2025 Arkansas State Opioid Response (SOR) 4

PROGRAM EVALUATION

Year 1

Matthew Wagner, PhD
Associate Research Scientist

Tashina Lemons, MPH
Associate Research Scientist

Rodney Wambeam, PhD
Senior Research Scientist

Andria Blackwood, PhD
Senior Research Scientist

Angel Phillips, BS
Project Coordinator

Miranda Greathouse, BA
Research Assistant

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

Wyoming Survey & Analysis Center

University of Wyoming

1000 E. University Avenue, Department 3592

Laramie, Wyoming 82071

307.766.2189 | wysac@uwyo.edu

This publication was produced for the Department of Human Services and the Office of Substance Abuse and Mental Health Services with funding from the 2025 State Opioid Response Grant.

Award Number

SUB-GRANT #: 4600055454

© 2025 Wyoming Survey & Analysis Center

About the Evaluators

The Wyoming Survey & Analysis Center at the University of Wyoming is a nonpartisan research center dedicated to delivering clear, accurate, and practical information to decision-makers. Through applied research, scientific polling, advanced information technology services, and rigorous program evaluation, the center supports evidence-based decision-making. Our evaluators conduct studies that inform funding and policy decisions in key areas such as public health, substance use prevention and treatment, education, and criminal justice. Guided by a mission to improve lives, we advance innovative, high-quality research that drives meaningful impact.

WYSAC Evaluation Team

Matthew Wagner, PhD, Associate Research Scientist

Dr. Wagner received his PhD in political science at the University of South Carolina. His main research interests include opioid use, methamphetamine use, and related behavior. He has worked on previous substance use and prevention-related projects in Arkansas and Wyoming.

Tashina Lemons, MPH, Associate Research Scientist

Tashina Lemons, an Associate Research Scientist at WYSAC, will aid with data analysis and program evaluation. Currently, she evaluates multiple states' tobacco prevention programs and chronic health programs and assists with the Wyoming Prevention Needs Assessment. She has advanced knowledge of qualitative and quantitative research methods, federal systems, and regulatory compliance and holds a secret security clearance.

Andria Blackwood, PhD, Senior Research Scientist

Dr. Blackwood received her master's degree in Sociology and her PhD in Geography at Kent State University. Her main research interests include prevention of substance use disorder (SUD), the relationship between SUD and recidivism, and the development and implementation of correctional programming for successful reentry.

Rodney Wambeam, PhD, Senior Research Scientist

Dr. Wambeam completed his PhD at the University of Nebraska. At WYSAC, Dr. Wambeam conducts numerous substance abuse prevention and treatment research projects in many states including Arkansas, North Dakota, Oregon, and Wyoming. He is the author of "The Community Needs Assessment Workbook" from Oxford University Press.

Table of Contents

About the Evaluators 3

Table of Contents 4
List of Figures 7
List of Tables 8

Executive Summary 9
SOR 4 Prevention Program Highlights 10
SOR 4 Treatment Program Highlights 10
SOR 4 Recovery Program Highlights 11

Introduction 12
Documenting Outcomes 13
Opioid Consumption 13
Opioid Consequences 16

SOR 4 Goals and Objectives 20

SOR 4 Prevention Initiatives 24
Arkansas Department of Higher Education (ADHE) 25
End Overdose (EOD) 27
MidSOUTH SOR-P (Agreement 2) 33

SOR 4 Treatment Initiatives 36
Arkansas Community Corrections (ACC) 37
Family Centered Treatment-Recovery (FCT-R) 39
MidSOUTH SOR-T (Agreement 4) 41
River Valley Medical Wellness (RVMW) 42
University of Arkansas Medical Services (UAMS) 47
UAMS MAT Services 116

SOR 4 Recovery Initiatives 119
Arkansas Alliance of Recovery Residence (AARR) 51
Arkansas Administrative Office of the Courts (AOC) 54
Arkansas Alliance of Recovery Centered Organization (AARCO) 59
CHESS Health 63

SOR 4 Qualitative Studies 70
Opioid Misuse and Recovery Residences 71
Executive Summary 72
Findings 73
Summary Conclusion 89
Recommendations 90

Results from Interviews with Leadership and Service Providers on Juvenile Re-Entry of the Arkansas Department of Youth Services (DYS) Juvenile Treatment Facilities 92
Executive Summary 93
Background 93
Methods 96
Demographics of Respondents 97
Analysis 98
Findings 98
Conclusion 109
Recommendations 109

Results from Interviews with Arkansas Drug Court Staff in SOR 4-Funded Programs 112
Executive Summary 113
Background 113
Methods 114
Respondent Demographics 115
Analysis 115
Findings 115
Summary Conclusion 122
Recommendations 123
References 124

Continuous Quality Improvement (CQI) Year-One Assessments in Training 125
CQI Evaluation Year-One 127
Training Evaluations 128
American Society of Addiction Medicine (ASAM) Training Observation May 232,2025 (Pilot) 128
Medication for Opioid Use Disorder (MOUD) Training Observation August 19, 2025 130
Training Assessment Summaries 133
Recommendations 135
Appendices 137

SOR 4 Program Recommendations 143
Prevention 143
Treatment 144
Recovery 145
Appendix A Acronyms and Abbreviations 146
Appendix B Logic Model 147

LIST OF FIGURES

Figure 1: Retail Pharmacy-Dispensed Opioid Rates per 100 People in Arkansas and the US, 2019 - 2023 25
Figure 2: Percentage of Opioid and Prescription Drug Misuse among College Students in Arkansas, 2021-2024 26
Figure 3: Past 30-Day Use of Prescription Opioids and Heroin/Opiates by 6th, 8th, 10th, and 12th Grades Combined in Arkansas from 2021 - 2024 26
Figure 4: 2022 – 23 Pain Reliever Misuse in the Past Year in Arkansas and the United States Among Ages 12 and Older 26
Figure 5: Opioid Misuse in the Past Year in Arkansas and the United States Among Ages 12 and Older, 2022 29
Figure 6: Adult and Juvenile Heroin Arrests in Arkansas, 2021 - 2024 29
Figure 7: Age-Adjusted Opioid Overdoses in Arkansas and the United States 2018 – 2023 per 100,000 People 30
Figure 8: Suspected Nonfatal Overdose ED Visits Involving All Opioids per 10,000 Total ED Visits, 2021 - 2024 30
Figure 9: Narcan Administration by EMS in Arkansas, 2022 - 2024 49
Figure 10: Retail Pharmacy-Dispensed Naloxone per 100 People in Arkansas, 2019 - 2023 50
Figure 11: Retail Pharmacy-Dispensed Buprenorphine per 100 People in Arkansas, 2019 - 2023 50
Figure 12: EOD Naloxone Kit Distribution by Recipient Type 50
Figure 13: EOD Gender of Online Survey Respondents 51
Figure 14: EOD Age of Online Survey 51
Figure 15: EOD Income of Online Survey Respondents 52
Figure 16: EOD Online Survey Respondents Witnessing an Overdose 52
Figure 17: EOD Online Survey Respondents Who Experienced an Overdose 59
Figure 18: EOD Gender of In-person Survey Respondents 59
Figure 19: EOD Race of In-person Survey Respondents 60
Figure 20: EOD Age of In-person Survey Respondents 85
Figure 21: EOD In-person Pre-test Respondents Indicating Loss 118
Figure 22: EOD In-person Pre-test Respondents Indicating Previous Training 121
Figure 23: EOD In-person Post-test Respondents Indicating Preferred Learning Method 125
Figure 24: In-person Post-test Respondents Indicating Interest in Learning About Other Types of Overdoses 143

LIST OF TABLES

Table 1: Arkansas Administrative Office of the Courts (AOC)....25
Table 2: AOC: Funded Schools and Focus of Effort....26
Table 3: End Overdose Naloxone Training Totals....29
Table 4: End Overdose Trainings by Type....49
Table 5: End Overdose Surveys by Topic....50
Table 6: ACC Status of Participants Accepted into Continuing Care....54
Table 7: ACC Potential Participants Attending Educational Sessions....54
Table 8: FCT-R Trainings by Type and Individual....54
Table 9: MidSOUTH SOR-T Trainings by Type....56
Table 10: RVMW Peer Recovery Services Totals at AJATC....57
Table 11: RVMW Peer Recovery Services Totals at AJATC (Individual Sessions)....59
Table 12: RVMW Individuals Trained in the SBIRT Method....61
Table 13: RVMW Individuals Educated on Substance Use Disorder and Mental Health....87
Table 14: UAMS Number of Project ECHO Attendees by Type and Quarter Attended....88
Table 15: UAMS Number of Methadone Doses Administered by Month....114
Table 16: UAMS Number of Individuals by Type of Concrete Support....114
Table 17: AARR Level Description....117
Table 18: AOC Incident Totals....118
Table 19: AOC Number of Peer Services Recipients Who Sustained Recovery....121
Table 20: AOC Number of Peer Services Recipients Who Sustained Recovery by Month....121
Table 21: AOC Number of Negative Incidents Documented by AOC Peer Services Recipients....121
Table 22: CHESS Health Number of Escalations by Type....121
Table 23: CHESS Health Number of Contacts and Direct Messaging....121
Table 24: NAADAC Active Peer Workers by Month and Type....121
Table 25: NAADAC Active Peer Workers Trained by Month and Type....121
Table 26: NAADAC Peer Workers Tested and Passed by Month and Type....121
Table 27: Qualitative Studies Topics of Interest, Participants, and Data Collection Methods....121

Executive Summary

The State Opioid Response (SOR) Grant, funded by SAMHSA, works to address the opioid crisis by expanding access to medications for opioid use disorder (MOUD) and strengthening prevention, treatment, and recovery support services. WYSAC's Year-One evaluation of Arkansas SOR 4 combined administrative data with qualitative studies to assess program activities and capture participant perspectives.

The evaluation identifies both key strengths and areas for improvement within the program. Stakeholders and clients shared common experiences while also offering unique insights. This comprehensive WYSAC report presents the findings and provides recommendations to build on the program's successes and address opportunities for enhancement.

It should be noted that not all SOR 4 vendors' initiatives began at the project's outset; some received funding in October 2024, while others did not begin until 2025. As a result, vendors entered process data into REDCap at different times, leading to misalignment in the data presented in this report. In addition, an unexpected funding gap occurred between the first and second grant years, resulting in the exclusion of September's data. This is reflected in Table 1 below, and comparisons between vendors should not be made.

Table 1: SOR 4 Vendor REDCap Data Collection Period

Vendor	Start Date	End Date
Arkansas Administrative Office of the Courts (AOC)	October 2025	August 2025
Arkansas Alliance for Recovery Centered Organizations (AARCO)	January 2025	August 2025
Arkansas Alliance of Recovery Residences (AARR)	October 2024	August 2025
Arkansas Community Corrections (ACC)	October 2024	August 2025
Arkansas Department of Higher Education (ADHE)	October 2024	August 2025
CHESS Health	October 2024	August 2025
End Overdose (Naloxone training data is October 2024-June 2025)	October 2024	August 2025
Family Centered Treatment Recovery	May 2025	August 2025
MidSOUTH SOR 4	October 2024	August 2025
National Association for Alcoholism and Drug Abuse Counselors (NAADAC)	October 2024	August 2025
River Valley Medical Wellness Maternal Grant	June 2024	August 2025
River Valley Medical Wellness Youth Grant	October 2024	August 2025
University of Arkansas Medical Services (UAMS)	October 2024	August 2025

The following Year-One highlights across Prevention, Treatment, and Recovery demonstrate the impactful work accomplished by the SOR 4 vendors.

SOR 4 PREVENTION PROGRAM HIGHLIGHTS

Prevention efforts in Arkansas reached diverse populations through collegiate initiatives, naloxone and drug-testing strip distribution, and training.

- The Arkansas Department of Higher Education (ADHE) led the launch of collegiate prevention and recovery initiatives, approving six proposals across five institutions to strengthen campus-based responses to substance use disorder.
- End Overdose distributed 30,776 naloxone kits and 4,500 drug-testing strips and delivered in-person and online trainings to 6,477 participants.
- Midsouth SOR-P (Agreement 2) trained 77 individuals in areas such as the neurobiology of addiction and substance use disorder, grant writing, and substance-specific prevention strategies.

SOR 4 TREATMENT PROGRAM HIGHLIGHTS

Comprehensive treatment efforts employed evidence-based strategies, including medication-assisted treatment (MAT), technical assistance, trainings, and provider consultations. Additionally, educational materials and pregnancy backpacks were distributed, and pregnancy screenings were conducted.

- ACC administered 86 Vivitrol injections and conducted 110 drug tests, all of which returned negative results.
- FCT-R provided technical assistance 16 times to the OSAMH FCT-R Implementation Team, offered prospective provider training to 8 community partners, and delivered implementation training to 4 stakeholders.
- Midsouth SOR-T (Agreement 4) hosted trainings on multiple topics, reaching 386 attendees.
- RVMW Youth distributed 923 educational materials on substance use disorder and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, and provided peer recovery services to 342 participants.
- RVMW Maternal trained 22 individuals in ultrasound equipment use and educated 664 individuals—including contracted medical providers and community-based staff—on a variety of maternal health topics.
- RVMW Maternal also distributed 80 pregnancy backpacks (with prenatal vitamins and educational resources) and provided pregnancy screenings to 44 individuals.

- UAMS facilitated 340 minutes of televideo consultations for providers treating patients with substance use disorders

SOR 4 RECOVERY PROGRAM HIGHLIGHTS

Recovery initiatives offered peer services, recovery housing, virtual support, and training and certification for peers to strengthen and sustain long-term recovery.

- AOC delivered peer support services 2,403 times to 1,224 individuals.
- AARCO provided peer support services 3,080 times to 1,117 individuals, supported 53 individuals with family reunification, and assisted 453 individuals in completing court obligations.
- Chess Health supported long-term recovery through the *Connection App*, facilitating 167 direct messages between peer workers and users.
- NAADAC approved 108 applications for the National Certification Commission for Addiction Professionals (NCC AP).

Introduction

The State Opioid Response (SOR) Grant, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), addresses the national public health crisis of opioid misuse, opioid use disorder (OUD), and opioid-related overdoses. The initiative expands access to medications for opioid use disorder (MOUD) and strengthens the continuum of care, encompassing prevention, treatment, and recovery support services for individuals with OUD and co-occurring substance use disorders.

WYSAC's Year-One evaluation of the Arkansas State Opioid Response IV (SOR 4) program utilized both administrative and qualitative data to assess prevention, treatment, and recovery activities. Administrative data provided an overview of key efforts, including information dissemination, education and training, community engagement, and direct service delivery. To complement this, qualitative studies with stakeholders from targeted populations offered deeper insights into participant experiences and perspectives.

The evaluation had two primary goals: (a) to use data to inform program improvement and (b) to document the program's accomplishments. WYSAC researchers designed and implemented the evaluation, collected and analyzed qualitative data, and reviewed administrative records in detail. Findings highlight both significant strengths and areas requiring further attention. While stakeholders and participants shared many common experiences, they also contributed unique perspectives that enriched the evaluation. This report presents the results, along with recommendations to build on the program's successes and address gaps and opportunities for enhancement.

