stated that they felt MAT was useful in addressing opioid use disorder (OUD). However, one participant felt that Vivitrol was not the best choice for a number of residents in the program based on their job description. Many of the participants described having preconceived ideas in the beginning about what MAT was and how it worked, and how their opinions changed after they received training and started interacting with clients.

Many focus group participants described MAT as an effective tool in treating OUD. However, these participants clearly stated that MAT was only part of the treatment program. Other elements were necessary such as therapy and a desire for change, for clients to be successful in their treatment.

- "I mean, I think it's a good program inside and out. When they get out, they have all these resources, they have counseling, and they have peer support specialists. And they have a lot of help if they're willing to put in the work. "

- "I think it's a good program. We had a lot of people say how it works and how their family members have been on it and been off it for a year and they haven't looked back to opiates and things like that. So, it works. But they say it works if you work it."
- "It's called Medication **Assisted** Treatment. Other things like cognitive therapy are necessary for it to work."

One staff member felt that using Vivitrol was unsafe for some clients that worked physically demanding jobs.

- "I think for some clients, it's [Vivitrol] not a good choice because you can't control pain. There was one client here In the program that went to work and fell from the second story and could not be given opioids to deal with the pain . . . I think we should have several MAT options. Vivitrol isn't for everyone."

For many focus group participants, feelings about MAT changed over time. Some acknowledged that they initially had negative feelings towards MAT, but once they completed the training process and interacted with clients, they had a much more positive opinion about MAT and the ACCMAT program.

- "So, you know, when I first started, in this field, I had preconceived notions. And of course, this was many years ago. But I found that as I got more education and training on it, my perception shifted."
- "Before I started this work . . . I didn't understand what it [MAT] was. I believed that it was just a crutch to sobriety. But now being [working] in this program and learning more about methadone and Suboxone and Vivitrol, [I see] it's saving lives."

How do clients feel about the MAT program?

All focus groups included a lengthy discussion of the seemingly polarized attitudes among ACC residents about MAT and the ACCMAT program.

For some residents, the feeling is decidedly negative. Rather than a viable treatment option, MAT is seen as a crutch for those that can't make it on their own.

- "Some residents are embarrassed of being in the program. They view MAT as changing one drug for another."
- "Some residents not in the MAT program view it as more of a crutch. They like to say that you don't have the willpower to stop yourself, so you're having to depend on something else. So, you're not truly recovered since you're having to depend on this medication. A lot of them are really closed-minded because they have that mindset of 'you're not in it for the real thing'."

For others, MAT is a positive avenue for change; a chance to finally break free from addiction and make a fresh start.

- "One of the residents said he was active in addiction; he was always looking for an exit and MAT will give him that exit. Another resident said he had a friend that overdosed, and he doesn't want to die. It's a steppingstone to his recovery. He wants to see long term change. Another resident said he likes the accountability."

How does the surrounding community feel about the community correctional center?

Focus group sessions revealed a definite rural/urban divide when discussing community acceptance of the correctional center and its residents. However, in both rural and urban communities, participants stated that regardless of the community's overall attitude, there were community members that were willing to volunteer at the center, and at least a few local organizations not specifically affiliated with the MAT program that offered services that ACCMAT participants could use.

Administrators and staff working at correctional centers in rural areas stated that negative opinions about the center and its residents were prevalent in their surrounding communities**.**

- "They [community members] only see the addiction. They don't see the recovery part."
- "Some of these rural communities are stuck in their old ways. Many of them don't like the center being here, they don't understand what we do, and they don't want to get educated."

However, attitudes toward the correctional centers in urban areas appeared to be somewhat more accepting.

- "This [urban] community has a lot of understanding. There is a lot of acceptance that more people have a problem."

Interestingly, focus group participants from both rural and urban areas described community support in similar ways – primarily being provided by churches, food pantries, and a core group of volunteers.

- **RURAL CCC:** "The local churches here supply food and hold AA/NA meetings that participants of the program can use. We also have quite a few people that come to the facility to volunteer their time."
- **URBAN CCC:** "The community was very against this building at first. But over time, things changed. Volunteers come in now. Churches have programs like NA or AA for people that come here. They also have pantries for people [like these] that need some help."

What are the challenges of the MAT program?

Focus group sessions disclosed a variety of challenges associated with the MAT program. These challenges occupied two main categories: resident/program participant challenges and staff/administrator challenges.

RESIDENTS/CLIENTS

Honesty: Several participants in focus group discussions stated that residents' lack of honesty in describing their drug use during the assessment process prevents them from being admitted into the program and getting the treatment they need in a timely manner.

- "I wish residents would be more honest early on about their drug use. I wish they wouldn't minimalize it. It sets them back. It doesn't help them."
- "They're not honest about the drugs they're using. It's a trust thing. Weeks or months down the road they tell you the truth and you kind of have to start all over."

Mental Health Issues: All focus groups agreed that underlying mental health issues are a key factor in some clients not being able to complete the program successfully.

- "I think about 80% of this population have a mental health diagnosis. I didn't realize it until I started working here how that goes hand in hand [with substance use disorder]. With most individuals, I didn't realize that either the mental health is causing you to use, or you have to use due to your mental health issues. It's a cycle that can be hard to break."
- "Mental health issues can cause people in the program to fail. So many are afraid to ask for help. It's OK to get mental health treatment. It's OK to not be OK."

Family Dynamics/Family Support: Many focus group participants discussed the influence of family on successfully completing the program and staying sober after release. Participants described negative family dynamics as a primary trigger for illicit drug use and mental health issues for some residents. Participants also stated that having little or no family support made it much more difficult for some to be successful in the program.

- "Once they're released, who's gonna listen to them? Even if they go back to their parents, you know, they've burned a lot of bridges and some residents when they go home, whether they know it or not, that's where their triggers are. Their triggers are right back there with their parents."
- "Family trauma in early childhood and not being able to get mental health services because of social economics are some of the main reasons we see people coming though these doors."

"Some have family support. One of the things I ask them is: Is your family supportive of your recovery? And most of them say yes, but then there's some like that young woman last week who had no family support. . . . She was really struggling. And I think that makes the situation [substance

STAFF/ADMINISTRATORS

Sustainability: Financial issues were discussed in all focus group sessions. Worries about money and being able to maintain treatment with a grant-funded program were frequent. Sustainability of funding was a prevalent theme in these discussions. Budgeting for staff needed to implement the program, and the cost of Vivitrol being out of reach for most (if not all) program participants without some kind of financial assistance were seen as high-priority issues. Included in these discussions was the emphasis on meeting grant enrollment numbers and how that emphasis subtly shifted the focus from the needs of the clients to the requirements of the grant.

- "I'm a big picture person in my role, so I see a lot of barriers and roadblocks that we have to consistently overcome, you know, primarily that this is a grant funded program. That's a big one. You know, in my mind, it needs to be a legislative appropriation as far as our agency budget goes. The staff needs to be absorbed in and the costs need to be absorbed in and you know, all of that. But that's probably not going to happen. So at least as far as the cost of the medication, I think we'll always have to have some kind of external component where we're trying to fund because, like, one of the barriers is just the simple cost of Vivitrol in and of itself, it's expensive. And our population doesn't typically have the income to be able to afford $1,000 shot a month without having some kind of assistance in place. And in even certain… as new buprenorphine medications come out because I think they come out with a new one here recently, right? It sounded very promising, especially for a program that we run, you know, but it's going to cost an exorbitant amount of money and insurances may not cover it. So that's what I think of when I think of big barriers to this program."
- "I think if we [should] focus less on the numbers and focus on the need, you know, we focus a lot on [that] we have to have so many numbers for the grant itself. But if we focused on the need of that resident, then we'll get us to a better success [rate] when they're not incarcerated. Because we can sign up twenty today, and only two out of twenty are going to complete the program."

What are the successful programming components of the program?

Many success stories describing the effects that the MAT program had on individual residents were discussed. However, it became evident that Peer Recovery Support (PRS) has clearly had a positive impact on the MAT program. PRS was mentioned as a supportive component in all focus group sessions.

Peer Recovery Support Services: All focus groups spoke of peer recovery support being an integral part of recovery post-release.

" . . . we set up positive relationships before they leave with the help of a Peer Support Specialist . . . and many times, the peer support specialist will be there during the exit interview and say, 'Hey, I'm

a peer support specialist, call me, text, me, email me, and I can tell you who a peer support specialist is in your area. There are 500 of us here in the state, so, you know, there's help available'."

- "Peer Support Specialists are an important part of this program. They connect people to resources and since they have lived experience, they help people say no to their triggers in a way other people can't."

Is there any stigma associated with the program?

Stigma, defined as the disapproval or discrimination against people or groups based on behaviors, characteristics, or other social traits, is often cited as one of the reasons why many individuals hesitate to seek treatment for substance use disorder. Focus groups revealed four distinct types of stigma that some program participants experience: resident stigma, community stigma, recovery group stigma, and law enforcement stigma.

Resident Stigma: All focus groups discussed the stigma of resident push-back against MAT that occurs in the centers by a small group of residents. Some residents are against MAT for philosophical reasons, while others are against it because they deem the program to be unfair because they cannot be included.

- "And yeah, the gentlemen that are in the MAT program have revealed to me, that the [other] residents feel like they're cheating. They don't understand what Vivitrol is, they don't understand that it can't be abused. So, I guess they may think that the residents on MAT are still getting a buzz. You know, like they were on methadone or Suboxone."
- "Well, even among residents, you know, there's push-back. So, for instance at ____, the residents who aren't in the program who have methamphetamine addiction are upset because the opioid use disorder is being treated, but theirs isn't. And they're anxious for something for methamphetamine. And it's coming, but it's not gonna be anytime soon, you know, so there's a lot of anger toward the [opioid] MAT clients. I don't believe it's ever gotten physical but there have been verbal altercations."

Community Stigma: Focus groups from all centers described how reentry back into the same community was difficult for some program participants due to negative community labeling.

- "Because the stigma is out there in the communities. Because communities . . . I'll just say they have that stigma, and all they see is this person was a drug addict. They don't see the recovery part. They don't see that they, you know, some people do, but then you just, there's always that stigma. Especially if you think about some of these rural communities that are stuck in their old ways."
- "In some places residents are viewed as not drug users but felons. Housing becomes an issue because many landlords will not rent to felons. In other areas it's, 'Is this person a crackhead?' These labels make it difficult to move on, find housing and employment."

Recovery Group Stigma: Focus group participants in three centers discussed how some support groups such as Narcotics Anonymous (NA) view MAT users as still using drugs and not genuinely being abstinent.

- "Some recovery groups really look down on MAT. This makes it harder to find a group where you feel you belong. I know that some MAT users choose to not tell the group about their MAT use, which kind of puts a damper on the whole 'group support' idea."
- "In some [recovery] places, MAT still has a bad reputation. It is still looked at as 'take home drugs.' MAT recovery groups don't fit in with other recovery groups for that reason."

Law Enforcement Stigma: Two focus groups talked about law enforcement not being entirely supportive of this type [MAT] of programming.

- "Law enforcement still has a harder time with MAT. There are a lot of officers and guards that still think that anyone doing MAT is cheating and not really in recovery."

Do you have any client-specific program recommendations?

All focus groups recommended earlier education for residents about MAT and additional resources for family education and family counseling. Two focus groups recommended the addition of mental health services to help address a potential gap in service.

Earlier Education on MAT for Residents: Discussions centered on getting the facts about MAT and the MAT program to individuals entering the system at orientation before they had much exposure to the facility's general population.

- "The better success rate is tied to getting them as soon as they get out of orientation when they first get here, or while they're in orientation before they can get to the floors to those other guys. Because that's when the negativity starts spreading. 'You don't want to do this, if you mess up, you're gonna get locked back up for this or that.' But if you can get to them before they start getting all of the negative information and like she said, give them the positive you're gonna live if you do this."

The most frequent suggestions for implementation of earlier education on MAT included films and videos, talks by former residents that have successfully completed the program, and more creative use of printed materials.

- **FILMS:** "I don't believe they have any videos on MAT itself, but there's a documentary on PBS that focuses on Arkansas, the opioid epidemic, and the MAT program. This was the movie that I told y'all about, *Four Good Days* with Glenn Close. It's about the MAT program. We're contracted with this site called Swank. And they approve correctional facility videos. And so it wasn't on the site, so we couldn't get approval for it. But I think that would be awesome. It's on Amazon Prime, but it is awesome."

- **TALKS:** "I personally think that they're [residents] more likely to participate and do better if they've seen someone who has actually used, used this program, and are doing well in the community at this point. We can tell you what's going to help you all day long. But until you actually see something that someone else has done, then it makes a big difference."
- **PRINTED MATERIALS:** "We need to be more creative. We need to make MAT standout more, like with a kiosk that displays information at facilities rather than just using handouts to prospective participants."

Additional Family Education and Family Counseling: Additional resources for family education and family counseling that targets post-release issues were discussed during all focus group sessions.

- "But I also think we touched on it earlier, the family dynamics and counseling so that families don't feel isolated or alone dealing [post-release] with an individual who has not only a substance abuse disorder, but this particular use [opioids]."
- "And we have some people who are the only person in their immediate family who have a substance use disorder. So, the family doesn't know how to deal with them when they come home. This is a real problem because you need that family support."
- "Like, when we're talking about reentry, and we're preparing them to be discharged if we could let the family know what to expect, and different things. So, if we could let them know and educate them on the MAT program that their family member is in, I think that would help some because they could be, you know, part of that support system."

Funding for Residents with Severe Mental Health Issues: Mental health was prominent topic in all focus group sessions. Two focus group discussions centered on concern for residents with more severe mental health issues and questioned how they would be able to navigate their treatment upon release.