Documenting Outcomes

When examining Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) in Arkansas, it is critical to analyze both national and state-level data to situate local trends within a broader epidemiological context. National datasets, such as those produced by SAMHSA, CDC, or NSDUH, allow for cross-state comparisons and help establish benchmarks against which Arkansas's trajectory can be evaluated. However, these data sources often have notable limitations, including time lags in reporting, reliance on self-reported survey responses subject to underestimation of stigmatized behaviors, and aggregation that masks within-state variability. State-level datasets, while more granular, present their own challenges: they may be fragmented across agencies, inconsistently defined, lack longitudinal comparability, or be constrained by small sample sizes that reduce statistical power. Additionally, state data frequently omit populations not well captured in administrative systems, such as individuals outside formal treatment networks.

Although national and state datasets have methodological constraints, integrating both is essential to provide a comprehensive understanding of the burden of SUD and OUD. This combined approach highlights broad national trends while also capturing state-specific dynamics, enabling more accurate assessments and better informing policy and resource allocation. With this context in mind, the report presents key outcomes related to opioid misuse and its consequences in the introduction to establish a foundation for the SOR 4 initiative, guide the evaluation that follows, and support future assessments of opioid-related projects in Arkansas. All data are presented at the state level and supplemented with national comparisons when available.

Opioid Consumption

Figures 1 through 5 show trends and the most recent data on opioid misuse and related topics. Figure 1 compares opioid dispensing rates in Arkansas and the United States from 2019 to 2023, indicating that Arkansas rates, though declining, remain about twice the national average. According to the Arkansas Collegiate Substance Use Assessment (ACSUA), prescription opioid use among college students spiked in 2022 but dropped sharply in 2023–2024 (Figure 2), while use among K–12 students has remained negligible (Figure 3). Across the state, misuse of pain relievers and opioids among individuals aged 12 and older is slightly higher than the U.S. average (Figures 4 & 5).

Figure 1: Retail Pharmacy-Dispensed Opioid Rates per 100 People in Arkansas and The US, 2019 - 2023

While declining, the opioid dispensing rate in Arkansas is still twice that of the United States.

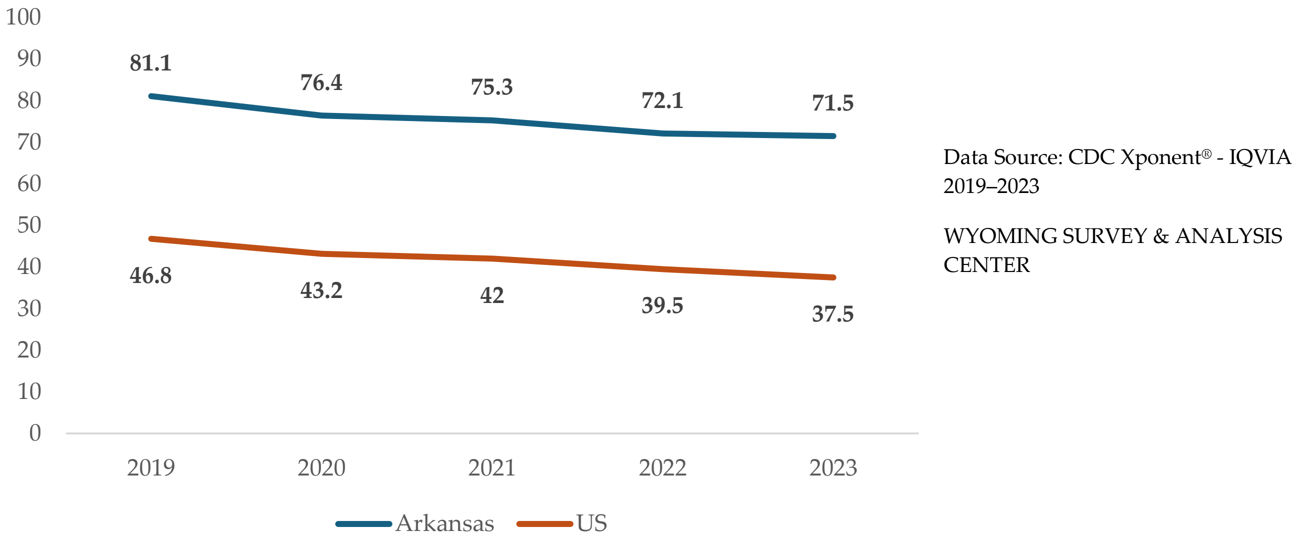


Figure 2: Percentage of Opioid and Prescription Drug Misuse among College Students in Arkansas, 2021-2024

Opioid use and prescription drug misuse among college students in Arkansas spiked in 2022 and then dramatically declined in 2023 – 2024.

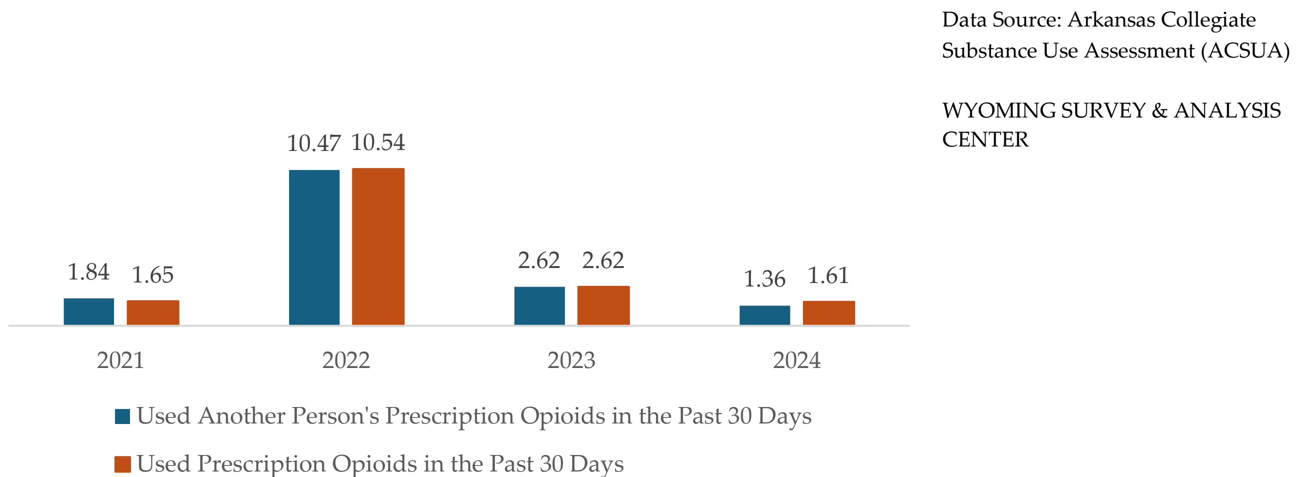
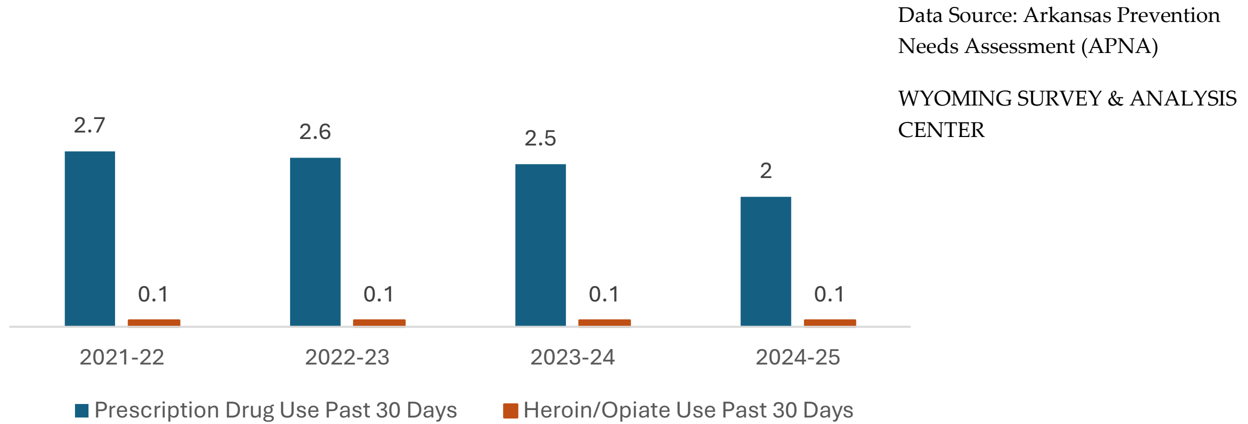


Figure 3: Past 30-Day Use of Prescription Opioids and Heroin/Opiates by 6th, 8th, 10th, and 12th Grades Combined in Arkansas from 2021 - 2024

Prescription Opioid use continues to decline, while Heroin/Opiate use rates remain negligible among 6th, 8th, 10th, and 12th graders in Arkansas.



Data Source: Arkansas Prevention Needs Assessment (APNA)

WYOMING SURVEY & ANALYSIS CENTER

Figure 4: 2022 – 23 Pain Reliever Misuse in the Past Year in Arkansas and the United States Among Ages 12 and Older

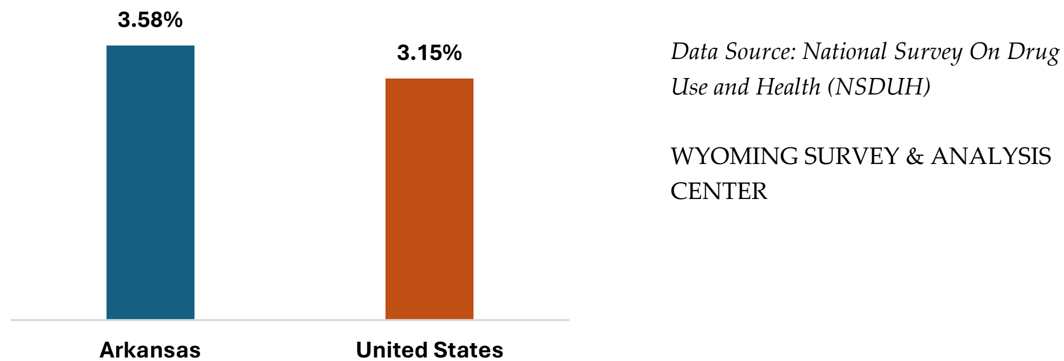
The percentage of individuals 12 years of age and older misusing pain relievers in Arkansas is slightly higher than in the US.

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

WYOMING SURVEY & ANALYSIS CENTER

Figure 5: Opioid Misuse in the Past Year in Arkansas and the United States Among Ages 12 and Older, 2022

The percentage of individuals 12 years of age and older misusing opioids in Arkansas is slightly higher than in the US.

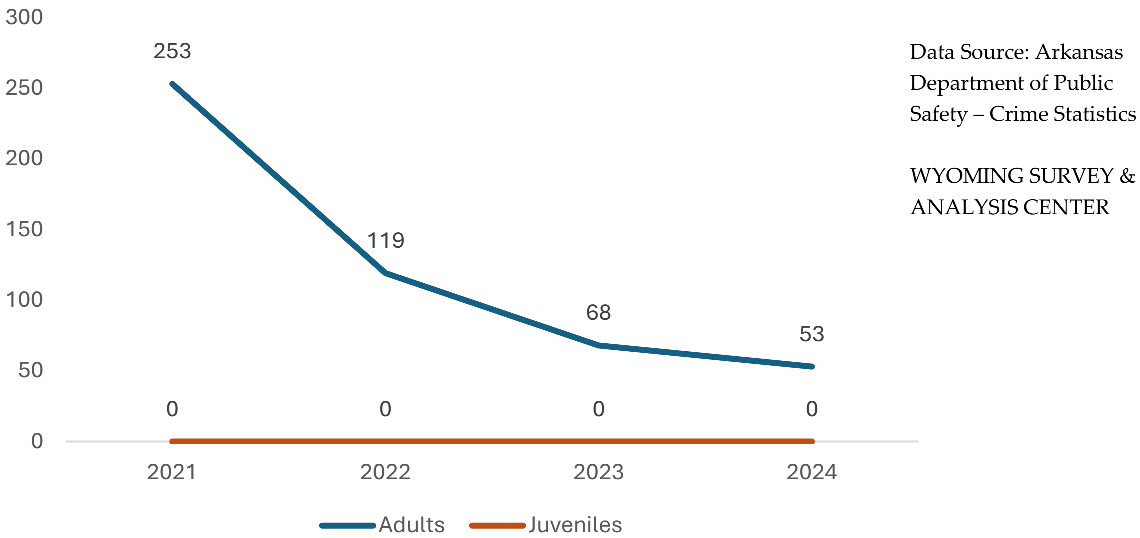


Opioid Consequences

Figures 6 through 11 display trends in opioid consequences. Adult heroin arrests in Arkansas show a steady decline, while juvenile arrests remain minimal (Figure 6). From 2018 to 2022, the age-adjusted opioid overdose rate rose in both Arkansas and the U.S., with national rates consistently higher. More recently, overdose rates have fallen, with Arkansas experiencing a notable drop from 14.2 to 11.0 per 100,000 population between 2022 and 2023 (Figure 7). Suspected non-fatal overdoses also declined, from 6.5 per 10,000 emergency department visits in 2021 to 5.0 in 2024 (Figure 8). The administration of Narcan by EMS throughout Arkansas declined by 17.4% (Figure 9). In 2023, Arkansas retail pharmacies dispensed nearly 2 naloxone units per 100 people, compared with fewer than 1 per 100 nationally(Figure 10). Buprenorphine dispensing in Arkansas increased by 37%, rising from 3.4 to 5.4 units per 100 people between 2019 and 2023, while national levels showed a slight decline over the same period (Figure 11).

Figure 6: Adult and Juvenile Heroin Arrests in Arkansas, 2021 - 2024

Adult heroin arrests demonstrate a consistent downward trend, while juvenile arrests are statistically insignificant in Arkansas.

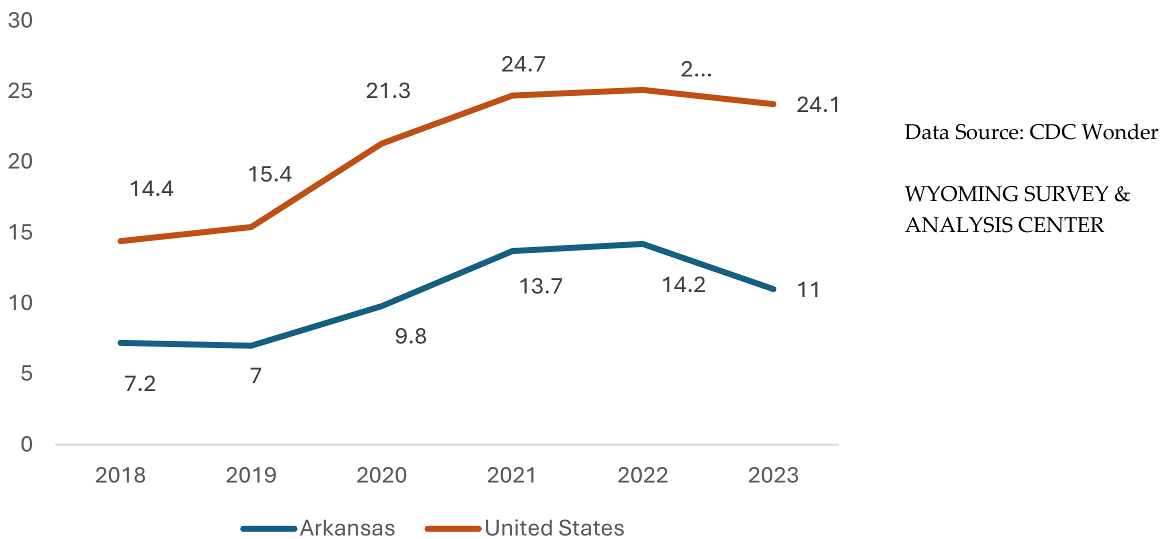


Data Source: Arkansas Department of Public Safety – Crime Statistics

WYOMING SURVEY & ANALYSIS CENTER

Figure 7: Age-Adjusted Opioid Overdoses in Arkansas and the United States 2018 – 2023 per 100,000 People

The age-adjusted rate of opioid overdoses increased in both Arkansas and the U.S. from 2018 to 2022, with national rates consistently higher than those in Arkansas. More recently, rates have declined in both, with Arkansas showing a substantial decrease from 14.2 to 11.0 from 2022 to 2023.



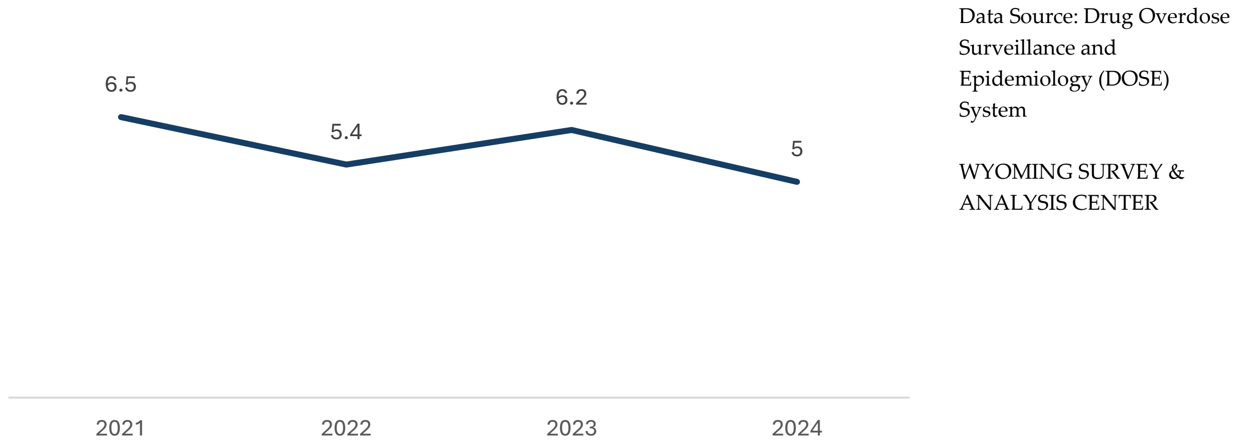
Data Source: CDC Wonder

WYOMING SURVEY & ANALYSIS CENTER

Data Note: MCD - ICD-10 Codes: T40.0 (Opium); T40.1 (Heroin); T40.2 (Other opioids); T40.4 (Other synthetic narcotics); T40.6 (Other and unspecified narcotics)

Figure 8: Suspected Nonfatal Overdose ED Visits Involving All Opioids per 10,000 Total ED Visits, 2021 - 2024

The number of non-fatal overdoses in Arkansas declined from 6.5 overdoses per 10,000 emergency department visits in 2021 to 5.0 overdoses per 10,000 in 2024.

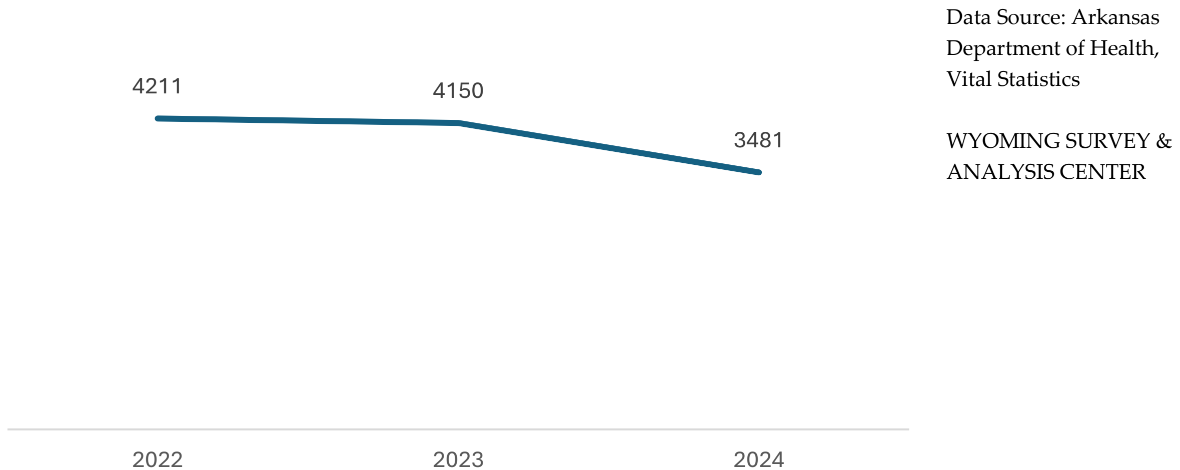


Data Source: Drug Overdose Surveillance and Epidemiology (DOSE) System

WYOMING SURVEY & ANALYSIS CENTER

Figure 9: Narcan Administration by EMS in Arkansas 2022 - 2024

The administration of Narcan by EMS throughout Arkansas declined by 17.4% from 4,211 administrations in 2,022 to 3,481 administrations in 2024:



Data Source: Arkansas Department of Health, Vital Statistics

WYOMING SURVEY & ANALYSIS CENTER

Figure 10: Retail Pharmacy-Dispensed Naloxone per 100 People in Arkansas 2019 - 2023

In 2023, retail pharmacies in Arkansas dispensed nearly 2 units of naloxone per 100 people, compared to fewer than 1 unit per 100 people nationwide.

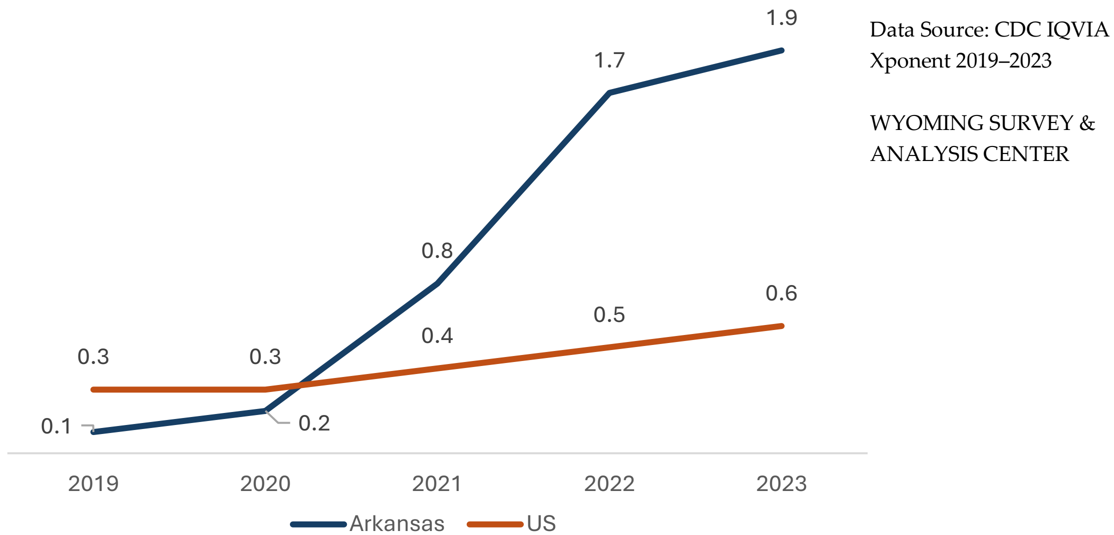
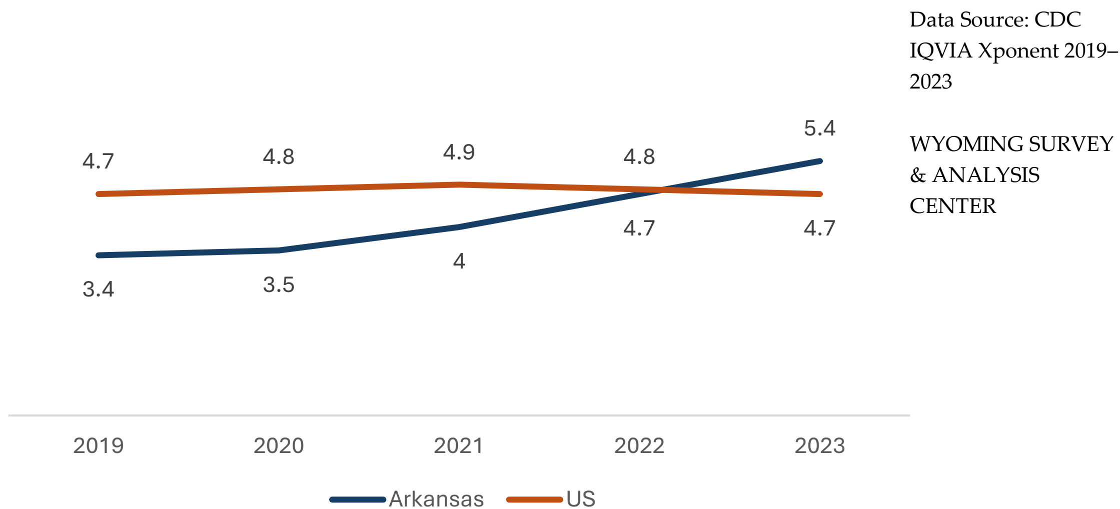


Figure 11: Retail Pharmacy-Dispensed Buprenorphine per 100 People in Arkansas, 2019 - 2023

The number of buprenorphine units dispensed in Arkansas retail pharmacies rose by 37.0%, increasing from 3.4 to 5.4 units per 100 people between 2019 and 2023, while national dispensing levels showed a slight decline over the same period.



SOR 4 Goals and Objectives

Goal 1: Strengthen prevention infrastructure, focusing on underserved communities with high substance misuse risks.	
Objective	**Objective Description**
1	By 09/29/2025, and annually thereafter, regional capacity to implement data driven prevention strategies as measured by number of sub-grantee prevention contracts and monthly activity monitoring of activities delivered in high-need communities.
2	Collaborate with Prevention Regions with identified underserved communities with high substance misuse risks to develop and disseminate state-of-the-art, culturally relevant substance misuse prevention and treatment resources.
3	By 09/29/2025, improve access to culturally and linguistically appropriate prevention education trainings as measured by development of standardized opioid response training curriculum in English and Spanish. By 09/29/2026, provide translated curriculum materials in Vietnamese and Marshallese.
4	Partner with an outside entity to distribute and train counties across the state as well as identify interested parties in receiving naloxone based on the distribution plan to meet the need of 100% saturation across all 75 counties throughout the grant period. 75% of participants will report increased confidence related to identifying signs and symptoms of opioid misuse as evidenced by post-training surveys.
5	By 09/29/2025, and annually thereafter, improve capacity of regional prevention providers to identify communities in need of naloxone as measured by maintenance of OSAMH Naloxone Distribution map and program documentation of naloxone distributed to targeted communities as a result.
6	By 09/29/2025, and annually thereafter, increase regional capacity to implement data driven prevention strategies as measured by number of sub-grantee prevention contracts and monthly activity monitoring of activities delivered in high-need communities.
Goal 2: Maximize positive health behaviors and substance use prevention outcomes throughout each region of the State of Arkansas.	
Objective	**Objective Description**
1	By the end of the project period in 2028, coordinate with an outside entity to utilize prevention strategies recommended by the Center for Substance Abuse Prevention (CSAP) to reduce underage drinking by 3%, as measured by the Arkansas Prevention Needs Assessment (APNA).
2	By the end of the project period in 2028, coordinate with outside entities to increase opportunities for school-based pro-social involvement by 20% (as measured by APNA) in high-poverty areas and those counties with the highest rates of substance misuse to support and engage youth ages 12-25.
3	By the end of the project period in 2028, contract with an outside entity to create educational opportunities to train counselors at participating schools to utilize the Screening, Brief Intervention, Referral and Treatment (SBIRT) method to promote annual screenings of students for opioid, stimulant, and prescription drug misuse and to implement evidence-based universal prevention interventions.
4	By the end of the project period in 2028, collaborate with participating schools in the Arkansas Collegiate Network to develop and disseminate prevention resources to their students.
5	By the end of the project period in 2028, increase collegiate recovery programs in the state by at least one.

Goal 3: Enhance the knowledge base for the workforce to better support individuals at risk or with an OUD, families and the community in prevention, treatment, and recovery support through trainings, consultation and evaluation.	
Objective	**Objective Description**
1	Modernize providers (prevention, treatment, and recovery) by training on the latest evidence-based techniques, skills, and assessment tools including ASAM to develop a more advanced workforce to combat substance use disorders and cooccurring disorders.
2	Develop a toolkit in collaboration with the Arkansas Department of Health to screen and treat STI, HIV, and other chronic illnesses associated with high-risk behaviors and SUD for funded providers to utilize.
3	Establish a quarterly meeting with stakeholders to discuss and educate providers and stakeholders on the importance of data collection best practices and ways to improve services based on data.
4	Contract with an outside provider to gather GPRA survey intake and follow-up data to improve the state's report to SAMHSA regarding progress toward grant requirements.
5	Identify the barriers in accessing MOUD treatment services for youth and young people through assessment and evaluation and develop a plan to mitigate these barriers.
Goal 4: Move towards ongoing sustainability for substance use disorder services along a full continuum of substance use disorders for the State of Arkansas.	
Objective	**Objective Description**
1	Create a toolkit for interested service providers to use as they engage with Medicaid toward becoming a new provider.
2	Establish regularly scheduled meetings led by a project management team with stakeholders and subject matter experts to develop a timeline for enrolling subgrantees as Medicaid providers.
3	Identify barriers to the enrollment process and make necessary revisions to the enrollment toolkit.
4	Develop educational opportunities with the Recovery Community Organizations (RCOs) to utilize Medicaid for reimbursable peer recovery support services.
5	By January 30, 2025, OSAMH will have a meeting with the Department of Health and other interested state entities to explore opportunities for braided funding to achieve goals and objectives.
6	By the end of the project period in 2028, increase the number of SUD treatment providers enrolled in Medicaid and increase utilization of Medicaid services.
7	Create educational opportunities to equip youth and young adults (16-25) with skills to navigate services and enroll in benefits including insurance.
Goal 5: Expand rural access to treatment for OUD and other concurrent substance use disorders.	
Objective	**Objective Description**
1	Collaborate with subject matter experts and external consultants to develop a hub and spoke model for access to FDA-approved medications for the treatment of SUD for hard-to-reach populations and rural areas.
2	Provide innovative telehealth strategies in rural areas to increase the capacity of support services for OUD/stimulant use disorder prevention, treatment, and recovery.
3	Improve access to health care utilizing mobile units to reach rural areas.
4	By the end of the project period in 2028, a low-barrier Buprenorphine treatment program will be piloted in the state.