- "We need additional funding to address the more severe mental health issues we see in some of our residents. We also need more recommendations for these types of people after reentry. How will those people keep up with their treatment? I have no idea."

Do you have any staff-specific program recommendations?

Focus group participants listed more staff and more funding as primary needs. With additional probing, focus group discussions revealed three recommendations that participants felt would enhance the effectiveness of the program: networking of resources, post-release follow up, and incentives.

Networking of Resources: Several focus groups mentioned the sharing of additional educational resources among centers. One focus group suggested a state-wide network linking health professionals to help disseminate information about MAT and the program.

- "We need EXTRA resources. Right now, I make my own flyers [about opioid addiction and MAT]. We need more pamphlets. We need films and workbooks. It would be great if someone found something [new], they could share it some way with the other centers."
- "A few years back, I had a nurse friend call me and ask, 'Hey, do you know what providers in our area provide medication assisted treatment? Do you happen to have a list?' And she's a medical provider. Like, why didn't she have a list? We need to network and make sure this kind of information is out there."

Post-Release Follow Up: Two focus groups expressed frustration in their lack of knowledge about residents' post-release outcomes and the desire for some kind of follow up after reentry.

- "So, there's no calling post-release going, 'Hey, how are you doing?' We'd like to know, but we can't do that. They can call us, but we can't call them."
- "I just ask the coordinator. 'Have you talked to them since they left?' [Sometimes] they'll call us and let us know if they're in relapse. Most of the time we don't really know how well they're doing."

Meaningful Incentives: One focus group discussed the idea of incentives for MAT participants as a way to maintain participation, build buy-in, and foster a feeling of belonging.

- "Arkansas has a lot of rural areas. We say if they had incentives, like we were throwing it out there with each other, like the government assisted phone service, because some days they can't even get in touch to call and say, 'Oh, hey, we can't make it to the appointment,' and they miss something and they are scared they're gonna get in trouble for that. Or we don't know if it's like bus passes, or something. Can we have you know, something that's easy. This, a click pen like this, is considered contraband here. But something like that, for them to walk around with that and it says MAT or something. It's just little things. But sometimes they have to have some kind of tricky, it's like a kid mentality. Some kind of incentive."

Are there any community needs related to the program?

Focus group participants listed a variety of general community needs including more school counselors trained in discussing the use of illicit drugs, additional resources to address poverty, and greater access to mental health treatment. Community needs related to the MAT program included more education on MAT in the communities, a positive media campaign about MAT, and additional education and training on MAT for law enforcement.

Education on MAT in Communities: Community education about opioids, MAT in general, and the program in particular was universally discussed in all focus groups. Focus group

participants stated that community education would help combat stigma and provide much needed information for individuals and families dealing with opioid use disorder.

- "I think that's where it comes back to community education, because you need the support of your community to help make things better for you."
- "We need more MAT information out there in the communities. More in the media, doctors' offices, billboards, and the like."
- "We need more education out there. Families tell their son or daughter, 'No, you can't be in the program.' Families don't understand it [MAT] and are afraid it will cause more problems down the road."

Positive Media Campaign for MAT: Several focus groups discussed the need for an ad campaign for MAT that was similar to Narcan. These discussions centered on ads and billboards that highlighted individuals with opioid use disorder that have successfully used MAT to treat their disease and maintain sobriety.

- "I think it makes a difference with advertisements. These advertisements (against opioids] show such a negative connotation, how people are dying, and that's all the public sees. The fentanyl, the abuse. We know that it's tragic. But they don't really see that there is an option to helping people stay clean and sober and not step over into that life or continuing that life. So, it makes it difficult when we're trying to educate on this side [treatment] when all they've seen is death. They don't see that there is a way to recover. And so, we're hitting that wall when we're trying to help them see something different."
- "If we could see commercials showing Joe and Mary walking, having a family dinner, going to their jobs, functioning as normal human beings, and then it's like 'Joe and Mary are on medication assistance and have been for the last 20 years.' That would probably go a long way towards normalizing it [opioid use disorder]. You don't see that like you do with other medications. You know, you see somebody who has type two diabetes and they're taking medication living they're best life. We need that same kind of thing."

Law Enforcement Education on MAT: Several focus groups discussed the need for additional law enforcement education and training about MAT to combat old ways of thinking.

- "We definitely want officers that have MAT caseloads to attend training. When officers get that dedicated MAT caseload, and they have to go to training, it also has the benefit of kind of giving them some education and kind of opens their eyes a lot."
- "We want officers with MAT caseloads to attend trainings. They need to have first-hand experience. They need to see it [MAT] work."
- "We need MAT education for officers. They need to speak with some knowledge. Judge education has worked. There is more buy-in [from the judges] than before."

Observations and Recommendations from the Evaluators

- **Provide more frequent MAT training for administrators, staff, and medical personnel. Offer law enforcement specialized training to help with MAT caseloads.** More types of training sessions and more frequent trainings were topics at all focus group sessions. We recommend including a mandatory hands-on and shadowing components for medical personnel. Moreover, we recommend live (either face-to-face or video conference) training sessions that include a question-and-answer period for law enforcement to help them better understand opioid use disorder, the behaviors associated with this disease, and the benefits of MAT. These sessions could include a certificate and printed reference materials.

- **Consider adding an MAT educational module to orientation:** Focus group comments suggest that adding an educational module to the orientation process might make recruiting applicants to the MAT program easier and also reduce resident stigma toward MAT. We therefore recommend an educational module describing MAT and its role as an effective component of treatment to be added to resident orientation.

- **Provide a "potential reentry issues" component to family counseling:** Focus group participants describe a need for family counseling to include challenges that are often present in the transition from incarceration to reentry. We therefore recommend the addition of therapeutic interventions to family counseling that provide adaptive methods to address the many challenges that may emerge during the reentry process. These challenges include those listed throughout this report such as mental health issues, employment, housing, transportation, social stigma, and reoccurrence, as well as others identified by counselors, therapists, peer support specialists, community supervision officers, and family members. We also recommend that Peer Recovery Support Services (PRSS) materials be

  placed in family counseling venues and that counselors review these materials with families to better inform them of the additional services that PRSS can provide.

- **Pursue funding for a state-wide media campaign outlining the many benefits of MAT:** Focus group participants referenced the positive ad campaign for Narcan/Naloxone and how it saved lives. We agree with those focus group participants that suggested this idea and recommend a campaign that highlights the many benefits of MAT, normalizes its use to treat opioid use disorder, and offers hope in overcoming addiction.

Closing Thoughts

Consider adding a program component to collect data that tracks the post-release progress of all program participants: Documenting the progress of program participants post-release by collecting data over the required six-month period including variables such as 1) basic demographics including county of residence, 2) the number of monthly vivitrol injections, 3) the number of one-on-one therapy sessions attended, 4) the number of group support sessions attended for each participant, and 5) any pre/post risk assessment scores, would help provide quantifiable evidence of the effectiveness of the program. Results of data analysis could help reveal any significant risk factors related to reoccurrence and any potential gaps in service delivery.

Appendices

Appendix A

COMMUNITY CORRECTIONS FACILITY (CCF) STAFF FOCUS GROUP QUESTIONS

We've invited you here today because you are MAT-trained staff at a community corrections facility (CCF) in Arkansas, and because of that, many of you share some common experiences.

We would like to talk to you about your attitudes, behaviors, and experiences treating clients with Medically Assisted Treatment (MAT) who are screened positive for opioid use disorder (OUD). Each of you has somewhat different training and experiences and so your attitudes and familiarities concerning this topic will be slightly different. That's why it's important that each of you tell us about your thoughts – even if it's different from what everyone else has to say. We don't expect everyone to have the same perspective, so if you disagree with something, don't be afraid to speak up. Often, we learn the most when people have different ideas about something.

Process Introduction

My name is _____. I will be the moderator. I will introduce topics and try to keep the discussion on track AND make sure everyone gets a chance to talk. BLANK will be taking notes during the discussion and so probably won't talk very much. I am taking some notes because I will be meeting around 5-7 groups of CCF MAT-trained staff from around the state, and we want to be able to keep track of what the different groups say. If it's okay with everyone, I will also be recording the discussion so that I don't miss any of your comments. We will be using each other's first names only during our discussion; but when I write up the summaries, no names will be used. [The *Note-taker]* and I will keep all of the information you share with us confidential, and I ask that all of you do too. Are there any questions before we begin?

Introduction

To get started, why don't we go around the room and have everyone introduce themselves using first names only.

Prompts for Discussion

- *First, we want to discuss a bit about your experiences with OUDs and their treatment.*
    - Tell me about the training you received around treating OUD and use of MAT.
    - I realize there are other MAT choices besides Vivitrol. Are there scenarios where Vivitrol is not appropriate? What other choices do you have besides Vivitrol? Are there non-MAT options available?
    - How do you decide which treatment would be best for your client?
    - What are some examples of community characteristics that contribute to successful and unsuccessful treatment outcomes? [*Probe for both individual level challenges as well as institutional, cultural, familial, environmental . . .*]
    - What are some challenges or barriers that make it difficult to appropriately treat individuals with OUD?
    - What things do you think would encourage other providers to prescribe MAT?

- *Next, we want to discuss how you feel about the systems currently in place to access and administer MAT to treat OUD.*
    - Could you describe the systems currently in place to access and administer MAT to treat OUD?
    - What systemic changes do you think would be needed to change or improve opioid treatment?
    - What systemic changes do you think would be needed to curb the current opioid epidemic?

Conclusion

The moderator provides a short overview of the purpose of the study (10 minutes before end of focus group).

The goal of this focus group is to gather CCF MAT-trained staffs' attitudes towards the use of MAT to treat opioid use disorder. The information that you provide will help the Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) gain a better understanding of how to increase access to FDA-approved medications for the treatment of OUD. This focus group is one data collection method we are using to gather information.

- Is there anything anyone would like to add that we haven't covered?

Thank you for participating in the focus group. We appreciate you taking the time out of your day to be part of our study.

Appendix B

COMMUNITY CORRECTIONS FACILITY (CCF) STAFF FOCUS GROUP INFORMED CONSENT

Thank you for agreeing to participate in this focus group. The purpose of this focus group is to find out about Medically Assisted Treatment (MAT) trained community corrections staff attitudes, behaviors, and experiences concerning (MAT) offered to clients of community corrections facilities (CCF) who are screened positive for an opioid use disorder (OUD). The Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) is collecting data to detail number of clients treated, successful completions, any identified barriers to treatment, and any opportunities to support the continuum of prevention, harm reduction, treatment, and recovery for OUD and other concurrent substance use disorders. This focus group is one data collection method we are using to gather information. This focus group will take approximately 1 to 1 ½ hours. Your participation is entirely voluntary. Your answers to questions will be kept confidential, and at no time will your name be attached to your answers or to any of the data collected through this discussion. You do not have to answer any question that makes you feel uncomfortable, and you may choose to leave the focus group at any time.

We will be reporting the results of this focus group in aggregate. While we may capture some meaningful quotes, they will not be connected to any individual. In order to protect confidentiality and to make everyone comfortable here today, we ask that you do not discuss specific things that any particular person said here after we leave. We are interested in both majority and minority viewpoints. We will not be upset by critical commentary, nor will that count as a strike against you, so please do not hold back even if you feel your comments may be discouraging or unpopular. During or after the focus group, if you have any feelings of discomfort or distress resulting from discussing this topic, the Virtual Mental Health Clinic at UAMS is available to you at (502) 526-3563.

During the focus group, we will ask you questions, and will listen to what you have to say. We will not participate in the discussion. Please feel free to respond to each other and speak directly to others in the group during the discussion. We want to hear from all of you. We may sometimes ask someone to speak who has been quiet or ask someone to hold their thought for a few minutes.

If you have questions about your rights as a research subject, please contact the University of Wyoming IRB Administrator, at 307-766-5320. You may also contact Dr. Andria Blackwood at (734) 678-5428 for general questions about this project.

"My participation is voluntary and my refusal to participate will not involve penalty or loss of benefits to which I am otherwise entitled, and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled."

_____ Participant name (please print)

Participant signature_____ Date

I consent to be recorded during this focus group: □ YES □ NO _ Date

TREATMENT

UAMS MAT Justice-Involved Program

The UAMS Justice-Involved Pharmacist Intervention Project was designed to prevent opioid overdoses among individuals transitioning from incarceration back into the community. This pharmacist-led initiative was part of a two-year research study aimed at supporting both incarcerated individuals and their families. The program provided comprehensive services, including rehabilitation, medication-assisted treatment (MAT), opioid overdose prevention education, and Naloxone training. Naloxone training was conducted one month prior to release to reduce the risk of overdose. The program identified individuals with opioid use disorder (OUD), initiated treatment during incarceration, continued treatment post-release, and conducted follow-up care after Naloxone training and ongoing treatment. Additionally, UAMS Justice-Involved ensured the replacement of used or expired Naloxone.

Program Goals

- To engage individuals in treatment for substance use disorder with MAT services immediately upon release from incarceration.
- To assist individuals in the reentry program with health insurance coverage as soon as possible to prevent reoccurrence and to address other health related issues.

Program Highlights

- The program trains incarcerated individuals in how to use Naloxone before they are released.
- The program has helped to prevent several overdoses.

Program Successes

- The principle investigators of the program feel this type of intervention has not been done before and that their process is exhibiting positive outcomes while meeting most of their goals.

Program Challenges

- The program has lost a lot of staff making it difficult to meet deadlines and accomplish tasks on time.
- The program must wait for IRB approval after hiring new staff, which has caused a massive delay.
- It has been difficult to pay people for their participation due to an error in funding.
- Patients have been denied MOUD at the pharmacy.
- There is a lack of transportation to the clinic.
- Lack of insurance coverage for some patients.
- Many housing programs do not allow MOUD.