Objective	Objective Description
Goal 6: Decrease severity of social determinates of health which negatively impact overall wellness of mothers, pregnant women, and their children in Specialized Women's Services programs.	
Objective	**Objective Description**
1	Contract with an outside entity to provide specialized maternal health services to pregnant women in SWS programs and to pregnant women at risk of needing SWS programs.
2	Identify pregnant women in collaboration with an outside entity working with justice-involved mothers, family court cases, or other entities to enroll them into services related to prenatal care and system navigation.
3	Develop a toolkit to educate providers in reducing discrimination for mothers and pregnant women needing SWS services.
4	Increase current admissions to SWS treatment by 10% through increasing accessibility of childcare services for mothers which is a deterrent to women admitting to SUD treatment.
5	Contract with an outside entity to assess and evaluate the effectiveness of SWS services in meeting the needs of mothers and pregnant women.
Goal 7: Work with DCFS to develop braided funding for Substance Use Services programs.	
Objective	**Objective Description**
1	Establish regularly scheduled meetings with stakeholders from DCFS, OSAMH, SUD treatment providers, and other interested parties to examine the data regarding unmet needs of pregnant and parenting women, families, and youth in care with SUD-related services and develop a collaborative resource network to address barriers.
2	Review and align contract language by both DCFS and OSAMH for contracts providing SUD-related services to pregnant and parenting women, families, and youth in care to produce a more collaborative, evidence-based, and relevant care plan by the end of the project period.
3	By the end of the project period in 2028, OSAMH will establish a working partnership with an early childhood development entity to address childcare, child development, parenting needs, and other services for pregnant and parenting women in SUD-related services.
Goal 8: Reduce lapse and overdoses for the justice-involved population.	
Objective	**Objective Description**
1	Collaborate with stakeholders to develop a roadmap for justice-involved individuals to receive the full continuum of care including MAT treatment.
2	Increase the number of active participants receiving justice-involved peer recovery support services in specialty courts as recorded on Goodgrid by 10% as an avenue towards recovery resources and referrals.
3	Implement a centralized reporting and management program in conjunction with an outside entity for justice-involved peer recovery support specialists as they work in specialty courts.
Goal 9: Work towards RCOs being centralized custodians for the peer recover support workforce in the community.	
Objective	**Objective Description**
1	Establish regularly scheduled meetings led by a project management team with the RCO leaders to develop strategies to encourage current employers of peer recovery support specialists (PRSS) to adopt RCOs as the custodians and develop a timeline for centralizing the peer recovery support workforce.

2	By January 30, 2025 OSAMH will facilitate a community forum with healthcare providers, law enforcement agencies, justice services, community partners and other interested stakeholders to collaborate on the process of converting the RCOs as the overall custodian of PRSS and develop a comprehensive referral system for recovery services through the RCOs.
3	OSAMH will plan, with or without outside entities, technical assistance on best practices for RCO development and management to increase capacity of peer recovery support services in underserved and/or rural areas.
Goal 10: Advance peer recovery support services to provide evidence-based services to families in the continuum of care.	
Objective	**Objective Description**
1	By the end of the grant period, OSAMH will contract with an outside entity to develop and provide specialty training of recovery support services for pregnant and parenting women with substance use related issues as well as a specialty training for family support services.
2	Increase the number of NARR certified recovery residences including applications, testing, training, and ethics enforcement to a nationally recognized credentialing entity.
3	OSAMH will outsource the peer certification process including applications, testing, training, and ethics enforcement to a nationally recognized credentialing entity.
4	Partner with an outside entity to schedule, plan, and implement core, advanced, and supervisor training for the continuation and growth of the PRSS workforce.

SOR 4 Prevention Initiatives

SAMHSA emphasizes the use of evidence-based strategies to guide prevention, treatment, and recovery efforts addressing opioid misuse and overdose. Grounded in rigorous research, these approaches ensure interventions are effective, efficient, and lead to meaningful outcomes. Examples of SAMHSA-supported prevention strategies include targeted Naloxone distribution, community training and technical assistance on opioids and OUD, and coordinated social and environmental initiatives to reduce the broader impacts of opioid misuse.

Arkansas' SOR 4 Prevention Activities include:

- Distribution of Naloxone and educational materials
- SUD and Naloxone Administration Training (in-person, virtual)
- Social and Advertising Media and Messaging
- Technical Assistance

The following state agency and community organization programs participated in prevention during Year-One of the SOR 4 program:

- Arkansas Department of Higher Education (ADHE)
- End Overdose
- MidSOUTH SOR-P Agreement 2

Arkansas Department of Higher Education (ADHE)

The Arkansas Department of Higher Education (ADHE) is committed to advancing substance use disorder (SUD) prevention initiatives within the state's higher education system. Recognizing that colleges and universities play a critical role in shaping healthy behaviors and providing early intervention opportunities, ADHE seeks to strengthen institutional capacity for addressing substance misuse among students. To this end, ADHE solicited proposals from colleges and universities for the development of collegiate prevention and recovery projects tailored to the unique needs and circumstances of each campus community. These projects included evidence-based prevention strategies, peer-led recovery support programs, training and awareness initiatives for students, faculty, and staff.

The Arkansas Department of Higher Education (ADHE), in collaboration with a committee convened by the Office of Substance Abuse and Mental Health (OSAMH), oversaw the application process and provided technical guidance to institutions, including feedback on proposal revisions. Institutions seeking funding were required to submit:

- A comprehensive community needs assessment identifying evidence-based risk and protective factors
- A detailed project plan, including a logic model
- A proposed budget
- An evaluation plan

During the first quarter of Year-One of the 2025 SOR 4 grant, ADHE and OSAMH worked jointly to establish the application process.

In the second quarter, ADHE posted the application on its website and distributed it to all members of the Arkansas Collegiate Network as well as the Chief Financial Officers of participating institutions. At the request of several universities, the application deadline was extended to accommodate additional time for internal administrative approvals. Despite these efforts, ADHE received fewer applications than anticipated, and the total funding requested was below the available budget. To address this, schools were encouraged to expand the scope of their proposals to more fully utilize the funds, resulting in an additional round of proposal revisions.

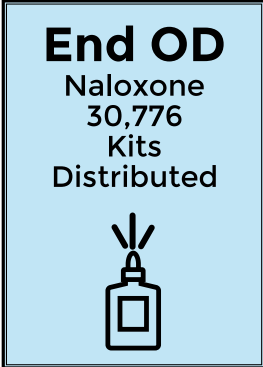
In the third quarter, six proposals were approved across five institutions. The University of Arkansas submitted two proposals—one focused on prevention and one on recovery—both of which were funded. In the fourth quarter, funding was disbursed to the approved programs.

Table 2: AOC: Funded Schools and Focus of Effort

Name of School	Effort Focus
Arkansas State University-Newport	Prevention
Philander Smith University	Prevention
University of Arkansas	Prevention and Recovery
University of Arkansas at Cossatot Community College	Recovery
University of Central Arkansas	Recovery

Additionally, ADHE allocated a portion of the remaining funds to host a Mobilize Recovery event, further strengthening statewide prevention and recovery efforts.

End Overdose (EOD)



End Overdose is a non-profit organization dedicated to ending drug-related overdose deaths. The organization advances this mission through education, medical intervention, and public awareness initiatives. The organization's work centers on equipping communities with practical tools and training, including the distribution of 30,776 naloxone kits and 4500 drug-checking test strips, to strengthen both prevention and response to the ongoing overdose crisis.

Fig. 12: EOD Naloxone Kit Distribution by Recipient Type*

Recipient Type	Kits
Behavioral/Mental Health Facility	2366
College or University	546
College/University Staff	510
Community Event Attendee	1795
Community Organization	4546
Detox Center	48
Drug/District Court	1986
Faith Based Organization	1300
First Responders	1746
Justice Involeved Organizations	144
K-12 Staff	1587
K-12 Students	155
Medical Center/Hospital	1232
Nightlife Business/Venue Staff	124
Nighlife/Music Event Attendee	179
Online Trainee	592
Other	468
People in Recovery	189
Person Experiencing Homelessness	1080
Pharmacists	40
Public Servants	442
Recovery Center Staff/Clients	5444
Regional Prevention Provider	1008
Treatment Center Staff/Clients	1092
Undergraduate/Graduate Students	1112

*Graph shows the number kits distributed, not the number of individuals who received a kit.

Naloxone Training

End Overdose offers online and in-person naloxone training. Trainings are available in English and Spanish. Online trainings offer instruction on naloxone and its proper administration, while also providing individuals in rural communities with the opportunity to obtain a no-cost naloxone kit by mail.

Table 3: EOD Naloxone Training Totals

Training Type	Total Number Trained	Number Trained in Rural Communities	Percentage of Total Trained in Rural Communities
Online	324	125	39%
In-Person	6153	1975	32%
Total	**6477**	**2100**	**32%**

Online Training: Following completion of online training, participants were asked to complete a survey capturing demographic information and experiences related to opioid misuse. Of the respondents, 113 (53%) identified as male and 142 (43%) identified as female, with the majority of respondents reporting being between the ages of 25 and 34 years old (81; 30%) and having a yearly income of between $25,000 and $49,999 (109; 41%).

Fig. 13: EOD Gender of Online Survey Respondents

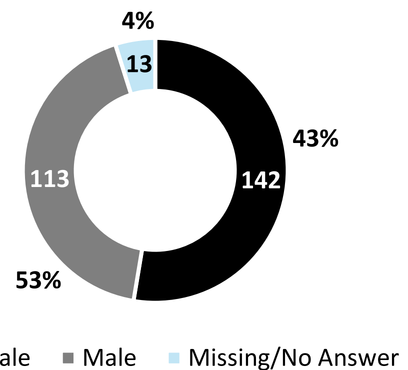


Fig. 14: EOD Age of Online Survey

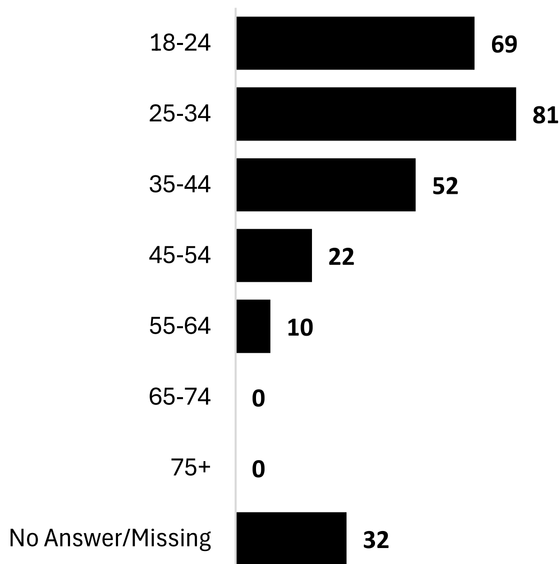
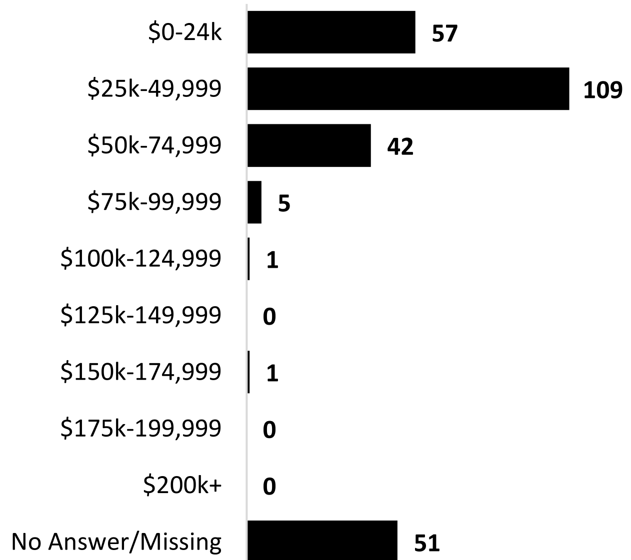


Fig. 15: EOD Income of Online Survey Respondents



A majority of online survey respondents (142 respondents, 54%) reported that they had never witnessed an overdose, while 178 respondents (68%) indicated that they had never personally experienced an opioid overdose. The majority of respondents (185; 70%) reported their motivation for taking the online course as "People who are close to me are at risk."

Fig. 16: EOD Online Survey Respondents Witnessing an Overdose

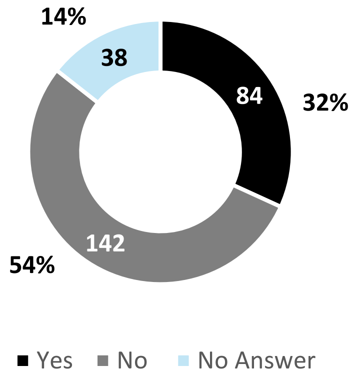
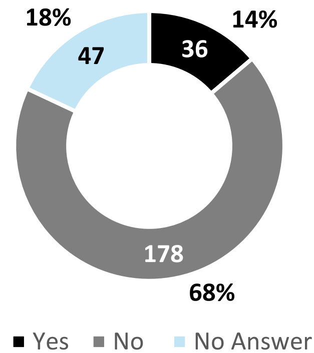


Fig. 17: EOD Online Survey Respondents Who Experienced an Overdose



In-person Training: End Overdose conducted in-person naloxone trainings at colleges, universities, and community events. Among pre and posttest survey respondents, 705 (57%) identified as male and 539 (43%) as female. The majority, 911 (78%), self-identified as White, and 849 (72%) were between the ages of 16–24.

Fig. 18: EOD Gender of In-person Survey Respondents

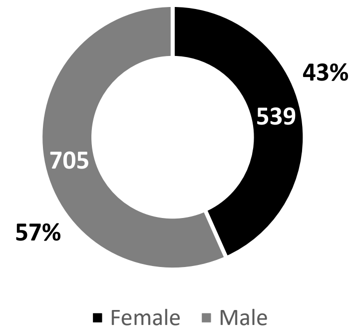


Fig. 19: EOD Race of In-person Survey Respondents

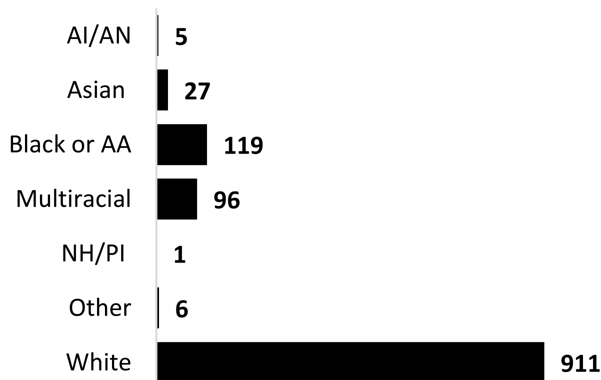
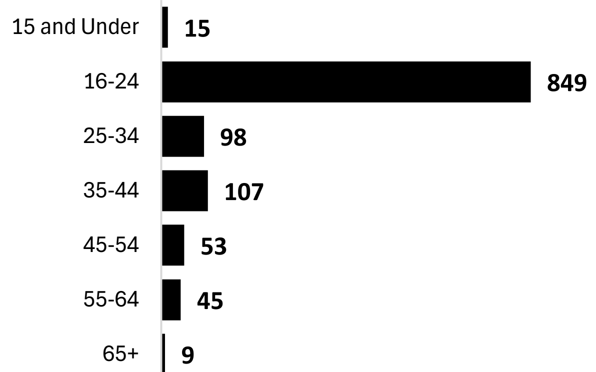


Fig. 20: EOD Age of In-person Survey Respondents



The majority of in-person training participants that chose to take the pretest reported that they had neither lost someone to an overdose (660; 79%) nor previously received training in how to use naloxone (825; 85%).

Fig. 21 EOD In-person Pre-test Respondents Indicating Loss

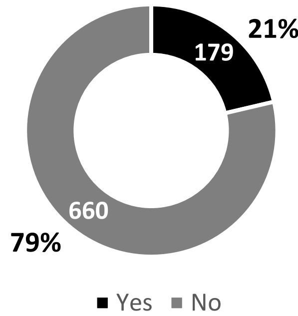
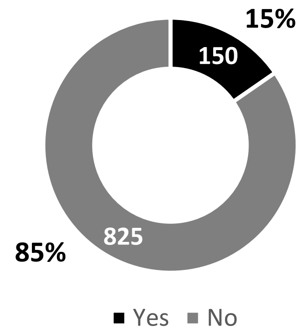


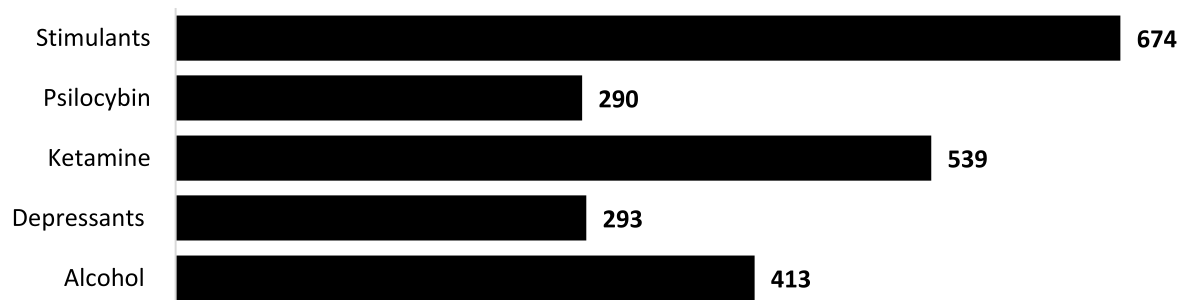
Fig. 22 EOD In-person Pre-test Respondents Indicating Previous Training



Among in-person training participants who completed the posttest, most indicated a preference for Hands-on Training/Role Playing (458) and Gamified Learning (344) as training methods, and the majority also expressed interest in learning about stimulant (674) and ketamine (539) overdoses.

Fig. 23 EOD In-person Post-test Respondents Indicating Preferred Learning Method

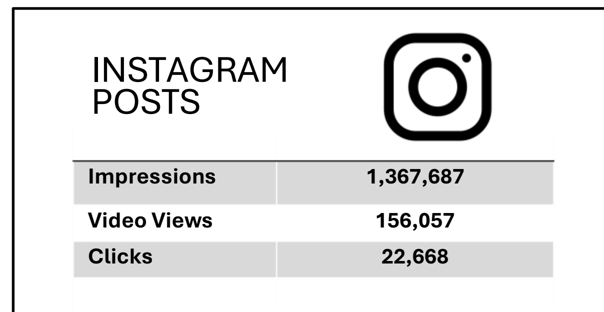
Fig. 24 EOD In-person Post-test Respondents Indicating Interest in Learning About Other Types of Overdoses



Media

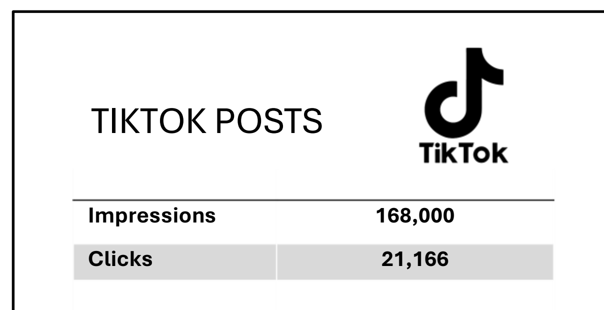
Instagram

End Overdose maintained an active presence on Instagram by publishing more than 20 posts designed to engage community members and raise awareness. Content included overdose prevention and response education, step-by-step information on accessing free naloxone and training opportunities, and introductions to members of the Arkansas team to build trust and local connections.



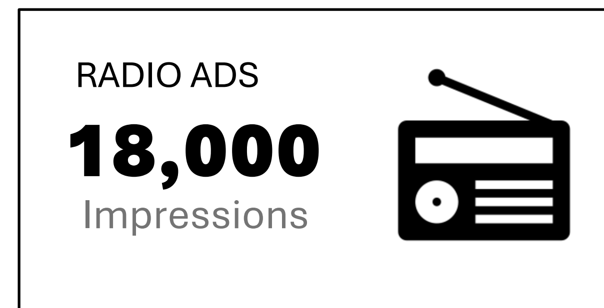
TikTok

To reach a broader and younger audience, End Overdose created a TikTok post that gained significant traction, generating 168,000 impressions and 21,166 clicks. The campaign highlighted the value of using creative and accessible media formats to promote public health messaging.



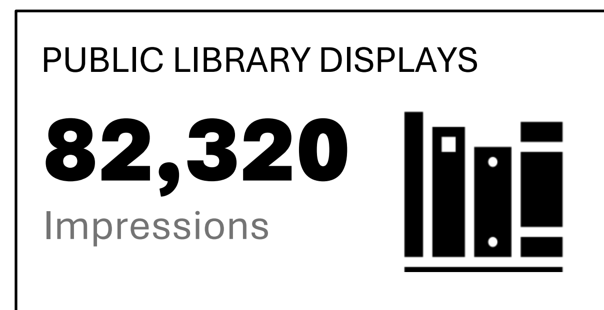
Radio

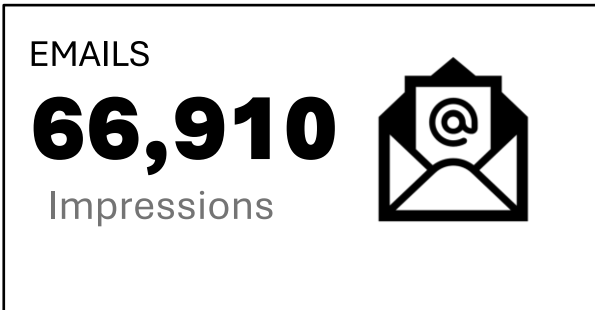
End Overdose also used traditional media by running statewide radio advertisements. These ads were tailored to share information on how to access free naloxone kits, ensuring that individuals without reliable internet or social media access could still receive critical information.



Public Library Displays

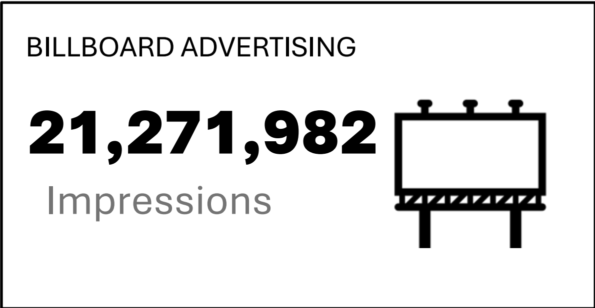
End Overdose further expanded community outreach by setting up displays in six public libraries throughout the state. These displays included accessible information about naloxone training opportunities and highlighted the importance of overdose prevention.





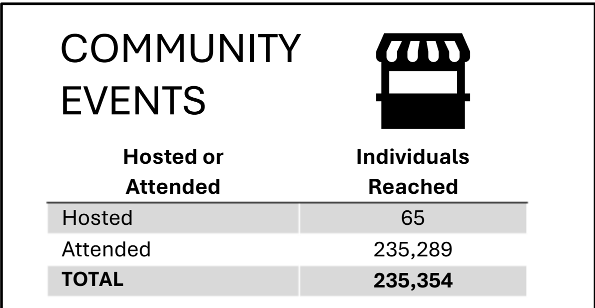
Emails

End Overdose employed a multi-channel outreach strategy to promote overdose prevention and naloxone training, reaching over 66,000 individuals through email campaigns.



Billboards

To increase visibility across the state, End Overdose funded billboard advertising in Lonoke, Hot Spring, St. Francis, and Washington Counties. These strategically placed billboards generated over 8 million impressions, raising public awareness about overdose prevention and directing individuals to available resources.



COMMUNITY EVENTS

Hosted or Attended	Individuals Reached
Hosted	65
Attended	235,289
TOTAL	**235,354**

Community Events

End Overdose strengthened its community presence by attending numerous local events and hosting one event at a university where they tabled to connect directly with students and faculty. Collectively, these outreach efforts reached 18,150 individuals.

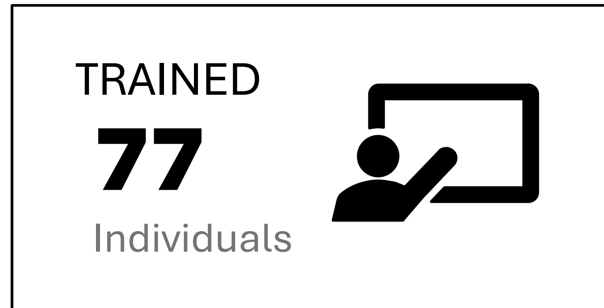
Educational Materials

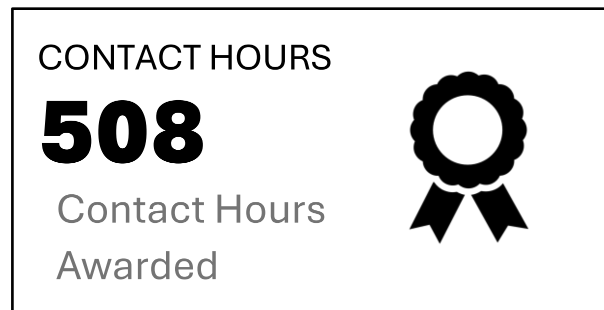
End Overdose distributed 8,565 educational materials at community events and in-person trainings. These materials included information on recognizing the signs and symptoms of overdose, instructions for accessing online training, and general overdose prevention messaging.

MidSOUTH SOR-P

Agreement 2

MidSOUTH SOR-P works to identify systemic barriers and expand service capacity for underserved populations, with priority given to high-needs communities. A core strategy involves the development and implementation of prevention training to address the opioid epidemic. These trainings are evidence-informed and align with national best practices, including those outlined by SAMHSA, to improve knowledge of opioid misuse, overdose recognition, and naloxone administration. By targeting students, community stakeholders, and frontline service providers, the program increases awareness, reduces stigma, and strengthens local prevention infrastructure.





During the reporting period, MidSOUTH Agreement 2 trained 77 individuals on subjects such as Neurobiology of Addiction/Substance Use Disorder, Grant Writing, and Substance Specific Training. Each attendee was awarded Contact Hours for attending the training, resulting in 508 total Contact Hours awarded. Attendees included prevention specialists, grant managers, counselors, and more.

Table 4: EOD Trainings by Type

Training Name	Method	Number of Attendees
Neurobiology of Addiction/Substance Use Disorder	Virtual	18
Substance Specific Training	In-person	22
Grant Writing	In-person	12
Beamer's Buddies	Virtual	14
Teen Intervene	Virtual	11
Total		**77**

Surveys

During Year-One of SOR 4, MidSOUTH administered two surveys to assess the resource and educational needs of prevention providers in Arkansas. Findings from the *Drugs of Misuse* survey indicated limited knowledge among respondents regarding Gamma-Hydroxybutyric Acid (GHB), U-47700 (U4), synthetic cathinones (bath salts), carfentanyl, and xylazine. Additionally, participants expressed a broader need for educational materials and resources beyond these specific substances. Results from the *Resource Dissemination* survey showed strong interest in all three available resources: *Operation Parent Handbooks* (English and Spanish), and the *Name That Drug Game Wheel*.

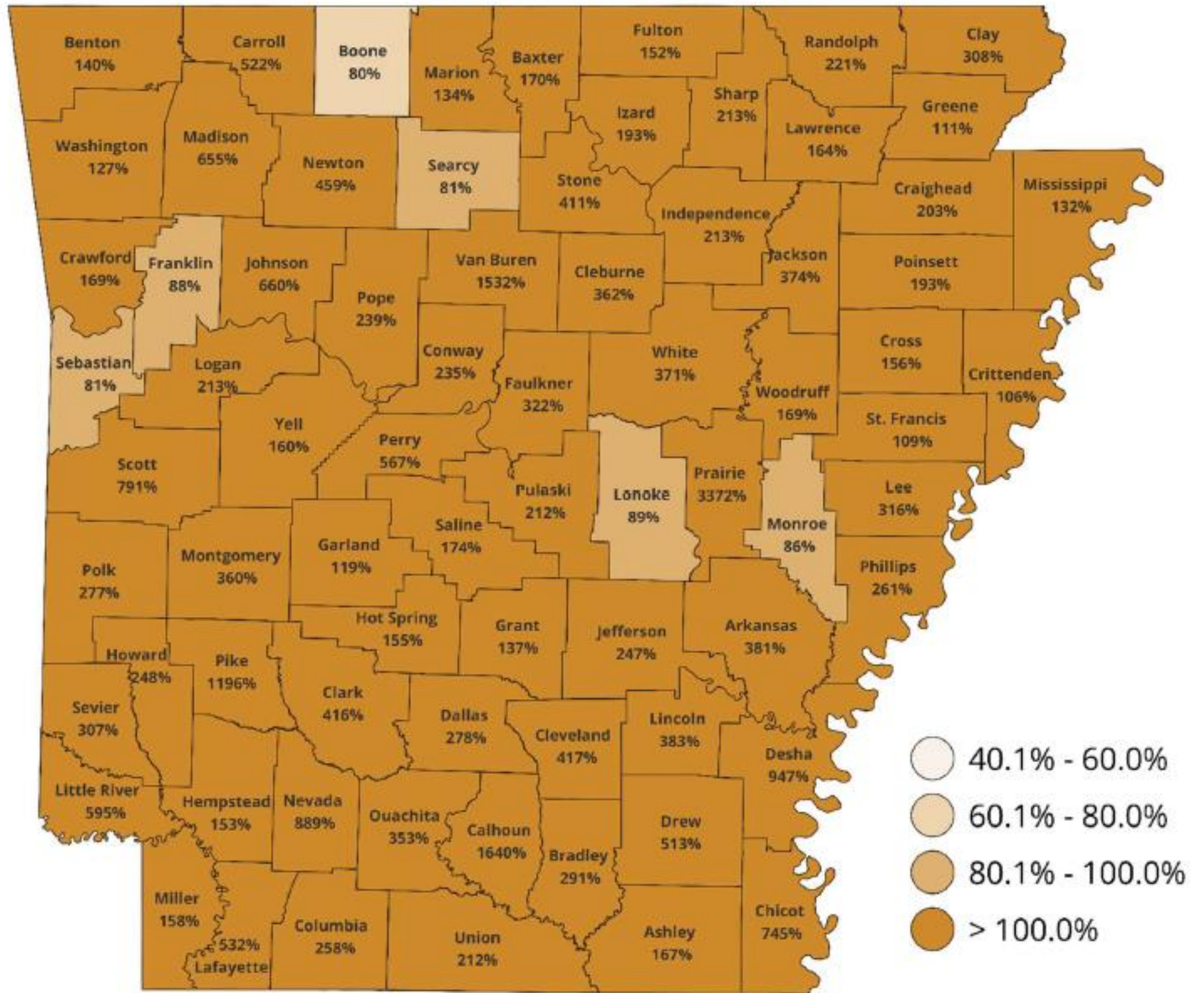
Table 5: EOD Surveys by Topic

Name of Survey	Topic	Number of Respondents
Drugs of Misuse	Assessing provider priority education of drugs of misuse	22
Resource Dissemination	Identifying quantities of specific resources to be purchased for prevention providers	12
Total		**34**

Naloxone Saturation

From October 2024 to August 2025, a total of 41,386 two-dose boxes of Naloxone were distributed across all 75 counties in Arkansas, bringing the number of fully saturated counties to 70. This increase in coverage is largely due to improved coordination between stakeholders via the Naloxone saturation map and a new state partnership with End Overdose for targeted statewide Naloxone distribution.