UAMS MAT Justice-Involved Program Administrative Data

Between October 2023 and September 2024, 42 pharmacists received specialized training through the UAMS MAT Justice Involved Program to support the prevention, treatment, and recovery of patients at elevated risk for, or currently diagnosed with, opioid use disorder (OUD). Twenty-four pharmacists were trained in standard medical counseling, 14 were trained in administering the Brief Intervention Referral to Treatment (BIRT) screening, and four were trained in some other form of evidence-based substance use disorder (SUD) assessment.

Table 15: Types of Training for UAMS Justice-Involved Pharmacists

Training Type	Q1	Q2	Q3	Q4	Total
Standard Medical Counseling	5	7	6	6	**24**
BIRT	5	3	3	3	**14**
Other	0	0	4	0	**4**
Total	**10**	**10**	**13**	**9**	**42**

Pharmacists conducted 179 follow-up calls to justice-involved patients who had received Naloxone administration to monitor their recovery progress.

In Q1 of the SOR3 program, Pharmacists identified 22 justice-involved patients with OUD, and 16 began treatment. Of those who initiated treatment, 4 were retained at 1 month, 3 at 3 months, and 2 were still engaged in treatment at the 6-month mark.

Table 16: Number of Justice-Involved Patients Treated per Quarter

Status	Q1	Q2	Q3	Q4
OUD Identified	22	11	15	8
Initiated Treatment	16	13	20	4
Retained 1 Month	4	3	5	0
Retained 3 Months	3	3	5	0
Retained 6 months	2	2	4	3

In Q2, 11 new individuals were identified, with 13 starting treatment (potentially including late initiations from previous quarters). Retention was similar, with 3 individuals retained at both the 1- and 3-month marks, and 2 retained at 6 months.

Q3 shows an increase, with 15 individuals identified and 20 starting treatment. This quarter had the highest retention rates, with 5 individuals remaining in treatment at both 1 and 3 months, and 4 retained at 6 months.

In Q4, the numbers decline significantly, with only 8 individuals identified and 4 initiating treatment. No individuals were retained at the 1- or 3-month marks, but 3 were still engaged at the 6-month follow-up.

A total of 94 justice-involved detainees with opioid use disorder (OUD), along with their significant others (if interested and available), attended training to recognize the signs and symptoms of opioid overdose and effectively administer Naloxone in an overdose situation prior to release and community re-entry.

NALOXONE TRAINING

	Attendees
Quarter 1	38
Quarter 2	22
Quarter 3	17
Quarter 4	17
Total	**94**

TREATMENT

UAMS MAT Services

UAMS MAT Services assisted agencies throughout the state in providing comprehensive Medication-Assisted Treatment (MAT) services using the three FDA approved medications (naltrexone, buprenorphine, and methadone) for the treatment of opioid use disorder (OUD). Through the MAT program, UAMS connected with medical professionals and treatment providers who lack access to resources and services. Distribution of MAT occurred at a variety of locations where minimal MAT providers currently exist in each of the eight regional catchment areas as defined by the Division of Aging, Adult & Behavioral Health Services (OSAMH).

Program Goals

- To provide MAT access to underserved, rural patients with no insurance.
- To perform drug screenings and basic lab tests within the first 90 days of getting ER patients and patients with OUD stable.

Program Highlights

- The program is in 58 counties and has visited every agency that manages MOUD.
- This program provides treatment access to underserved, rural patients with no insurance.
- The program offers site visits and has embedded peer support in physician offices.
- Education awareness provided by this program helped to combat stigma.
-

Program Successes

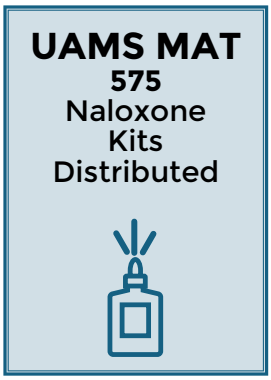
- At the start of the program, they were in 12-15 counties, The program has successfully expanded to 58 counties.
- They started with 6 grantees and now have 22.
- Embedding peers was highly successful and changed the attitudes of many physicians.
- Stigma has been improved in offices among physicians as well as patients, leading to recovery and long-term support.

Program Challenges

- The program has encounter stigma with treating patients with dual diagnoses.
- The program has struggled with solutions for transportation and childcare.
- The program struggles to adequately reach the African American population and homeless population.

UAMS MAT Services Administrative Data

UAMS conducted 23 site visits with clinical entities interested in providing Medication-Assisted Treatment (MAT). The purpose of these visits was to offer performance contracts, establish outcome measures, and assess progress in meeting performance benchmarks required for continued state funding. Additionally, UAMS MAT Services distributed 575 Naloxone kits during these site visits.



SOR III funding was provided by UAMS to agencies for individuals to receive Medication Assisted Treatment (MAT) services in the form of Medications for Opioid Use Disorder (MOUD) and Medications for Use Disorder (MUD). Some individuals received both MOUD and MUD MAT services. Between October 2023 and September 2024, a total of 2,131 individuals received MAT for MOUD, 28 individuals received MAT for MUD and 761 individuals received MAT for both MOUD and MUD.

Table 17: UAMS MAT Distribution by County Oct 2023 – Sept 2024

Month	MOUD	MUD	MOUD & MUD	Total
October 2023	251	8	91	**350**
November 2023	204	5	72	**281**
December 2023	154	5	53	**212**
January 2024	140	3	53	**196**
February 2024	147	3	51	**201**
March 2024	116	10	67	**193**
April 2024	147	10	70	**227**
May 2024	169	15	54	**238**
June 2024	185	17	54	**256**
July 2024	215	30	68	**313**
August 2024	214	31	67	**312**
September 2024	189	28	61	**278**
Total	**2131**	**165**	**761**	**3057**

UAMS MAT Services awarded 21 agencies with funds for MAT services. Nineteen (19) of the awardees have at least one prescribing provider. Funding for Peer Support Specialists was also provided. Eighteen of the agencies utilized peer workers who often provided services to multiple agencies in their catchment area.

Figure 21: Arkansas Catchment Areas

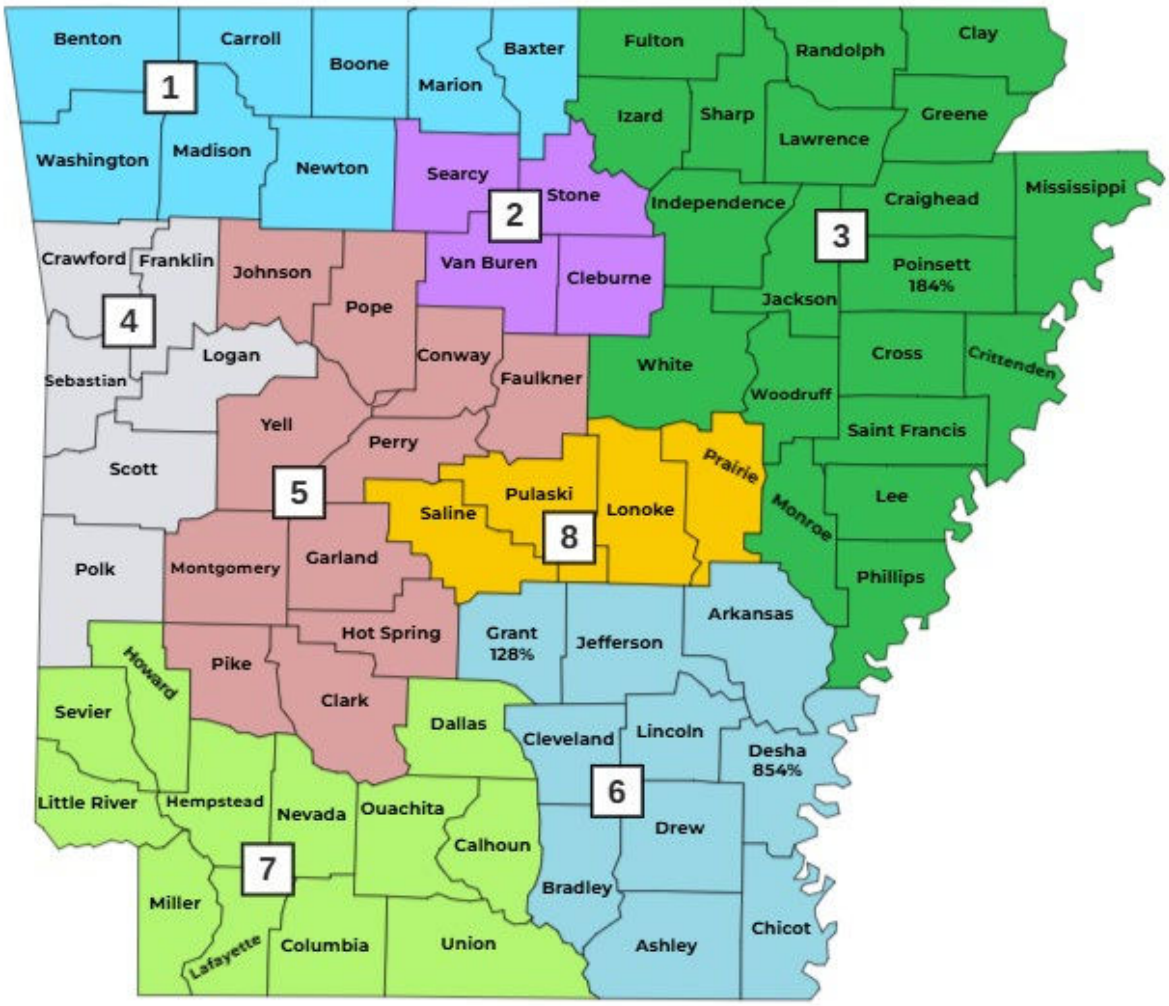


Table 18: Number of UAMS MAT Services Providers, Counselors, and Peers by Catchment Area

Catchment Area	Providers	Counselors	Peer Workers
1	7	3	4
3	16	13	8
4	20	1	5
5	11	4	7
6	2	2	1
8	7	5	4
Total	**63**	**28**	**29**

SOR III Recovery Initiatives

SAMHSA\CSAT supports peer recovery support services in which peers with lived experience assist others in achieving and maintaining recovery, in conjunction with clinical treatment services. Peer support is recognized as an evidence-based practice for individuals with substance use disorders and/or mental health challenges.

Arkansas' SOR III recovery activities include:

- Peer Recovery Support Services
- Peer Recovery Support Certification
- Core Training to Educate Peers in Naloxone and Recovery Processes
- Ethics Training
- Peer Specialist Services that Begin During Incarceration

The following state agency and community organization programs participated in recovery efforts for Arkansas' SOR III Program:

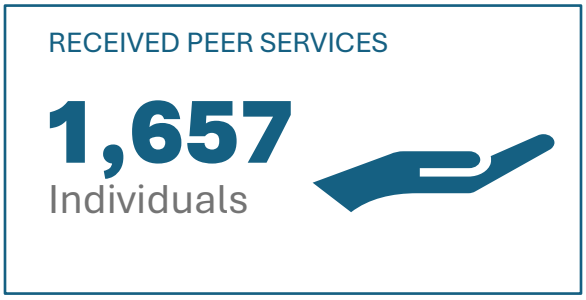
- DHS Peers Achieving Collaborative Treatment (PACT) Recovery Project
- UALR SOR-R Peer Specialist and Recovery Project

DHS Peers Achieving Collaborative Treatment (PACT) Recovery Project

The Peers Achieving Collaborative Treatment (PACT) project provided vital peer recovery support services through cross-agency collaboration with law enforcement, prisons, drug courts, reentry programs, transitional housing and sober-living houses, and hospital emergency rooms. This project, under the direction of the DHS Division of Aging, Adult & Behavioral Health Services (OSAMH) empowered Peer Recovery Support Specialists to use their unique "lived experience" to inspire hope in individuals with substance use disorders – i.e., who have a history of opioid misuse, alcohol intoxication, and/or addiction to stimulants like methamphetamine or cocaine that is often complicated by co-occurring illnesses. All awarded agencies utilized the Arkansas Model of Peer Recovery and provide authentic peer recovery support services by peer workers trained, registered, or certified under the Arkansas approved certification process.

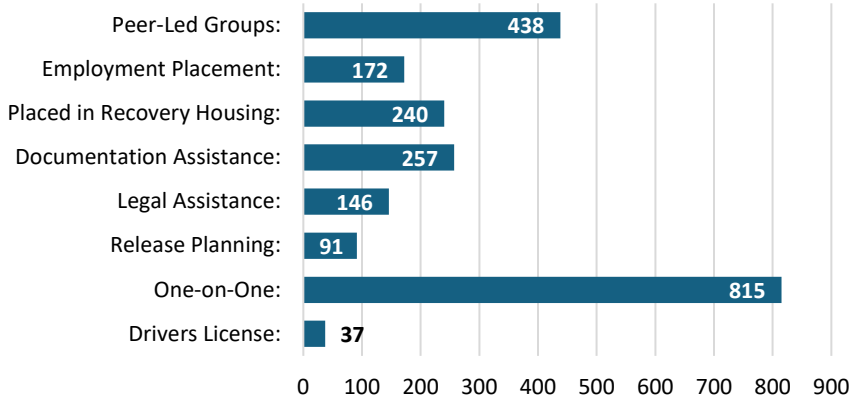
Program Goals	Program Highlights
▪ To provide a peer specialist program in jails, hospitals, and other public service places designed to introduce individuals to receiving treatment. ▪ To support strong reentry into society.	▪ This program anchors itself in resource brokering in the outlying communities to build a strong recovery community.
Program Successes	**Program Challenges**
▪ A strong partnership with River Valley Medical has been successful. ▪ $8k in fines were dropped due to peer advocacy. ▪ 20 participants graduated IOP ▪ 14 peers furthered their education.	▪ Navigating how to serve rural areas. ▪ Not being able to serve pregnant women or women with custody of their children. ▪ Combatting stigmas in the community about addiction. ▪ Transportation issues. ▪ Out-of-State document assistance. ▪ A place to facilitate groups outside of jail. ▪ Stable housing. ▪ Employment assistance vs. criminal background.