Fig. 25: Arkansas Naloxone Saturation Map October 2023 – August 2025



SOR 4 Treatment Initiatives

SAMHSA supports evidence-based interventions for opioid use disorder (OUD), recognizing that effective treatment often requires a combination of pharmacological, behavioral, and psychosocial approaches. Because OUD frequently co-occurs with mental health disorders, integrated care—such as combining medication-assisted treatment (MAT) with behavioral therapy—is emphasized as a key strategy. Comprehensive treatment also includes counseling, peer support, and psychiatric care to address high-risk situations and promote safety and stability. Evidence-based practices include MAT, therapy and counseling, and participation in long-term recovery supports such as sober living communities and peer programs.

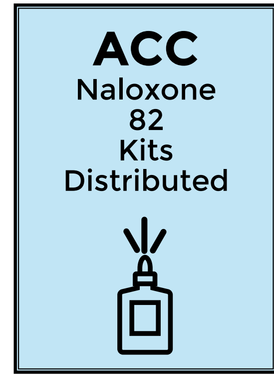
Arkansas' SOR 4 Treatment Activities include:

- Distribution of Naloxone and training
- Training and Education
- Clinical Services including MAT
- Technical Assistance

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

- Arkansas Community Corrections (ACC)
- Family Centered Treatment Foundation Recovery (FCT-R)
- MidSOUTH SOR-T (Agreement 4)
- River Valley Medical Wellness (RVMW)
- UAMS

Arkansas Community Corrections (ACC)



The ACC MAT program offers a six-month medication-assisted treatment (MAT) intervention for individuals diagnosed with opioid use disorder (OUD) who are in community corrections treatment. The program begins with group sessions addressing substance use and addiction. As participants approach their release date, they receive an initial Vivitrol injection. Following release, participants are required to continue group treatment, maintain their medication regimen, and complete ACC's six-month Continuing Care Program to meet program requirements.

During the reporting period, a total of 115 participants were released into Continuing Care: 44 successfully completed the program, 36 were discharged unsuccessfully, 1 withdrew for medical reasons, and 34 remained active. Unsuccessful discharges were primarily due to noncompliance, including failed drug tests or missed counseling sessions. ACC distributed a total of 82 naloxone kits to exiting residents.

Table 6: ACC Status of Participants Accepted into Continuing Care

Status of Participant	Number
Successfully completed the program	44
Unsuccessfully discharged	36
Withdrew for medical reasons	1
Still participating in the program	34
Total	**115**

Educational Sessions

At each of the three centers, monthly educational sessions are conducted. These sessions include education about the MAT program, naloxone, and signs and treatment for an opioid overdose. While MAT participants are required to attend, any resident of the center is free to join and is counted as a potential participant in the MAT program. During Year-One of SOR 4, ACC distributed 1,239 educational materials.

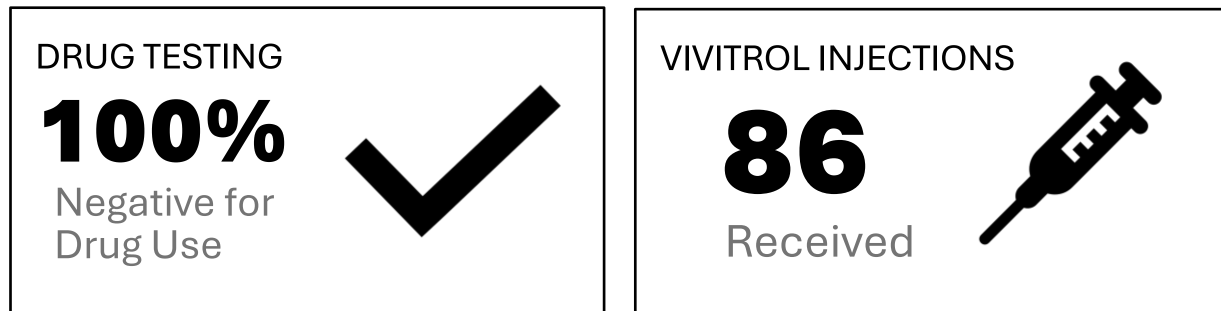
Fig. 7: ACC Potential Participants Attending Educational Sessions

Month	Potential Participants
November 2024	8
December 2024	2
January 2025	399
February 2025	250
March 2025	237
April 2025	62
May 2025	43
June 2025	19
July 2025	37
August 2025	32
Total*	**1089**

*Individuals may have joined the monthly sessions several times, this total may represent duplicate numbers.

Drug Testing and Vivitrol Injections

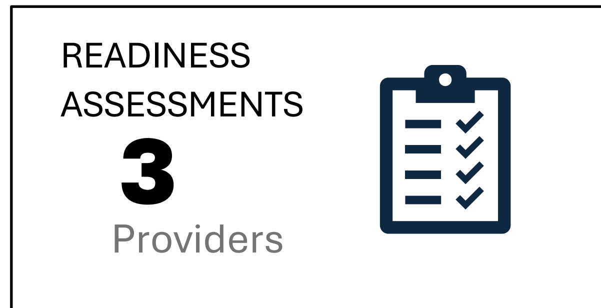
As participants in the MAT program near release, they receive an initial Vivitrol injection funded by ACC. Before the injection is administered, each participant undergoes a drug screening to confirm they are substance-free. Of the 110 drug tests conducted this reporting period, zero returned positive results and 86 vivitrol injections were administered.



Participant Perception of the Continuing Care Program

Participants noted that they valued the program primarily for the accountability and support it provided, which they viewed as essential to their progress and recovery. At the same time, several participants acknowledged facing difficulties within the program, citing challenges such as scheduling difficulties and boredom due to the repetitive nature of some of the classes..

Family Centered Treatment - Recovery (FCT-R)



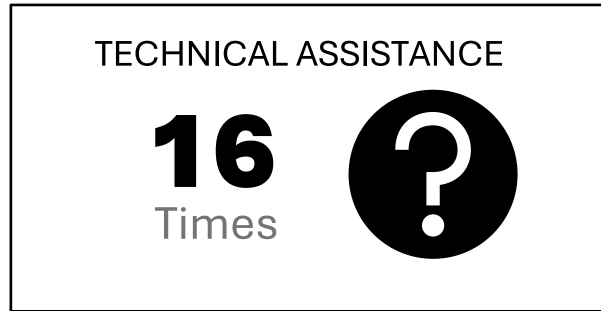
Family Centered Treatment-Recovery (FCT-R) works with providers in Arkansas to implement the FCT-R model. This innovative model integrates Family Centered Treatment (FCT) with best practices in substance use treatment to address the intersection of addiction and trauma. Built on the premise that families play a central role in both the development and recovery from substance use disorders, it maintains all elements of FCT while adding supports tailored to addiction and recovery.

The approach keeps families intact, serves as a reunification tool, and treats substance use through family systems and trauma-informed perspectives grounded in biological, social, and cultural factors. Using a recovery ecosystem framework, it connects families to community resources such as peer support, education, employment, and housing, while leveraging family attachment bonds to promote long-term recovery.

The process begins by recruiting providers and generating interest in adopting the model within their organizations. Once a provider expresses interest, FCT-R conducts a full-day, on-site Readiness Assessment—a 60-point checklist evaluating data systems, clinical practices, and staff capacity to determine readiness for implementation. If gaps are identified, FCT-R collaborates with the provider to build necessary capabilities, though some may choose not to proceed. When a provider is prepared, they sign an agreement, after which onboarding, licensing, and training begin. During the reporting period, FCT-R completed three Readiness Assessments and anticipates securing signed agreements from all three providers by late September 2025.

Technical Assistance

FCT-R provided technical assistance Sixteen times during the reporting period, thirteen times virtually and three times in-person, to the OSAMH FCT-R Implementation Team.



Trainings

FCT-R provided prospective provider training to eight community partners and implementation training to four stakeholders during the reporting period.

Table 8: FCT-R Trainings by Type and Individual

Type of Individual Trained	Number of Individuals Trained	Method of Training	Types of Training Received
Community Partners	8	In-Person	FCT-Recovery training with prospective provider
Stakeholders	4	In-Person	FCT-Recovery Implementation training

MidSOUTH SOR-T

Agreement 4

MidSOUTH SOR-T works to strengthen the state's capacity to respond to the opioid crisis by expanding the use of evidence-based practices. The initiative focuses on equipping providers, community organizations, and justice system partners with training, technical assistance, and resources that support the adoption of evidence-based practices aligned with treating opioid use disorder (OUD). By building knowledge, improving service delivery, and fostering cross-sector collaboration, MidSOUTH SOR-T aims to lower the incidence of opioid use disorder and enhance the effectiveness and sustainability of state and local responses.

Trainings

Under Agreement 4, MidSOUTH hosted virtual and in-person trainings on subjects such as the American Society of Addiction Medicine Criteria, 4th Addition (ASAM IV), Motivational Interviewing and Internal Family Systems. Each attendee was awarded Contact Hours for attending the training, resulting in 2,392 total Contact Hours awarded. Additionally, 340 ASAM IV textbooks were distributed. Attendees included mental health professionals, peer recovery specialists, social workers, and more.

Table 9: MidSOUTH SOR-T Trainings by Type

Training Name	Method	Number of Attendees
ASAM IV		29
ASAM IV		208
Internal Family Systems	Virtual	19
Motivational Interviewing	In-Person	15
Mindfulness-Oriented Recovery Enhancement (MORE)	In-Person	22
Trauma Informed Care Approaches	Virtual	25
Chronic Disease of Addiction/Neurobiology of Addiction	Virtual	20
Stimulant Use Disorder	Virtual	23
Pharmacotherapy: AUD and OUD	Virtual	25
Total		**386**

Naloxone Distribution

During the reporting period, MidSOUTH Agreement 4 distributed 793 naloxone kits.

River Valley Medical Wellness (RVMW)

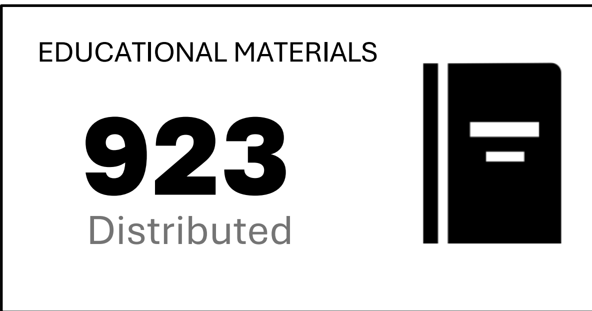
River Valley Medical Wellness (RVMW) provides evidence-based addiction treatment services aligned with the standards of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine (ASAM). Their continuum of care addresses varying levels of treatment intensity, including long-term residential care, inpatient and outpatient services, medically supervised detoxification, and structured sober living environments.

Youth Grant

RVMW supports youth ages 12 to 25 through school-based partnerships that strengthen resiliency, expand pro-social activities, and train counselors in the SBIRT method for early identification of substance misuse. At the Arkansas Juvenile Assessment & Treatment Center (AJATC), RVMW provides medical care, therapy, peer recovery support, and staff education to address substance use and co-occurring mental health needs. These services continue post-discharge, ensuring youth remain connected to recovery resources as they transition back into their communities.

Educational Materials

During the reporting period, RVMW distributed 923 educational materials about Substance Use Disorder and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method.



Peer Recovery Services at AJATC

RVMW provided peer recovery services to residents at the Arkansas Juvenile Assessment and Treatment Center. Peer group topics included: Anger Management, Re-entry Support, and Coping Skills.

Table 10: RVMW Peer Recovery Services Totals at AJATC

Type of Service	Number of Participants
Peer Group	311
1:1 Recovery or Peer Coaching	9
Aftercare 1:1	10
Narcan Training	12
Total	**342**

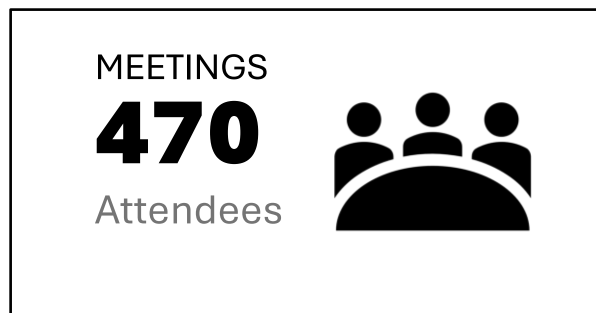
Table 11: RVMW Peer Recovery Services Totals at AJATC: Individual Sessions

Type of Service	Topic	Number of Participants
Peer Group	Unmanageability due to drugs	16
Peer Group	Rewriting your story	8
Peer Group	Love vs Lust	9
Peer Group	Recovery Plan	10
Peer Group	Intrusive thoughts and triggers	8
Peer Group	Lyrics and Life: The Soundtrack of Recovery	5
Peer Group	Re-entry support	9
Peer Group	Goal setting short- and long-term goals	9
Peer Group	Anger management	5
Peer Group	Goal setting inside Alexander and upon release	6
Peer Group	Attitude	10
Peer Group	Anger management	5
Peer Group	Moral and Values	5
Peer Group	Combatting depression	9
Peer group	Moral and Values	7
Peer Group	Cognitive thinking	25
Peer Group	Coping Skills	26
Peer Group	Lived Experience	7
Peer Group	Peer Survey	16
Peer Group	Vaping	12
Peer Group	Marijuana	14
Peer Group	Anger management	17
1:1 Recovery or Peer Coaching	Re-entry	1
1:1 Recovery or Peer Coaching	Establish relationship	1
1:1 Recovery or Peer Coaching	Coping Skills	1
1:1 Recovery or Peer Coaching	Following up/checking in	1
1:1 Recovery or Peer Coaching	Release	1
1:1 Recovery or Peer Coaching	Vaping	1
1:1 Recovery or Peer Coaching	Cannabis	1
1:1 Recovery or Peer Coaching	Post release planning	1
Aftercare 1:1	Aftercare planning	1
Aftercare 1:1	Aftercare planning	1
Aftercare 1:1	Aftercare planning with family	2
Aftercare 1:1	Aftercare planning with family	1
Aftercare 1:1	Job searching	1
Aftercare 1:1	Job searching	1
Aftercare 1:1	Conference call with family, discuss job search	1
Aftercare 1:1	Job searching	1
Total		**342**

*note: Individuals may have participated in more than one group or 1:1 session, so numbers may be duplicated.

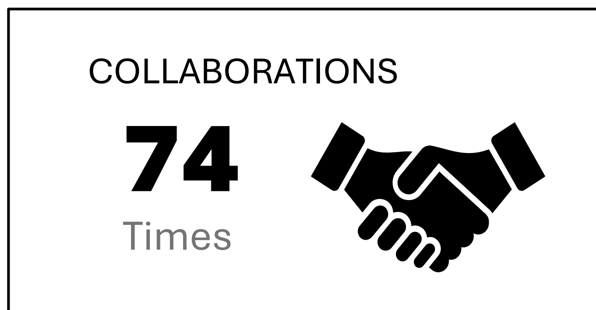
Meetings

During the reporting period, RVMW attended or conducted 74 meetings with 470 attendees. Meetings were with AJACT leadership, Arkansas Department of Health Staff, CHESS Health, UALR MidSOUTH, and more.

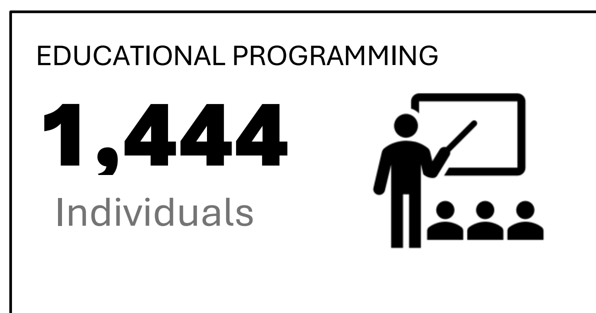


Collaborations

RVMW collaborated with several organizations to enhance the mental wellbeing of youth in Arkansas. During the reporting period RVMW collaborated with organizations such as Arkansas Behavioral Health Integration Network (ABHIN), Project AWARE, Arkansas Foundation for Medical Care (AFMC), Family Centered Treatment (FCT), community-based treatment providers, pediatric addiction specialists, and more 74 times.



Educational Programming



RVMW provided educational programming to AJATC staff, medical providers, and probation and parole officers on subjects such as Project AWARE, Co-occurring Disorders in Youth, Hazelden Betty Ford Evidence-Based Curriculum, and MOUD in Youth. During the reporting period, 1,444 individuals received educational programming. Individuals may have attended multiple sessions, so numbers may be duplicated.

SBIRT Training

RVMW trained 196 individuals on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method.

Table 12: Individuals Trained in the SBIRT Method

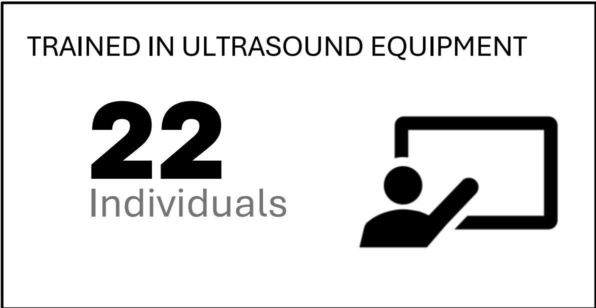
County	Type of Individual	Number Trained
Saline	Department of Youth Services Staff	32
Pulaski	BHI Institute	28
Statewide-Virtual	BHI Institute	68
Statewide-Virtual	Stakeholders	68
Total		**196**

Maternal Grant

RVMW aims to address the opioid crisis among women who are pregnant or may become pregnant by providing specialized, direct services tailored to their unique needs. The program sought to reduce risks associated with substance use during pregnancy, improve maternal and infant health outcomes, and connect women to comprehensive care. Services included screening, counseling, case management, and referrals to treatment and recovery supports, along with education on healthy pregnancy and parenting. By focusing on this population, RVMW worked to break cycles of substance use and strengthen the wellbeing of both mothers and their children.

Ultrasound Equipment Training

RVMW trained twenty-one medical professionals in ultrasound equipment in Pope, Garland, and Faulkner Counties.



Substance Use Disorder and Mental Health Educational Sessions

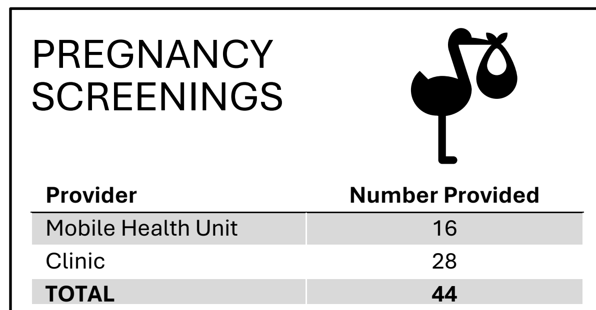
RVMW educated community-based staff and contracted medical providers in Garland, Pope, Pulaski, and Saline Counties. Sixty-five percent of the individuals were in rural communities. Educational topics included: Maternal Health-Medical and Recovery Services, Co-occurring Disorders, and Integrated Care in The Perinatal Period.

Table 13: RVMW Individuals Educated on Substance Use Disorder and Mental Health

County	Type of Individual	Number Educated
Garland	Community-Based Staff, Contracted Medical Providers	60
Pope	Community-Based Staff	174
Pulaski	Community-Based Staff, Contracted Medical Providers	170
Saline	Community-Based Staff	260
Total		**664**

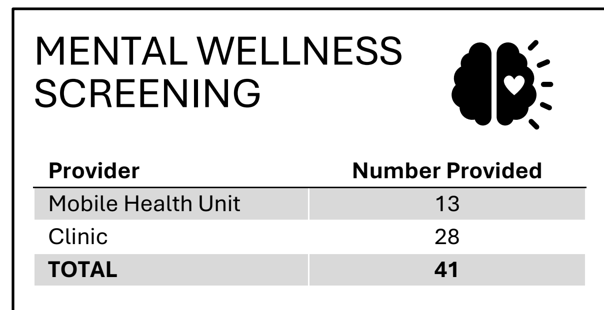
Services to Women

RVMW delivered services through a mobile health unit in Saline County and through clinics located in Pope and Garland Counties. Individual women could receive the same service more than once, depending on their needs. During the reporting period, the program provided 44 pregnancy screenings, 41 mental wellness screenings, 6 ultrasounds, and 26 infectious disease screenings. In addition, 80 pregnancy backpacks were distributed, and 44 peer connections were facilitated. The pregnancy backpacks included educational resources on substance use disorder, peer recovery support, mental health, and maternal care, along with prenatal vitamins to support healthy pregnancies.



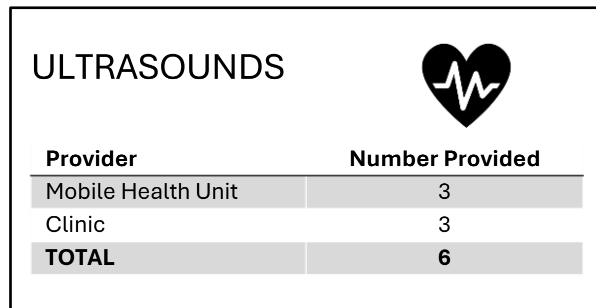
PREGNANCY SCREENINGS

Provider	Number Provided
Mobile Health Unit	16
Clinic	28
TOTAL	**44**



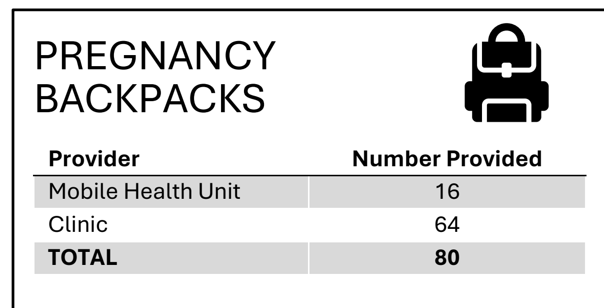
MENTAL WELLNESS SCREENING

Provider	Number Provided
Mobile Health Unit	13
Clinic	28
TOTAL	**41**



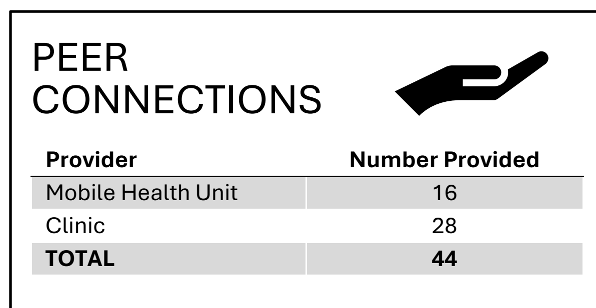
ULTRASOUNDS

Provider	Number Provided
Mobile Health Unit	3
Clinic	3
TOTAL	**6**



PREGNANCY BACKPACKS

Provider	Number Provided
Mobile Health Unit	16
Clinic	64
TOTAL	**80**



PEER CONNECTIONS

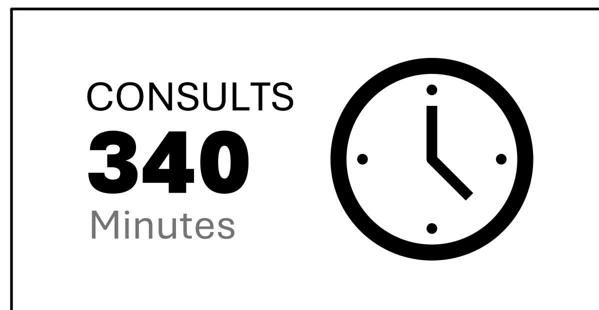
Provider	Number Provided
Mobile Health Unit	16
Clinic	28
TOTAL	**44**

University of Arkansas Medical Services (UAMS)

UAMS delivers weekly video conferences to support community health centers in treating opioid addiction. In addition, participants can access in-person telemedicine consultations with an addiction psychiatrist from the UAMS Psychiatric Institute's Center for Addiction Services and Treatment. The program's primary goal is to expand provider knowledge and strengthen treatment capacity for opioid use disorder, particularly in settings with limited resources.

Physician/MHP and Televideo Consults

Physicians and other providers were able to request consultations with Dr. Mancino, primarily focused on managing patients with substance use disorders, particularly in cases where standard medications were not appropriate due to the patient's condition. UAMS also facilitated televideo consultations with providers and their patients to review and adjust medication treatment plans. These sessions were conducted primarily by phone and virtual platforms, ensuring accessibility for rural providers. During the reporting period, Dr. Mancino conducted 13 Physician/MHP consultations totaling 310 minutes, with 50% originating from rural communities. In addition, one televideo consultation was conducted for 30 minutes.



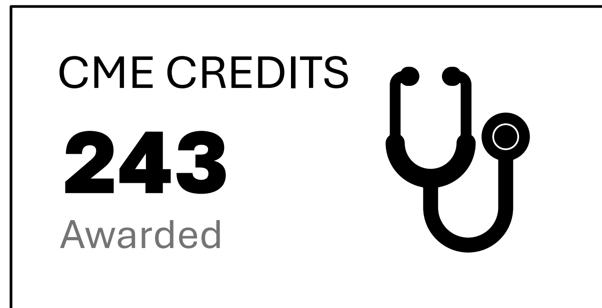
Project ECHO

Project ECHO connected healthcare providers treating patients with Medication for Opioid Use Disorder (MOUD) to subject matter experts through weekly interactive online sessions. Each session offered one (1) Continuing Medical Education (CME) credit for eligible participants and was designed to strengthen provider capacity in managing Opioid Use Disorder (OUD) and co-occurring conditions. Physicians, pharmacists, nurses, and other healthcare professionals were encouraged to present cases and receive expert feedback and guidance.

Table 14: UAMS Number of Project ECHO Attendees by Type and Quarter Attended

Type	1st	2nd	3rd	4th	Total
Doctor of Medicine	8	11	9	5	**28**
Physician Assistant	1	2	2	1	**5**
Pharmacist	3	5	2	1	**10**
Doctor of Philosophy	1	1	1	0	**3**
Advanced Practice Registered Nurse	9	11	26	4	**46**
Registered Nurse	3	2	2	1	**7**
Licensed Practical Nurse	0	2	3	0	**5**
Licensed Master Social Worker	0	0	1	0	**1**
Licensed Clinical Social Worker	5	3	6	3	**14**
Mental Health Professional	11	10	13	3	**34**
Other	29	31	42	13	**102**
Total	**69**	**78**	**107**	**31**	**286**

CME Credits

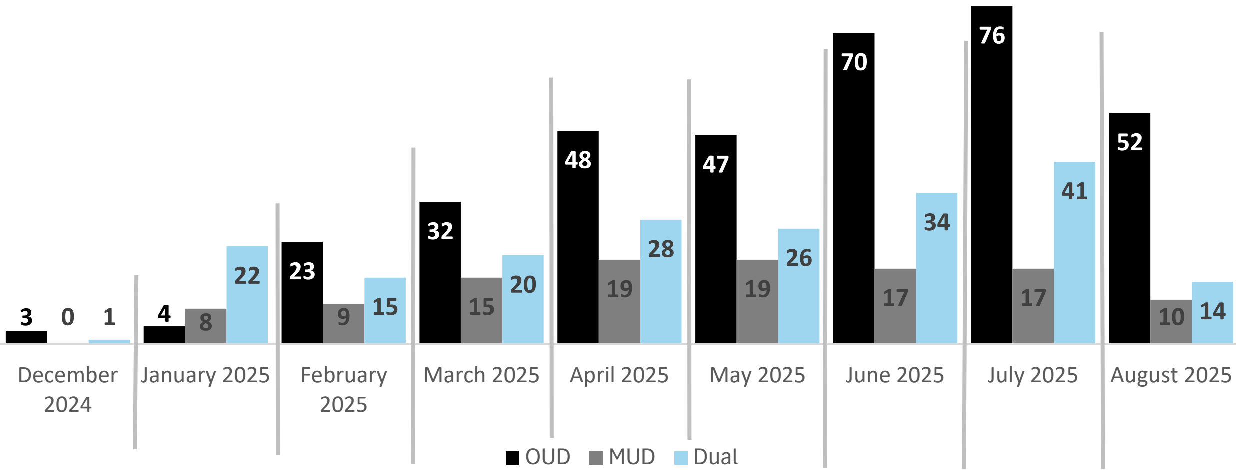


During the reporting period, Project ECHO conducted 35 sessions with a total of 286 attendees, many of whom participated in multiple sessions each quarter. Across all four quarters, 243 CME credits were awarded. Beyond providing continuing education, this initiative fostered a collaborative learning community where providers could exchange insights and best practices in MOUD treatment.