DHS Peers Achieving Collaborative Treatment (PACT) Recovery Project Administrative Data



Between October 1, 2023 and September 30, 2024, 1,657 individuals received a variety of peer recovery support services through PACT. The majority of PACT services used (*n*= 2,196) were One-on-One counseling (*n* = 815; 49.2%), followed by Peer-Led Groups (*n* = 438; 26.4%), Documentation Assistance (n = 257; 15.5%), Placed in Recovery Housing (*n* = 240; 14.5%) , Employment Placement (n = 172; 10.4%), Legal Assistance (*n* = 146; 8.8%), Release Planning (*n* = 91; 5.5%), and Driver's License (*n* = 37; 2.2%). Of those served, 51.8% (*n* = 859) of individuals participated in abstinence-based recovery for substance use disorder, while 11.8% (*n* = 195) received medicated-assisted treatment.

Fig: 22: PACT Services: Oct 1, 2023 - Sept 30, 2024



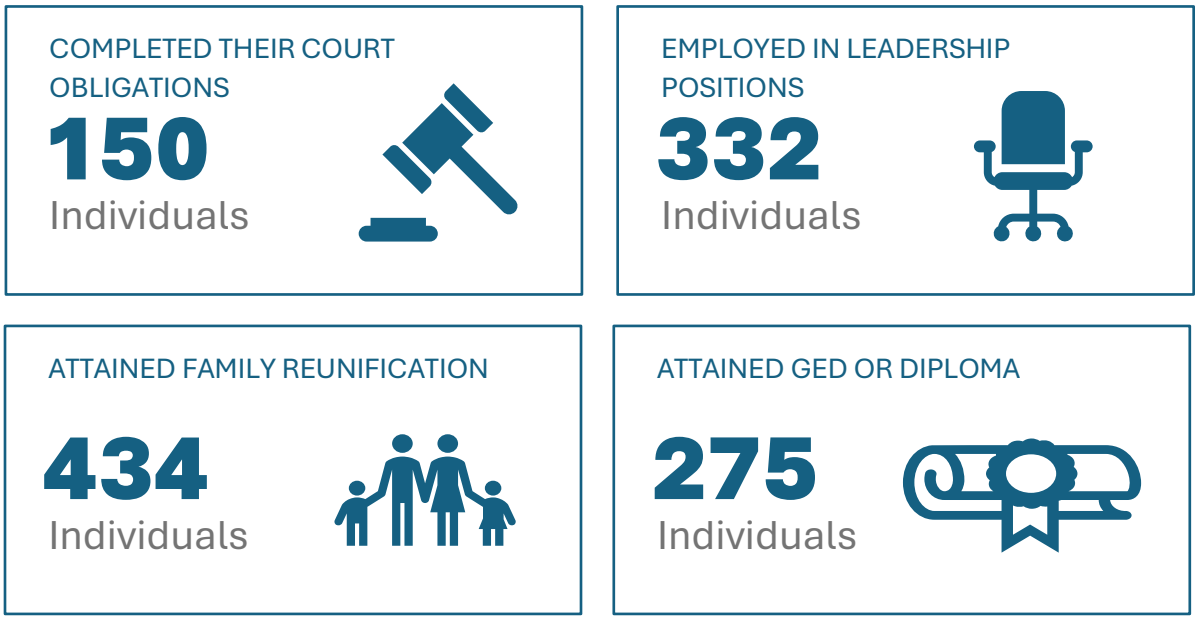
Between October 2023 and September 2024, 622 admissions were reported with the majority of individuals (24.0%; *n*= 397) admitted due to a substance use disorder, while 2.8% (*n* = 46) were admitted due to an overdose, and 10.8% (*n* = 179) were admitted for a mental health issue.

Table 19: Number and Percent of PACT Admissions by Type

Types of Admissions	Number of Admissions	Percent
Substance Use Disorder (SUD)	397	24.0%
Mental Health	179	10.8%
Overdose	46	2.8%
Total	**622**	**100.0%**

Successes to the program include 150 PACT participants completed their court obligations, and 332 were employed in leadership positions. Four hundred and thirty-four (434) individuals attained family reunification through the successful completion of cognitive behavior

programming and family counseling services. Two hundred and seventy-five (275) individuals earned their GED or diploma utilizing the educational services offered through PACT.



RECOVERY

UALR SOR-R Peer Specialist and Recovery Project

The UALR SOR-R Peer Specialist and Recovery Project aimed to enhance the Peer Certification system in Arkansas by introducing a new forensic peer training track and adding supervisory dimensions to the existing tracks. This addition created a framework for future specialized concentrations and extended the curriculum to incarcerated individuals to aid their reentry process. The project has organized one-day Addiction Recovery mini-summits across the state to educate local communities on the peer specialist certification process, focusing on regions with few or no certified peer specialists. It also used online webinars to update and educate the Peer network.

Program Goals	Program Highlights
▪ To increase the number of Peer Workers. ▪ To reintegrate people going through recovery back into society. ▪ To provide training to people in the peer system, including ethics training. ▪ To give Naloxone training to peers during core training.	▪ This program is rooted in the belief that the program benefits the entire state population by educating and reintegrating peers. ▪ This program uses a "core training" to educate their peers in Naloxone and the recovery process.
Program Successes	**Program Challenges**
▪ Pass/fail rates have been going well since Midsouth took over. ▪ They have become a visible part of the community. ▪ Their advertising campaign has been successful. ▪ Peers can become nationally certified.	▪ Unable to adequately serve the homeless population, the Marshallese population, and Vietnamese population. ▪ They have struggled with future planning with unsure funding.

UALR SOR-R Peer Specialist and Recovery Project Administrative Data

Trainings: The UALR SOR-R program managed the registration, logistics, supplies, communications, and promotional activities for several peer training sessions. A total of 535 participants attended various types of training, including: Core (227 participants; 42%), Advanced (24 participants; 5%), Supervisor (22 participants; 4%), Justice-Involved (40 participants; 8%), Ethics (117 participants; 21%), Professional Development (97 participants; 18%), and the Facilitator Guide Workshop (8 participants; 2%).

PEER TRAINING

535

Trainees

Financial Support: The program also provided financial support for eligible trainees, covering expenses such as travel and meals (254 trainees; 48%). Two hundred and thirty-six (44%) trainees also qualified to receive additional lodging support.

ATTENDANCE SUPPORT

254

Trainees

LODGING SUPPORT

236

Trainees

Peer Certification Exams: The UALR SOR-R program funded certification exams for three levels of Peer Specialists: Core Peer Recovery Specialist (CPRS), Advanced Peer Recovery Specialist (APRS), and Peer Recovery Supervisor (PRS). These levels correspond to three tiers of training: Core, Advanced, and Supervisor. OSAMH identified eligible candidates for testing. Candidates needed to achieve a passing score of 70% and were allowed up to three attempts to pass. The University of Arkansas at Little Rock (UALR) Survey Research Center administered both in-person and online proctored testing.

PEER CERTIFICATION EXAMS

Certification Type	Passed
PR	57
APR	19
PRPS	3
TOTAL	79

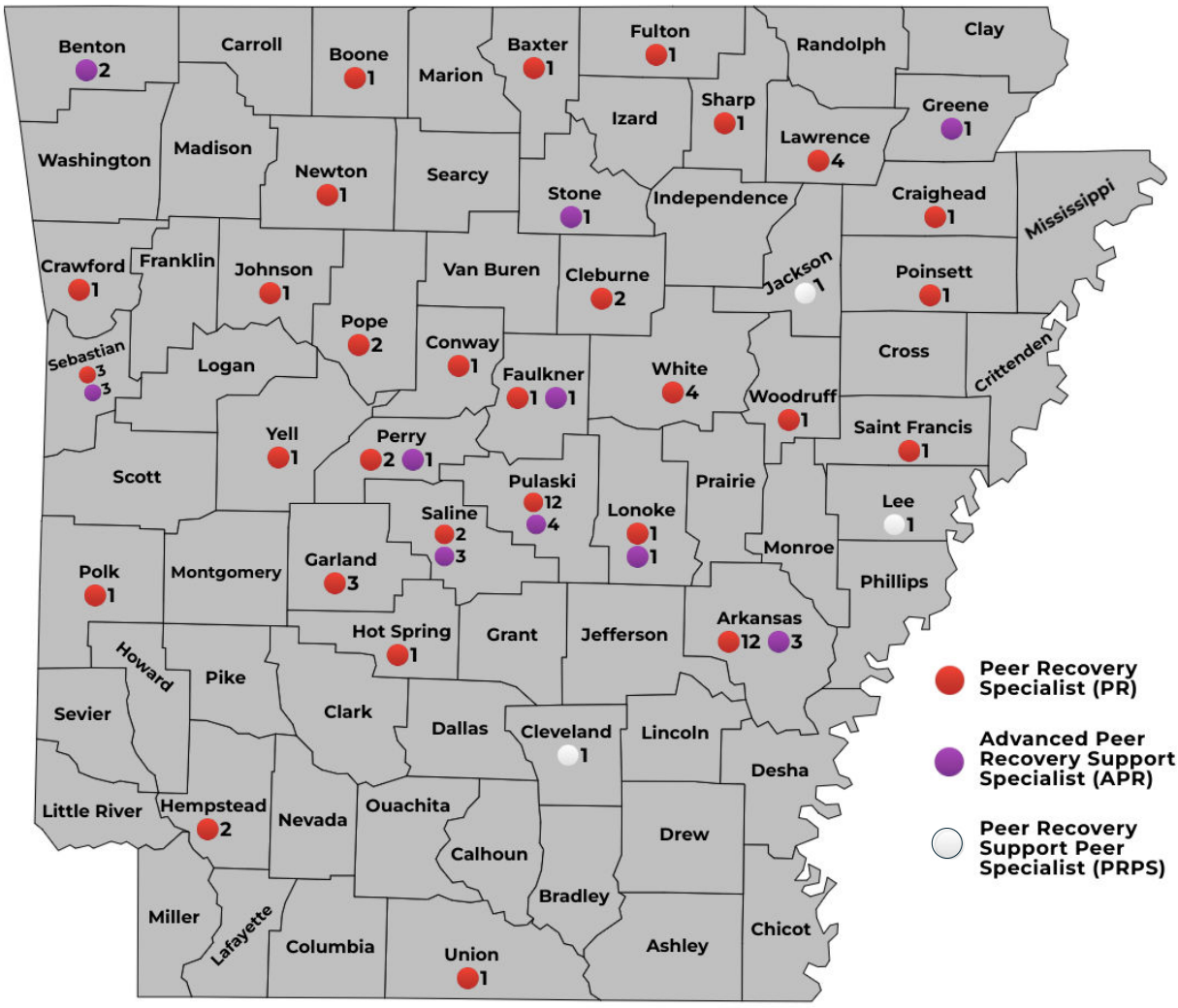
EXAMS PASSED ON FIRST ATTEMPT

Certification Type	Passed
PR	52%
APR	15%
PRPS	2%
Total	69%

Peer Workers play a vital role in supporting individuals on their recovery journey, assisting them in identifying and achieving their personal needs, desires, and goals. Advanced Peer Recovery Support Specialists undergo more comprehensive training, enabling them to handle more complex cases, provide specialized support, and assume leadership responsibilities, including mentoring other peer specialists. Additionally, Peer Recovery Support Peer Specialists supervise their peers, offering mentorship, sharing knowledge, and disseminating best practices based on their own experiences.

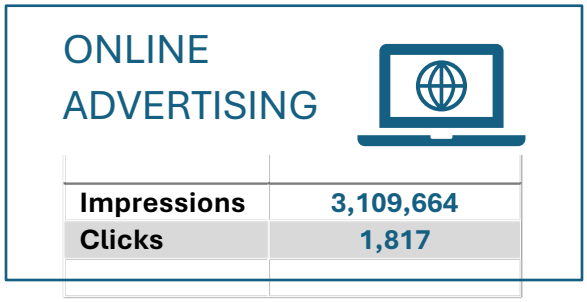
During SOR III, 79 peers were certified as Peer Specialists across 28 counties. This included 57 individuals as Peer workers, 19 as Advanced Peer Recovery Support Specialists, and 3 as Peer Recovery Support Peer Specialists.

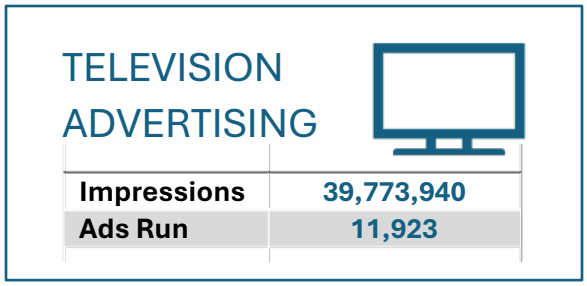
Fig. 23: Certified Peer Types by County



Arkansas Peer Advisory Committee (APAC): APAC, or its sub-committees, met a total of 35 times during the reporting period. APAC advises the DHS Recovery Unit on best practices and to offer guidance to strengthen the peer recovery workforce across the state. APAC committee members are appointed by the Arkansas Drug Director. Members of the team include the DHS Recovery Team, as well as up to 15 community stakeholders who are certified peer workers with significant knowledge and experience in the field.

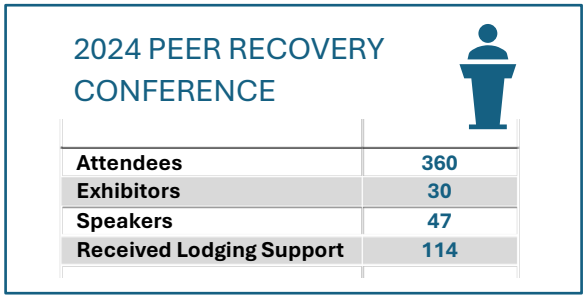
Media: The SOR-R program funded a media campaign that utilized both online platforms and television to promote the message, “Would You Like a Career in Recovery?” These advertisements directed individuals to the AR.GOV/Recovery website for resources and information on pursuing a career as a peer specialist. During the reporting period, the campaign generated a total of 42,883,604 impressions, with television accounting for the majority. Online advertising generated 3,109,664 impressions, while television advertising yielded 39,773,930 impressions.





Peer Recovery Conference: The SOR-R program hosted the 2024 Peer Recovery Conference on August 28th and 29th, featuring sessions such as "Peers in a Medical Setting," "Lived Experience," and "More Than Our Recovery: Approaching Peer Support Through an Intersectional Lens."

Participants were invited to voluntarily complete evaluation surveys regarding individual speakers and the overall conference. The surveys primarily focused on attendee satisfaction and the relevance of the information to their peer support practice. Speaker evaluations garnered 268 responses, with an average score of 4.8 or higher out of five for each question. The overall conference evaluation received 36 responses, also achieving a mean score of 4.8 or above out of five.



Qualitative Study #4

Results from Interviews with Individuals Participating in Peer Recovery Support in SOR III Sponsored Programs

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Executive Summary

The SOR III Peer Recovery Support (PRS) program evaluation assessed the experiences of individuals involved in utilizing PRS services at four different program sites throughout the state of Arkansas: two correctional facilities, one non-profit community behavioral healthcare center, and one primary care clinic.

The PRS evaluation has two primary goals: first, to use data to enhance or improve PRS program services as they relate to SOR III, and second, to document PRS program success. Researchers from Wyoming Survey & Analysis Center (WYSAC) designed the evaluation and facilitated the interview session, visiting all four sites in December 2023.

Researchers found consistent patterns in respondent answers. Among participants, access to a PRS program was most commonly found during incarceration. Common topics during discussions included facing ongoing legal challenges, mental health issues, interpersonal relationships, transportation, and a lack of resources in rural areas. Also discussed were many positive behavioral and attitudinal changes stemming from access to PRS. Respondents found success in relationships they've built through the program, noting the common ground they found with peers.

Background

Formally started in 2017, the Arkansas Peer Recovery Program (ARPR) is a comprehensive support initiative designed to assist individuals with substance use disorders through the process of recovery. At its heart, PRS is distinguished by its peer-led support framework. This pivotal aspect involves the engagement of peer recovery support specialists— individuals who have lived experience with substance misuse recovery. These specialists bring invaluable knowledge, abilities, and empathy, rendering the support they offer useful, authentic, and relatable.

The scope of services offered through the PRS program is broad and multifaceted, tailored to meet the diverse needs of people engaging in the recovery process. This inclusive approach focuses on not just the physical aspects of recovery, but also the psychological, social, and emotional dimensions to help enable a well-rounded and effective path for those in the process of recovering from a substance use disorder.

The overall goal of the PRS program is to support long-term recovery through the promotion of self-empowerment and personal autonomy. The program actively involves individuals in

the creation of their own recovery plans, promoting a sense of ownership and responsibility over their recovery process.

Empowerment is further enhanced by encouraging active participation within the recovery community that fosters a supportive network. This community not only provides a network of support for individuals but also plays a critical role in reducing the stigma associated with substance use recovery. Participation in a peer community helps develop a sense of belonging, shared purpose, and mutual understanding, which creates a nurturing environment where individuals can thrive and support one another on the path to recovery. Through these efforts, the PRS program embodies a comprehensive, compassionate approach to recovery underpinned by the principles of peer support, self-empowerment, and community building.

In September of 2022, DHS/OSAMH contracted with the University of Wyoming, Wyoming Survey & Analysis Center (WYSAC) to evaluate the SOR III program. The evaluation of Peer Recovery Support (PRS) in various SOR III sponsored programs is part of WYSAC's overall evaluation process. The University of Wyoming granted WYSAC researchers an IRB exemption, determining that individuals would experience less than minimal risk for participating in this research.

Methods

Semi-structured interviews were used to collect qualitative data. WYSAC evaluators developed an interview instrument (Appendix A) containing prompts to help guide discussion about PRS and related topics. All interview participants were informed of their rights, and each signed a consent form (Appendix B) explaining the goals of the study and the interview format prior to participation. Researchers provided each facility with a copy of the consent form which included 1) contact information if participants had any later concerns or wanted additional information and 2) consent for the session to be digitally recorded. Contact information of a virtual counseling organization was also provided for participants if they experienced feelings of discomfort or distress resulting from discussing issues related to the process of recovery and to PRS in particular. All participation was voluntary, and participants could refrain from answering any or all questions and could end the interview at any time.

The interview research instrument listed questions asking for the opinions and experiences of individuals involved with PRS. Interview prompts asked participants about their history with substance misuse and recovery, their thoughts and experiences utilizing PRS, the challenges and barriers related to PRS, perceived stigma surrounding opioid use disorder and PRS, notable successes, and their recommendations for PRS services improvement. Interviews lasted between 30 and 60 minutes and were held at each of the four locations in a semi-private meeting room.

Demographics of Participants

Demographics of interview participants are described in Table 1 below. There were nine respondents: seven women and two men. Nine self-identified as white and one as Hispanic/Latino. Of the available demographics, the youngest was 26, and the oldest was 57 years of age. The average age was 39. Four were single, two divorced, two married, and one unmarried with a partner. Only one interview participant did not have children, three were employed, and three unemployed. The amount of time in recovery ranged from approximately two months to an estimated 12 years. Facilities were not identified to maintain the confidentiality of participants.

Table 1: Demographics of Interview Respondents (*n* = 9)

	Response Frequency	Percent	Mean	Range
Age	7	78%	39	26 - 57
Missing	2	22%		
Race				
White	9	100%		
Ethnicity				
Hispanic/Latino	1	11%		
Non-Hispanic/Latino	8	89%		
Gender				
Female	7	78%		
Male	2	22%		
Marital Status				
Married	2	22%		
Single	4	45%		
Partner	1	11%		
Divorced	2	22%		
Number of Children	6	67%	1.3	0-3
Missing	3	33%		
Employment Status				
Employed	3	33%		
Unemployed	3	33%		
Missing	3	33%		
Time in Recovery	7	78%	46 months	2-144 months
Missing	2	22%		

Analysis

WYSAC researchers and support staff transcribed the digitally recorded interviews verbatim. All personally identifying markers were removed from the documents during the transcription process to preserve confidentiality. Consent forms are stored in a locked file cabinet and digital files of transcripts have been uploaded to WYSAC's password protected secure server. Content and thematic analysis using R statistical software were used to determine patterns of responses that describe the experiences, opinions, thoughts, and recommendations of the interview participants.

Findings

What led you to use PRS as part of your recovery?

Many respondents discovered the PRS program through their experiences with incarceration and struggles with mental health issues, substance use disorder, including the illicit use of heroin, crack, fentanyl, and methamphetamine. For many, incarceration served as a pivotal moment, prompting them to reevaluate their lives and seek help for their substance misuse.

> **"If I hadn't been put in jail, I probably wouldn't have even had a clearer mind to want to quit."**

- "I had a crisis in 2020. I had a flare up with my PTSD. And I ended up in jail. And I ended up getting my mental health court. . . [and] that's how I became part of it [PRS]"

What challenges have you faced on your path to recovery?

Interview respondents discussed facing a variety of challenges on their paths to recovery. The most often mentioned challenges fell under two categories: personal and structural. Participants felt that these challenges often hindered their recovery progress and, at times, made it more difficult to commit to a life of sobriety.

Personal Challenges

Personal issues ranged from problems with reoccurrence, changes in friendships, challenges to current romantic relationships in recovery, and the effects of mental health issues on their relationship choices.

Friendships: Respondents discussed the effect changes in their behavior had on their relationships during their recovery, for instance, difficulty in forming stable friendships that do not involve substance use.

- "I got bored and lonely. And the only people I knew were users. So, I would go hang out and use. They weren't my friends. They all like stole from me and screwed me over. So yeah, at this point, making friends is hard if that makes sense. Like I know a lot of people already had to cut out a lot of people when I don't really hang out anymore."
- "I have a few [friends who don't use] . . . The rest of them are still using, and I can't be around that."
- "Yeah, I mean, I have acquaintances that I kind of like, but I have to keep the guard up right now."

Relationships: For some participants that were single, finding a partner that supported them and shared their values was difficult. Those who were married or had partners mentioned these relationships in the context of their recovery journeys, indicating either receiving support or dealing with challenges within these intimate relationships. There was noticeable variation in their experiences and expectations.

One respondent said they faced challenges in finding a compatible romantic relationship.

- "I'm gay. . . and it's just not . . . the South isn't really you know [accepting] . . . it's a very conservative town."

One respondent talked about how their husband had never used drugs and was supportive of their recovery journey despite its difficulties, while another noted how both they and their partner were in recovery.

- "My husband has never taken drugs in his life. . . . And when I met him, I was a heroin addict. And I was hiding it from him. And we just were poor people, and I didn't have the ability to do treatment or anything like that. And when I told him that I was a heroin addict, he couldn't believe it. He was like, I don't even know what that is [to start with]. And he's like, what can I do to help?"
- "We've been together for a year. There's an age difference. So, it's rocky. We're both in recovery. . . I definitely can't be in a relationship with someone that's in active addiction and I can't be around someone that doesn't understand addiction. So, it only makes sense [to be in a relationship with someone] in recovery."

Others still discussed challenges related to their substance misuse and recovery journey that directly or indirectly affect their immediate family members.

- "I love my son. I have two granddaughters. They're precious. I've got a beautiful daughter-in-law. But they're all busy and I try to have a relationship with them. I'm sure there's lots of anger there

and stuff from the past. You know, being absent [and] on drugs and stuff . . . but he's not ready to talk to me about it."

- "I'm separated from my kids right now. Actually, this month, I'm able to start going back to court after them so I can get visitation."

Some have immediate family members that currently misuse or previously misused substances.

- "Both my sisters and my brother are in active addiction."
- "My mom, she was an addict . . . she doesn't go to groups, she doesn't do anything like that. . ."
- "My son was coming here and telling me about this place. My son had a short bout with opiates himself."

Mental Health Challenges: Several respondents candidly discussed their struggles with mental health and how it affected their substance misuse. Some admitted to relapsing during a difficult period in their lives. Others were proud of the fact they resisted the urge to use. All stated they were committed to getting and staying clean.

- "You know, I have my days. I just went through a year and a half of major depression. I mean, but I didn't use."
- "I feel like things are still stressful, but I feel like I have better ways of handling stress now than I did before."
- "Right now, I'm struggling. I'm just kind of dabbling every now and then , but I want to get rid of it. I've been a crackhead, and I've been a heroin head. So, I know that there's hope for me with this last one. This is it, there's no more left."

Structural Challenges

The two most prominent structural challenges discussed during interviews were transportation challenges and scheduling challenges due to overlapping work schedules and mandatory treatment appointments.

Licensing Challenges: Several participants indicated they did not drive and discussed the general challenges in getting their driver's license reinstated.

- "I don't have a license, or I do but it's suspended, but I'm getting help with that."

"A lot of times, I'll walk . . . because [my appointments] are only like a mile and a half [away]."

Affordable Transportation Challenges: Others pointed to the challenges of finding affordable public transportation that meets their needs.

- "I don't drive. I take the bus and then I have the demand bus. That's one-on-one, whenever my PTSD or schizophrenia has flared up, I take the demand bus where it's just me and the driver. . . . It's just 50 cents for public riding, [but it's] $2.54 for the demand bus."

Geographic Challenges: Respondents also discussed the difficulties of living in a rural community with a lack of public transportation, and the limited number of group NA/AA meetings.

- "But in the more rural areas, we found that it's really hard for somebody to get to those [NA/AA] meetings and [to other] resources."
- "I feel bad asking someone who lives 50 miles away to come get me and to take me to an appointment that's an hour away."

Scheduling Challenges: Another discussed the challenges of balancing the demands of both an inconsistent work schedule and meeting times.

- "I work at a gas station and the schedule is not really set in stone there. But I have, my boss has given me Tuesdays off, and that's the day that we do group. So, the schedule is a challenge."

Where did you see success in the PRS process?

Analysis found most client discussions fell into two major categories of success in the PRS process: the ability of PRS to promote personal growth and its capacity to provide access to resources.

PRS influenced personal growth by guiding clients to improve and build upon relationships, connect with a higher power, and promote positive habits, attitudes, and behaviors.

Personal Growth

Family Relationships: Numerous respondents discussed how PRS helped to develop more positive relationships with family members.

- "My kids got taken [away from me] whenever I went to jail, and now I'll be able to get them back because I'm clean. . . whereas before I would have just went back to using."
- "Everything about me changed. . . My relationship with my family has changed. My kids want to talk to me now. I feel like my life has purpose now."

Peer-to-Peer Relationships: Other clients emphasized the one-on-one nature of the program, the mutually supportive relationships among peers, and the trust they built with other peers through the program.

- "There's a whole fellowship thing that goes along with it."
- "It's a sisterhood . . . you see."

- "It's easier to talk to them. They're living in recovery. I see them live in recovery. I've seen them in meetings and know what they've done. I know that they're clean. . ."
- "They care. They've been through the same things. So, they understand if you relapse, or you know, they just want the best for you and everybody else."
- "If you ever need anything like they are literally a phone call away."
- "My PRS helped me move. He's offering to help again. It's just like family."
- "They're hands on. They come to your home, getting to know you well, getting to know you personally as a human being, not just a client or a number."

Connecting with a Higher Power: Several clients discussed the relationship between PRS and spirituality, and how this relationship helped enhance their spiritual practice.

- "For me, I've grown a lot in my relationship with God, because there is a whole spiritual side to this program as well."
- "Support is a huge help, but the Lord has [also] helped me out a lot."
- I'm a spiritual person, but it's different than you know, most, I guess. I had a weird spiritual experience last December during this year . . . . And that's when I started coming back here and stuff.

Promoting Positive Habits, Attitudes, and Behaviors: All clients discussed the positive changes in habits, attitudes, and behaviors. Many clients attributed these changes – in large part – to the support given in the PRS program.

- "I went from being depressed and miserable to being happy and joyful, [and] that's how my life has changed."
- "So, this is the first time in my life I've ever been mentally stable. I'm finally at a good spot in my life and have hope for the future for once."
- "Without the drugs and alcohol, I've got the clarity to grow. As far as the growing, it's happening slowly."

Moreover, several respondents described how their personal experiences with substance misuse and with the PRS program have influenced them to pursue their own career that provides support for others.

- "I always wanted to be like a counselor of sorts. So, my gratification I get is through helping other people, [and] it helps me as well."
- "I volunteer with the PACT program. I go into the jail a lot. I tell them my testimony and I spend time with them. I always bring them stuff."

Access to Resources

Respondents often noted the support they found within the PRS program, including access to much needed resources such as help in obtaining a driver's license, housing, employment, and education. Many respondents highlighted how this support helped reintegrate them into society.

- "They help you get your license back or help you do different things. Like we've had classes on banking and stuff like that."
- "I applied for 911 dispatch . . . That's the best thing that ever happened to me. The job is amazing, [and] if it wasn't for this place, I wouldn't be where I am today."
- "I am eight classes away from having my bachelor's degree in addiction studies."

I was homeless for three years, from 2020 until December 2023. So, I just got my place recently. They helped me.

What additional resources or services are needed to support PRS?

The PRS program works in concert with resources and agencies within the community. This includes assistance with substance use disorder treatment, mental health services, social support, and access to housing, employment, and education opportunities. Respondents discussed the need for greater or different access to these resources, especially for women.

- "One thing I would like is a female therapist. That would be nice. I mean, I don't feel comfortable there. They have a male I know. They've offered me you know, two or three times if I just try him, but I've done that before. And I don't know what the reason is, but I'm not comfortable talking to another man."
- "I'd like to see more volunteers come in and share their testimony."
- "I'd like to see more girls be able to be in here. I'd like to see a bigger classroom. More peers and maybe longer classes." (PACT Program member)
- "Maybe a few parenting classes. That would be something that I would like to see added because since the focus is on the women, why not have more women-focused classes? I think that would be monumental for us." (PACT Program member)

Observations and Recommendations

- **Develop a "Peers in Your Community," advertising campaign that embraces diversity.** Interview participants expressed the importance of communities knowing and supporting Peer Recovery Support and that these services are community-based and for everyone that needs them. We recommend an inclusive media campaign featuring individuals from a variety of backgrounds that promotes Peer Recovery Support Specialists as caring, compassionate, knowledgeable individuals that live and work in the communities they serve.

- **Consider adding a "Communicating with Couples in Recovery" module to the Effective Communication component of the PRS training curriculum.** Several participants discussed the difficulties of going through recovery while in a relationship. We recommend adding a "Communicating with Couples in Recovery" component to the training program for Peer Recovery Support Specialists to learn how to build rapport with both partners while maintaining a non-biased position.

- **Integrate services to provide greater access to resources to address the specific needs of women in recovery.** Participants spoke of the siloed services and support for women in some areas of Arkansas. We recommend more women-centered services to cover the specific needs of women including education, employment, childcare, reproductive healthcare, mental health services, and gender-based violence in communities.

- **Link community services within each county to address unmet needs for those suffering from substance misuse.** Participants directly discussed access to services within their communities. Having a greater presence within counties throughout the state will increase access to resources while decreasing the stigma surrounding substance misuse.

- **Require that all individuals receiving MAT be offered a PRS Specialist in all SOR III sponsored programs as part of their recovery process.** Interviews indicate that Peer Recovery Support for individuals using MAT has had a substantial positive impact on their recovery and reentry. We recommend that all individuals be connected to a Peer Recovery Support Specialist in all MAT programs to support their recovery and reentry process.

Conclusion

It is evident that peer-led support, comprehensive care strategies, and the cultivation of a supportive recovery community play pivotal roles in addressing substance use disorders in Arkansas communities. The incorporation of Peer Workers, bringing their lived experience into the support framework, provides knowledge, experience, and empathy to facilitate a more personalized and holistic process for clients in recovery.

Through the analysis of respondent experiences, several key themes emerge that underscore the complexities and multifaceted personal nature of recovery. Respondents discussed both personal and structural challenges in their recovery, including working through legal and financial barriers, dealing with transportation matters, and struggles with relationships and mental health issues. They also highlighted the positive effect the program had on their personal growth: expanding and/or mending important relationships, reinvigorating their spiritual life, and developing positive habits, attitudes, and behaviors. Many respondents reported successful reintegration into society. In particular, the support structure of the PRS program has been instrumental in helping individuals find meaningful employment and pursue education opportunities.

The active involvement of participants in their own recovery plans and the support from the recovery community emerge as significant factors in fostering resilience and long-term sobriety. The PRS program represents a critical step forward in addressing substance use disorders through a community-based, peer-led approach. However, continued efforts to refine and expand the program, alongside broader societal and policy-level interventions, are essential to fully support individuals in their recovery journeys.

Appendices

Appendix A

PEER RECOVERY SUPPORT PARTICIPANTS
INTERVIEW INSTRUMENT

Hi, my name is _____, and I will be your interviewer for this Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) research project. We are speaking with you because of your experiences using Peer Recovery Support services as part of your treatment and recovery process. The purpose of this interview is to find out about your thoughts, attitudes, and experiences using Peer Recovery Support. DHS/OSAMH is interested in gathering information concerning methods of support and treatment of individuals experiencing substance use disorder in the state of Arkansas. Everyone has somewhat different backgrounds and experiences and so your attitudes and familiarities about this topic might be different than someone else's. That's why it's important you tell us about your ideas and opinions – even if you might feel it may be different from what you think someone else might say. We don't expect everyone to have the same perspective, so don't be afraid to speak up. Often, we learn the most when people have different ideas about something.

Do you have any questions before we begin?

Introduction

To get started, can you please answer some basic demographic questions: Gender, race, age, marital status, number of children.

Next, can you please tell me a little bit about yourself and why you chose to participate in peer recovery support?

Prompts for discussion

1. How long have you been using peer recovery support?
2. Can you tell me about the process? What differs about this process than with other support groups like AA or NA?
3. What are the benefits of this type of support? The challenges?
4. Do you feel that peer recovery support is personally working for you? Why or why not?
5. Since you started using peer recovery support, has your life changed? If so, how?
6. In your opinion, what would you like to see change about the process or program? What would make peer recovery support better?
7. Would you refer this type of support to a friend or family member? Why or why not?

Conclusion

The interviewer provides a short overview of the purpose of the study.

Thank you for participating in the interview. We appreciate you taking the time out of your day to be part of our study. The information that you provide will help the Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) gain a better understanding of how to reduce unmet treatment needs and opioid-related overdose deaths in the state of Arkansas. This interview is one data collection method we are using to gather information.

- Is there anything you would like to add that we haven't covered?

Appendix B

PEER SUPPORT RECOVERY PARTICIPANTS INTERVIEW
INFORMED CONSENT

Thank you for agreeing to participate in this interview. We are speaking with you because of your experiences using Peer Recovery Support services as part of your treatment and recovery process. The purpose of this interview is to find out about your thoughts, attitudes, and experiences using Peer Recovery Support. The Arkansas Department of Human Services/Division of Aging, Adult, and Behavioral Health Services (DHS/OSAMH) is interested in gathering information concerning methods of support and treatment of individuals experiencing opioid use disorder (OUD) in the state of Arkansas. Interviews are one data collection method we are using to gather this information. This interview will take approximately 30-60 minutes. Your participation in this interview is entirely voluntary. You may choose not to answer any or all of the questions, and you may choose to end the interview at any time. Your answers will be kept confidential, and at no time will your name be attached to your answers or to any of the data collected through this discussion. You will receive a $15 gift card for your participation. You do not have to answer any question that makes you feel uncomfortable, and you may choose to leave the focus group at any time. You will receive your $15 gift card whether you complete the focus group session or not.

We will be reporting the results of the interviews in aggregate. While I may capture some meaningful quotes, they will not be connected to any individual. I am interested in both majority and minority viewpoints, as well as common and uncommon experiences. I will not be upset by critical commentary, nor will that count as a strike against you, so please do not hold back even if you feel your comments may be discouraging. I am interested in your experiences and opinions concerning your use of Peer Recovery Support. After the interview, if you have feelings of discomfort or distress resulting from discussing this topic, a free UAMS online counseling service is available to you at (501) 526-3563.

If you have questions about your rights as a research subject, please contact the University of Wyoming IRB Administrator, at (307) 766-5320. You may also contact Dr. Andria Blackwood at (734) 678-5428 for general questions about this project.

"My participation is voluntary and my refusal to participate will not involve penalty or loss of benefits to which I am otherwise entitled, and I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled."

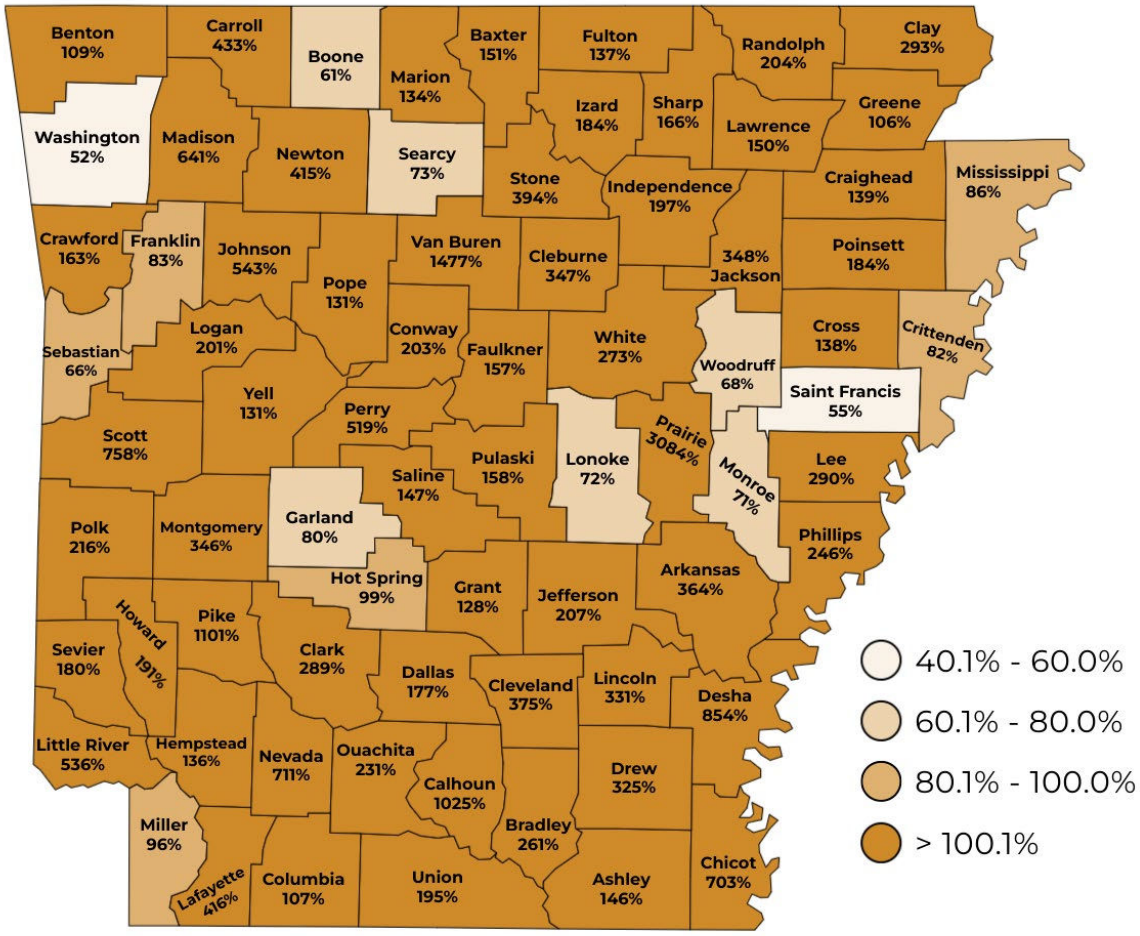
_____ Participant name _____ Date

I consent to be recorded during this interview: □ YES □ NO

Statewide Naloxone Distribution and Saturation

In May 2023, the Office of Substance Abuse and Mental Health (OSAMH) allocated $2.5 million to distribute Naloxone across Arkansas. The project concluded on April 1, 2024, achieving full coverage in 61 out of the state's 75 counties. This initiative has played a significant role in reducing the opioid-related overdose rate in Arkansas by 13%. The saturation map below depicts the percent of Naloxone saturation by county in Arkansas from all sources from October 2023 to April 2024.

Figure 24: Naloxone Saturation Map October 2023 – April 2024



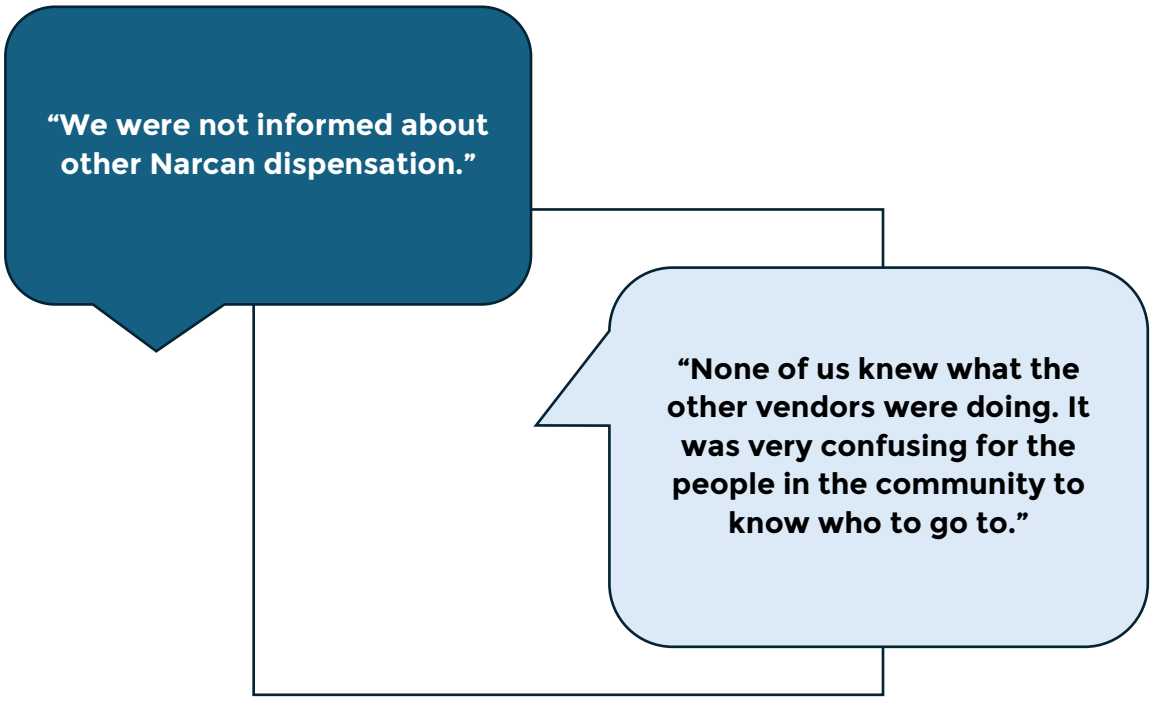
Methods

WYSAC evaluators conducted semi-structured interviews with stakeholders to gather context, history, and insights on the programs they oversee. An interview guide (Appendix A) was developed to facilitate discussion on program goals, achievements, challenges, and future concerns. WYSAC researchers and support staff transcribed the interview notes, removing all personally identifying information to ensure confidentiality. Analysis revealed three main themes: (1) Gaps in Communication, (2) Staffing Issues, and (3) Success and Sustainability.

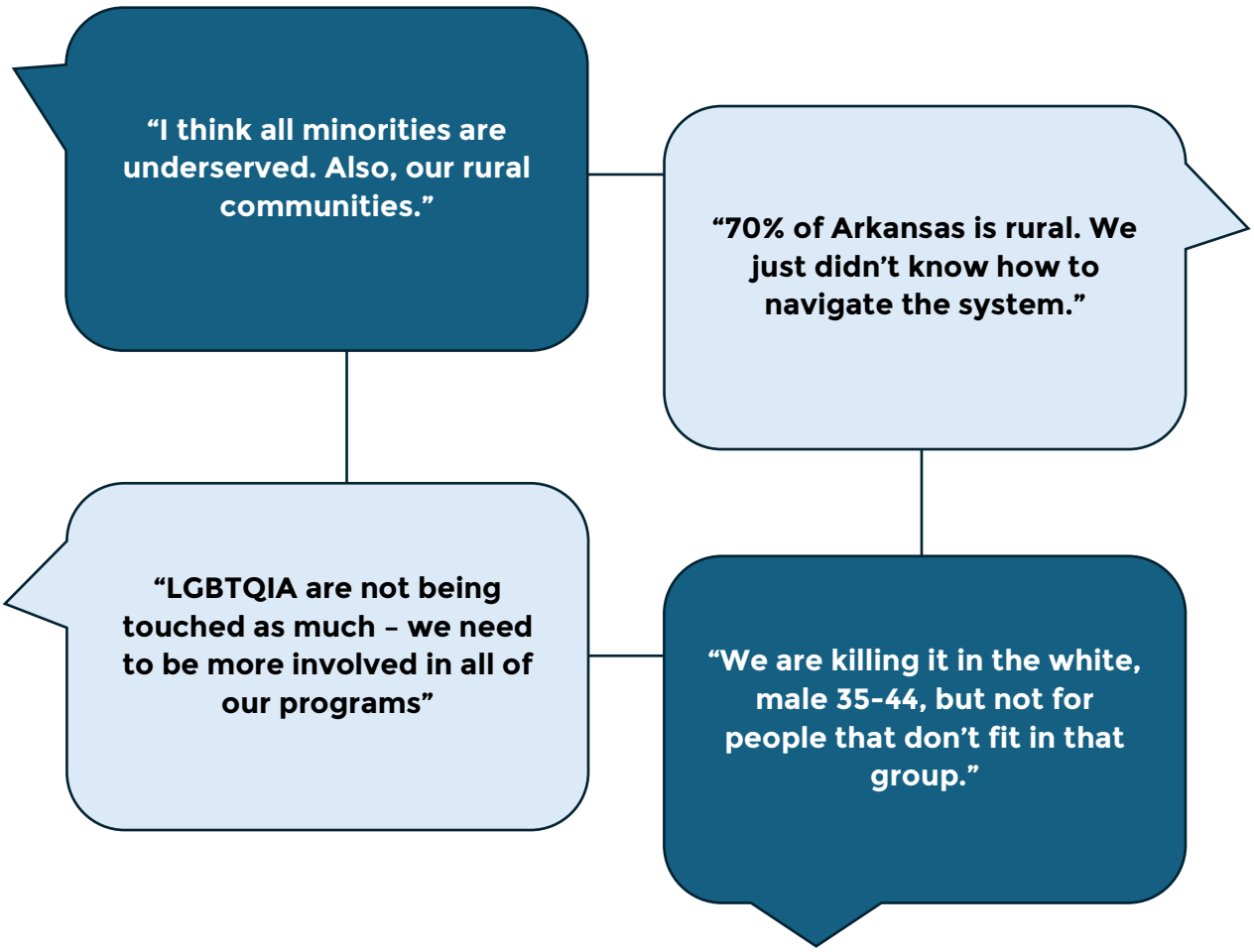
Findings

GAPS IN COMMUNICATION

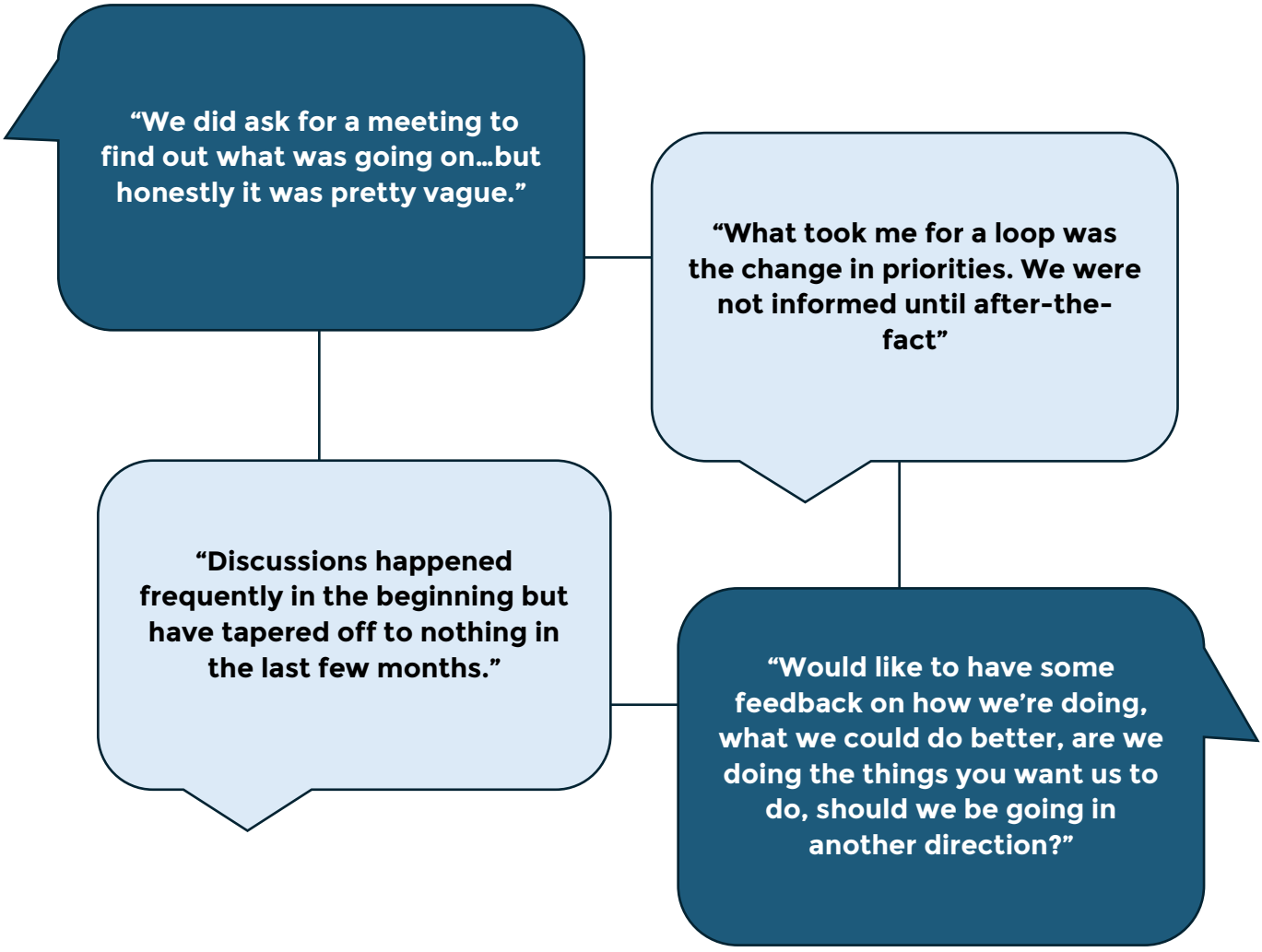
Between Stakeholders: Several of the stakeholders cited a lack of communication between different programs, especially in regard to Naloxone distribution. Some stated they would prefer that programs work together distributing Naloxone to better serve the community and avoid competition and misunderstandings.



Underserved Populations: Most programs reported challenges in reaching individuals in rural areas and those experiencing homelessness. Several noted language barriers that limited their ability to serve certain populations, while others identified gaps in services for minority groups, including Black or African Americans and LGBTQIA+ individuals. Some programs also noted a need for broader public training. Additional underserved groups included pregnant women, individuals with co-occurring substance use or mental health disorders, and people with disabilities. To improve outreach, many programs suggested strategies such as public and business training, targeted media outreach, and cultural-sensitivity training.

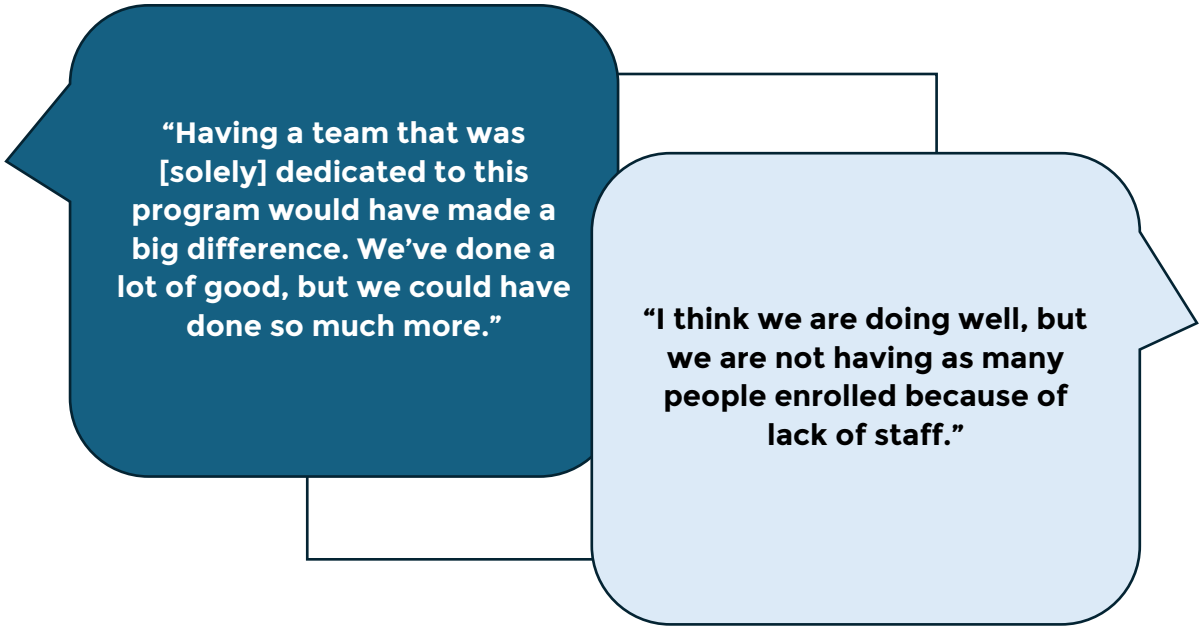


SOR Leadership: All stakeholder groups expressed concerns regarding communication with SOR leadership. Many were uncertain about the continuation of their programs or funding and felt that leadership did not keep them adequately informed about future plans. Others noted a lack of feedback and clear guidance for their programs, with some feeling that leadership support was insufficient. Several stakeholders observed changes in communication under new leadership, while others voiced concerns about state transparency and an unclear alignment between their programs and state objectives.



STAFFING ISSUES

Many stakeholders faced challenges related to understaffing and high staff turnover. Several programs highlighted the success of peer support services, with some expressing interest in expanding peer services within their own programs. The need for funding to increase staff, enhance peer services, and support transportation for staff, peers, and clients was a frequent point of discussion.



SUCCESSES AND SUSTAINABILITY

All programs reported feeling successful or nearly successful in achieving their goals, often citing the number of individuals or establishments served as evidence. However, they emphasized that additional and sustained funding is crucial for the future of their initiatives, with many uncertain about receiving further support. Program leaders also expressed a strong desire to expand services and maintain their information-sharing efforts, even if future funding is unavailable.

Program Recommendations

The following recommendations are based on analysis of administrative data provided by each of the SOR III subcontractors.

PREVENTION

- **Focus on high-risk groups for Naloxone distribution**. The data indicate that a high number of overdose recipients are among individuals aged 65 and older. *We recommend that targeted initiatives for this age group continue to be prioritized.*

- **Integrate Naloxone in all emergency equipment**. Integration of Naloxone with AED units has shown to be a positive addition to Naloxone distribution by targeting specific settings and populations. *We recommend that this type of integration be replicated across other initiatives to ensure life-saving access in critical situations.*

- **Improve Naloxone refill and replacement procedures**. Missing data suggest the need to standardize reporting requirements for used and expired Naloxone. *We recommend the streamlining of replenishment processes across all program to improve refill and replacement procedures and to facilitate the collection of data.*

- **Require periodic refresher training for agencies and individuals receiving Naloxone kits**. Staff turnover and shifting responsibilities of key employees indicate the need for refresher training in Naloxone administration. *We recommend yearly refresher training to maintain readiness and compliance.*

- **Improve data collection processes during training sessions.** Missing demographic data indicate the need for improved data collection procedures during training sessions to better understand and address gaps in outreach efforts. *We recommend developing data collection procedures that focus on obtaining demographic data using QR codes or free mobile app surveys before training sessions.*

- **Leverage technology for engagement during training sessions, conferences, and meetings.** Continued engagement is key to sustainability for all programs. *We recommend promoting apps like the MidSOUTH app for conferences and Naloxone resources as well as developing similar tools for broader initiatives.*

- **Invest in primary prevention programming.** Primary prevention programming is essential because it proactively addresses the root causes of issues, reducing the long-term social,

health, and economic burdens associated with crises like substance misuse or chronic diseases. *We recommend adding primary prevention strategies to ongoing programs.*

TREATMENT

- **Build upon the success of educating community members.** ACC MAT data indicate that nearly 4,400 community members have been reached through education initiatives. *We recommend increasing partnerships with local organizations and schools to broaden reach and impact on the use and successes of MAT.*

- **Broaden MOUD access.** Data reveal that access to MOUD is geographically limited. *We recommend prioritizing funding to underserved areas to reduce geographic disparities in access to MOUD and MUD treatments.*

- **Leverage Project ECHO hotline insights.** Data from the 601 assistance calls can be used to identify common provider challenges and gaps in knowledge. *We recommend quarterly analysis of data to identify these challenges and gaps, tailoring future Project ECHO sessions based on the findings of this analysis.*

RECOVERY

- **Enhance access to recovery support services**. Data suggest the need to increase focus on underutilized services such as Driver's License assistance (2.2%) and Legal Assistance (8.8%). *We recommend promoting these services more effectively through outreach and communication within programs.*

- **Expand MAT participation**. Only 11.8% of participants in the PACT program utilized MAT. *We recommend providing more education on MAT as an evidence-based approach to address potential stigma and misconceptions.*

- **Increase training participation in underrepresented training types.** Low numbers in Advanced (5%), Supervisor (4%), and Facilitator Guide Workshop (2%), indicate the need for more sessions or incentives to boost participation. *We recommend additional virtual training options to make these programs more accessible, especially to rural areas and for those with limited mobility.*

- **Integrate support systems**. The integration of PACT and SOR-R support systems offers an opportunity for enhanced success. *We recommend collaboration between these programs to create seamless pathways for individuals transitioning from per recovery training to active support roles in the community.*

Interviews were conducted with key stakeholders of each subcontractor/vendor including program directors, program coordinators, data managers, and peer recovery support specialists. The following recommendations are based on content analysis of notes taken from these interviews.

PREVENTION

Common challenges across these programs highlight issues with **engagement, accessibility, and sustainability.** Many struggled to involve key stakeholders, whether it was higher-level hospital staff (ACHI), students and faculty (SOR-C), or specific populations such as rural residents, older adults with disabilities, or underserved communities like the Marshallese and Vietnamese (OPAL). Turnover and lack of dedicated teams or consistent staffing negatively impacted program cohesion and continuity, particularly in SOR-C and SOR-P. Accessibility challenges, especially in rural areas, were recurring themes for ACHI, OPAL, and SOR-P, with limited engagement from rural hospitals, difficulty reaching certain populations, and a lack of tailored approaches to meet specific needs. Additionally, several programs faced funding and resource limitations, with unclear guidance on implementation (SOR-P) or disruptions due to external factors like the pandemic (OPAL). Together, these themes suggest the need for stronger institutional support, targeted outreach strategies, sustainable staffing models, and adaptable funding and implementation plans.

TREATMENT

These programs face recurring challenges related to **accessibility, funding limitations, staffing shortages, and systemic obstacles.** Accessibility remains a significant hurdle, with programs struggling to address gaps in insurance coverage, transportation, and childcare, as well as encountering barriers to reaching specific populations such as African Americans, the homeless, and justice-involved individuals. Funding challenges, including lags in grant cycles and errors in financial processes, disrupt the ability to provide consistent services. Staffing shortages and delays, such as those caused by the need for IRB approval, further hinder program efficiency and timely service delivery. Systemic barriers like stigma toward treating patients with dual diagnoses, housing program restrictions against medication for opioid use disorder (MOUD), and pharmacy denials for MOUD exacerbate the difficulty of sustaining treatment. Organizational issues, such as data management and patient tracking, add to these challenges, underscoring the need for more robust infrastructure, and policy changes to support these programs effectively.

RECOVERY

The programs share common challenges related to **accessibility, stigma, infrastructure, and funding stability**. Accessibility remains a key issue, with difficulties in serving rural areas, pregnant women, women with children, and marginalized populations such as the homeless, Marshallese, and Vietnamese communities. Transportation barriers and the need for stable housing further hinder effective service delivery. Both programs face challenges combatting community stigma around addiction, which affects engagement and support. Structural

limitations, such as a lack of facilities to hold group sessions outside of jail and assistance with out-of-state documentation, add to the difficulties. Additionally, securing employment for individuals with criminal backgrounds and planning for the future is complicated by uncertain funding, highlighting the need for sustainable resources and comprehensive support systems.

Across prevention, treatment, and recovery programs, common challenges emerged related to **engagement, accessibility, funding, staffing, systemic barriers, and stigma**. Programs often struggled to engage key stakeholders, including hospital staff, students, faculty, and marginalized populations such as rural residents, African Americans, the homeless, and ethnic minorities such as the LGBTQ community, and the Marshallese. Accessibility barriers, such as transportation, childcare, housing, and insurance gaps, limited the reach and impact of services. Funding instability, including delays in grants and financial errors, disrupted program continuity, while staffing shortages and turnover undermine cohesion and efficiency. Systemic barriers, including stigma against addiction, restrictions on medications for opioid use disorder (MOUD), and challenges in navigating structural limitations like criminal records and out-of-state documentation, further hindered progress. *Together, these themes point to the need for stronger institutional support, sustainable funding, targeted outreach strategies, robust infrastructure, and policies that reduce stigma and address systemic inequities to ensure effective and equitable service delivery.*

The following recommendations are based on an overall summary of the above SOR III Program findings:

- **Build partnerships with trusted community leaders to improve outreach and trust among marginalized populations, including LGBTQ, African Americans, rural residents, and ethnic minorities like the Marshallese.** Although outcome data across all programs indicate that African Americans are participating in a variety of programming, LGBTQ and ethnic minorities such as the Marshallese are notably absent from the data. *We recommend seeking out partnerships with marginalized populations and incorporating feedback from them in all areas to improve outreach and ensure programs are culturally relevant and accessible.*

- **Push for policies to invest in transportation solutions, such as ride-sharing partnerships, or mobile units.** Transportation issues were discussed in all aspects of programming. Interviews with stakeholders, including people with lived experience, expressed frustration in the lack of reliable transportation to training events, programming, medical appointments, and daily errands. *We recommend promoting the need for funding to policy makers for building reliable alternatives to improve access for rural and underserved populations.*

- **Advocate for funding for childcare services to enable women with children to participate in treatment and recovery programs.** Lack of reliable childcare can negatively impact health and well-being of women by forgoing necessary treatments, preventative care, and/or recovery programs. Stakeholders indicated that lack of childcare was preventing a number of

women with children from completing their programming and/or starting or continuing treatment. *We recommend promoting policies for reliable and affordable childcare for women with children pursuing treatment and recovery programming, especially during group sessions and medical appointments.*

- **Advocate for policies to remove housing and employment restrictions related to MOUD use and criminal records.** Research has shown that lack of stable housing and employment can derail treatment and recovery. *We recommend promoting policies that support housing and employment initiatives for individuals involved in the justice system that are in treatment/recovery and using MOUD.*

- **Encourage policy makers to find solutions for expanded health insurance.** Insurance can ease the financial burden often associate with comprehensive addiction treatment by covering a range of services from outpatient programs to more intensive residential treatment and sober living homes. *We recommend encouraging policy makers to support expanded insurance coverage and streamlined enrollment processes to reduce gaps in care.*

- **Develop user friendly data systems to track program outcomes, identify gaps, and make data-driven improvements.** The ability to assess a program's efficacy relies on accurate, complete, and timely data. *We recommend user-friendly data systems along with data entry training and yearly refresher training sessions to all date entry personnel involved in SOR-related programming.*

Appendix A

STAKEHOLDER PROGRAM INTERVIEW QUESTIONS

Project Name\Organization _____

GENERAL QUESTIONS

Purpose and Objectives

1) What do you perceive are the primary goals and objectives of the program?
2) How well do you think the program is currently achieving its goals?

Target Population

1) Who do you believe are the primary beneficiaries of the program?
2) Are there any groups or individuals who are not adequately served by the program?

Program Components

1) What specific activities or services provided by the program do you find most effective?
2) Are there any aspects of the program that you think could be improved or expanded?

Implementation

1) How would you describe the overall implementation of the program?
2) Are there any logistical or operational challenges that affect the program's effectiveness?

IMPACT AND OUTCOMES

Effectiveness

1) From you perspective, what evidence or data indicates that the program is successful?
2) 2) How do you measure the success or impact of the program?

CHANGES AND IMPROVEMENTS

1) Based on your experience, what changes or improvements would you recommend for the program?
2) 2) Have there been any changes in the program over time, and if so, how have they affected its effectiveness?

STAKEHOLDER ENGAGEMENT

Collaboration and Partnerships

1) How would you describe the level of collaboration between stakeholders (e.g., staff, partners, community members) in the program?
2) Are there any partnerships or collaborations that have been particularly effective or challenging?

Feedback and Communication

1) How does the program solicit feedback from stakeholders, and how is that feedback used?
2) 2) Do stakeholders feel adequately informed about the program's activities and outcomes?

SUSTAINABILITY AND FUTURE DIRECTIONS

Long-Term Sustainability

1) What factors do you think are critical for ensuring the long-term sustainability of the program?
2) Are there any potential risks or challenges that could impact the program's sustainability?

Future Vision

1) Are there any emerging needs or opportunities that the program should address moving forward?

REFLECTION AND CONCLUSION

1) What are the overall impressions of the program, considering its strengths and weaknesses?
2) Is there anything else you would like to share about your experience with the program?

Appendix B

ACRONYMS\ABBREVIATIONS

Acronym	Definition
ACC	Arkansas Community Corrections
CARES	Center for Addictions Research, Education and Services
CJI	Criminal Justice Institute
CSAT	Center for Substance Abuse Treatment
OSAMH DHS	Division of Aging, Adult & Behavioral Health Services
DEA	US Drug Enforcement Agency
DHS AR	Department of Human Services
GPRA	Government Performance and Results Act
IMPACT	Improving Multi-disciplinary Pain Care and Treatment
MAT	Medication-Assisted Treatment
MATRIARC	UAMS MAT Recovery Initiative for Arkansas Rural Communities
NSDUH	National Survey of Drug Use and Health
OUD	Opioid Use Disorder
OSAMH	Office of Substance Abuse and Mental Health
PACT	Peers Achieving Collaborative Treatment
PDO	Prescription Drug/Opioid Overdose
PRSS	Peer Recovery Support Specialists
REDCap	Research Electronic Data Capture
RIOA	Reynolds Institute on Aging
SAMHSA	Substance Abuse and Mental Health Services Administration
SATC	UAMS Substance Abuse Treatment Center
SOR	State Opioid Response
STR	State Targeted Response
SUD	Substance Use Disorder
SWAC	Southwest Arkansas Community Correction Center
UAMS	University of Arkansas for Medical Sciences

Appendix C

SOR III LOGIC MODEL