Substance Use Disorder Program

UAMS allocates funds to support treatment for Substance Use Disorders (SUDs), including medication-assisted treatment (MAT) for Opioid Use Disorder (OUD) and both behavioral therapies and medications for Methamphetamine Use Disorder (MUD). Individuals diagnosed with both OUD and MUD are identified as having a dual diagnosis. Between December 2024 and August 2025, 355 individuals were treated for 201 individuals were treated for a dual diagnosis. SUD, 114 individuals were treated for MUD, and 201 individuals were treated for a dual diagnosis.

Fig. 26: UAMS Individuals Receiving SOR-Funded Treatment by Month and SUD Type



Methadone

Table 15: UAMS Number of Methadone Doses Administered by Month

Month	Doses Given
June 2025	29
July 2025	42
August 2025	51
Total	**122**

Beginning in June 2025, UAMS funded methadone, a medication used to treat Opioid Use Disorder, for use by individuals in Washington and Pulaski Counties. A total of 122 doses were administered between June and August of 2025, with some individuals receiving more than one dose over the course of the three-month period.

Concrete Supports

Table 16: UAMS Number of Individuals by Type of Concrete Support

Type of Support	Individuals Receiving Support
Medical/Medication	6
Housing/Rent/Utilities/Car Repair/Gas	18
Driver's License Reinstatement	2
Total	**26**

Concrete Supports are financial assistance given to families in the SUD programs to ensure they have access to the necessities for survival and well-being, alleviating stress for both the patient and their families.

SOR 4 Recovery Initiatives

SAMHSA/CSAT supports peer recovery services, where individuals with lived experience assist others in achieving and sustaining recovery alongside clinical treatment. These services are often integrated with recovery housing, providing safe, structured living environments that reinforce recovery goals. Peer support, combined with supportive housing, is recognized as an evidence-based approach for individuals with substance use disorders and co-occurring mental health challenges.

Arkansas' SOR 4 Recovery Activities include:

- Peer Recovery Training and Certification
- Supporting Certification of Recovery Housing and Infrastructure
- Community Engagement
- Recovery Housing Program Implementation and Monitoring
- Technical Assistance

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

- Arkansas Alliance of Recovery Residence (AARR)
- Arkansas Administrative Office of the Courts (AOC)
- Arkansas Alliance for Recovery Centered Organization (AARCO)
- CHESS Health
- National Association of Alcoholism and Drug Abuse Counselors (NAADAC)

Arkansas Alliance of Recovery Residence (AARR)

The Arkansas Alliance for Recovery Residences (AARR) works to ensure that recovery residences in Arkansas meet high quality standards. Guided by the principles of the National Alliance for Recovery Residences (NARR), AARR obtained NARR accreditation early in the grant year, enabling the organization to certify recovery residences across the state using NARR 3.0 standards. These standards are grounded in the social model of recovery, which recognizes the critical role of social and environmental factors in sustaining recovery. Central to this model are peer support, community engagement, and the development of strong social networks. NARR defines four levels of recovery housing, all of which provide sober living environments rooted in the social model approach. The levels vary, however, in their staffing intensity, decision-making processes, and the scope of services offered.

During the first grant year, one application was processed for Lotus House, a women's sober living residence. Classified as a Level 2 (Type M) home, Lotus House was designated as the pilot site for this grant. Over the course of the year, Lotus House successfully completed Phase 1 and advanced to Phase 2.

Table 17: AARR Level Description

Level (Type)	Description
Level 1 (Type P: Peer-run)	Peer-run, democratically governed-decisions are made by residents
Level 2 (Type M: Monitored)	Monitored and managed environment, appointed resident leader, some recovery support services and life skills development
Level 3 (Type S: Supervised)	Supervised by trained or credentialed staff, higher intensity recovery support services and life skills development
Level 4 (Type C: Clinical)	Clinical addiction treatment, supervised peers, professional staff, recovery support services and life skills development

AARR utilizes State Opioid Response (SOR) funding to assist applicant recovery residences by covering inspection costs, certification fees, and other operational expenses associated with achieving certification. There are four phases of certification.

Phase 1 (Verification Documents): To move on to Phase 2, the applicant must provide the following documents:

- Signed Code of Ethics and Attestations: Applicants will adhere to the NARR Code of Ethics during the certification process
- Articles of Incorporation: Verification of legal business entity in good standing
- Proof of Insurance: Provide proof of commercial general liability insurance (Certificate of Insurance or ACORD Statement)
- Permission from Homeowner: If the residence is a leased property, provide a letter from the owner acknowledging that their property is being used as a recovery residence

Phase 2 (Staff Policies and Procedures): To complete this phase the applicant must submit the following for review:

- Mission Statement & Vision Statement
- Nondiscrimination Policy
- Code of Ethics
- Staff Organizational Chart and Directory
- Social Media Policy
- Staff Resident Work Policy
- Overdose Procedure
- Resident Records Policy
- Good Neighbor Policy
- Contested Drug Screen Policy
- Resident Rights
- Residential Peer Leader Roles & Responsibilities
- Community Resources

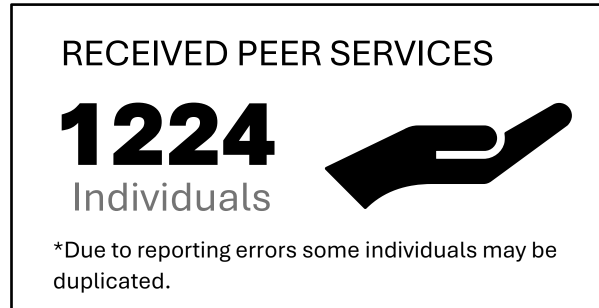
Phase 3 (Resident Orientation Handbook): To complete this phase the applicant must submit their resident orientation packet for review, including the following materials:

- Resident Agreement
- Resident Rights & Rules
- Nondiscrimination Policy
- Refund Policy
- Financial Policies (including all fees and services provided)
- Resident Work Policy
- Good Neighbor Policy
- Social Media Policy
- Grievance Policy
- Data Collection Policy
- Personal Property Policy
- Recurrence of Use Policy
- Medication Policy
- Drug Testing Policy
- Search Policy
- Smoking Policy
- Contagious Disease Policy
- Emergency Contact Information
- Release of Information (suggested)
- Waiver of Liability (suggested)

Phase 4 (On-Site Assessment): After completing Phases 1–3, an on-site inspection of the residence is conducted. At this stage, the residence must be fully operational with active residents. The inspection evaluates the home's maintenance, overall condition, and safety, and includes interviews with current residents. Any incomplete documentation or policies and procedures that do not align with NARR standards must be corrected and resubmitted within 60 days. Organizations that fail to meet NARR standards or that violate the Code of Ethics and Attestations may be denied certification. Reapplication is permitted after a minimum of six months, with longer waiting periods possible depending on the severity of the deficiencies.

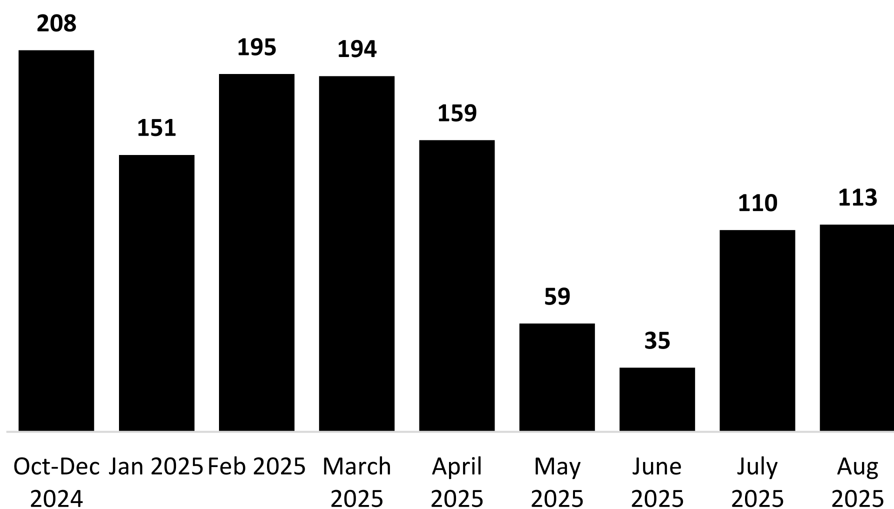
Arkansas Administrative Office of the Courts (AOC)

The Arkansas Administrative Office of the Courts (AR-AOC), part of the judicial branch of state government, provides comprehensive administrative, legal, financial, managerial, programmatic, and information technology services to Arkansas courts on behalf of the Arkansas Supreme Court. Among its initiatives, AR-AOC funds justice-involved Peer Workers in specialty courts across the state. When individuals enter the Drug Court program and a Peer Worker is available, they are offered peer support service, which may continue throughout the duration of their court involvement. There is no limit to the number of services an individual may receive.



Currently, AR-AOC supports 24 full-time Peer Workers through the State Opioid Response (SOR) grant. Recipients of peer services are counted on an unduplicated basis, meaning each individual is recorded once at the time of their initial service, even if they receive multiple services in a single month or across subsequent months (as a result, the number of services provided exceed the number of unique individuals served). During the reporting period, 1,224 individuals received peer support services.

Fig. 27: AOC Received Peer Services by Month



A slight majority of peer services recipients were reported as male (52%; 640), while 44% (537) were reported as female, and 4% (47) were unreported. Regarding race, 49% (599) of recipients were reported as White, while the race of 372 individuals (30%) was not reported. The majority of recipients were between the ages of 25 and 64.

Fig. 28: AOC Gender of Peer Services Recipients

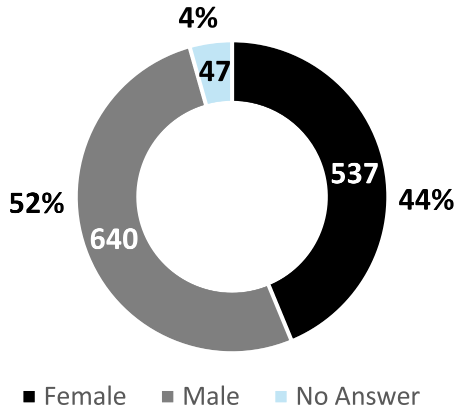


Fig. 29: AOC Race of Peer Services Recipients

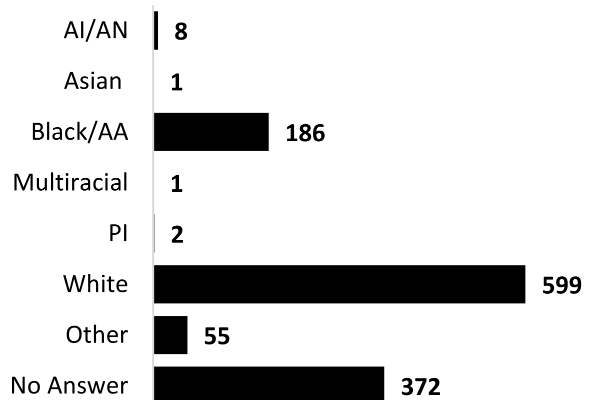


Fig. 30: AOC Age of Peer Services Recipients

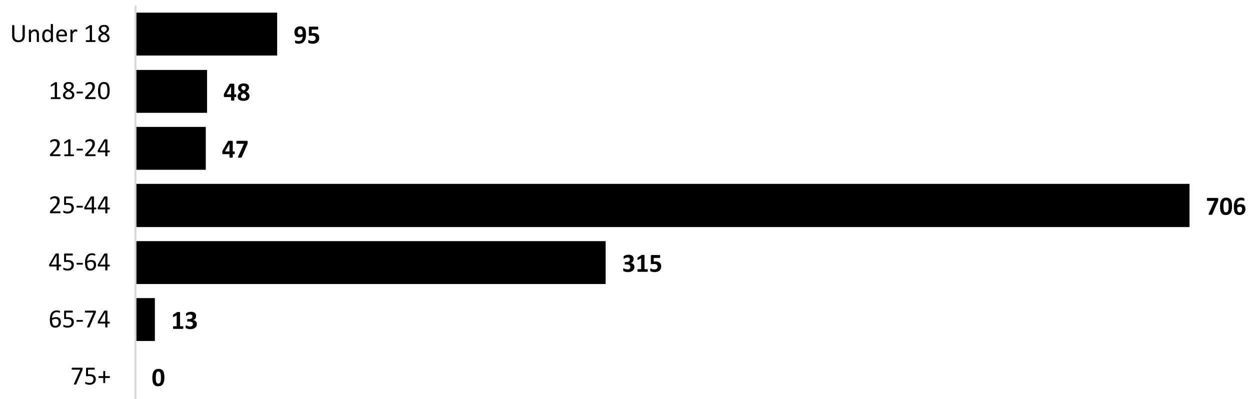
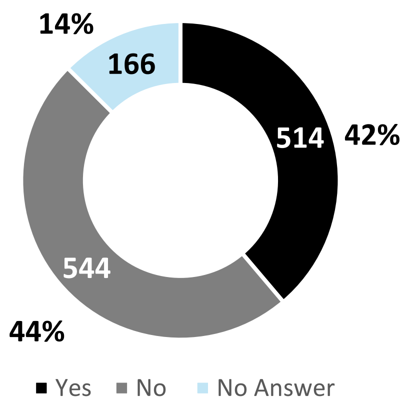


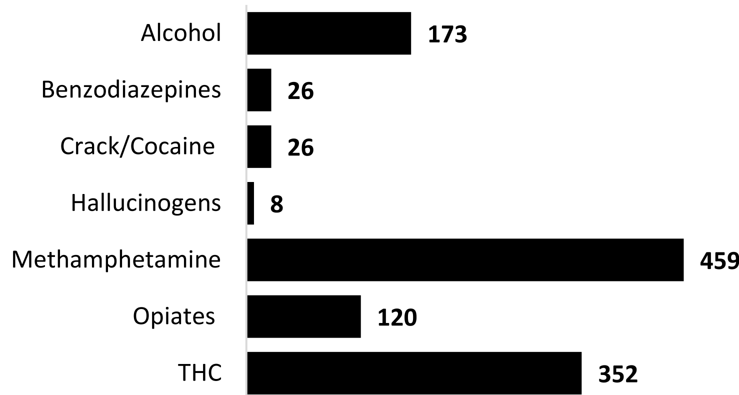
Fig. 31: AOC Habitual Offender Status of Peer Service Recipients



The majority of peer service recipients (44%; 544) were reported as not being habitual offenders, while 42% (514) were identified as habitual offenders, and 14% (166) were unreported.

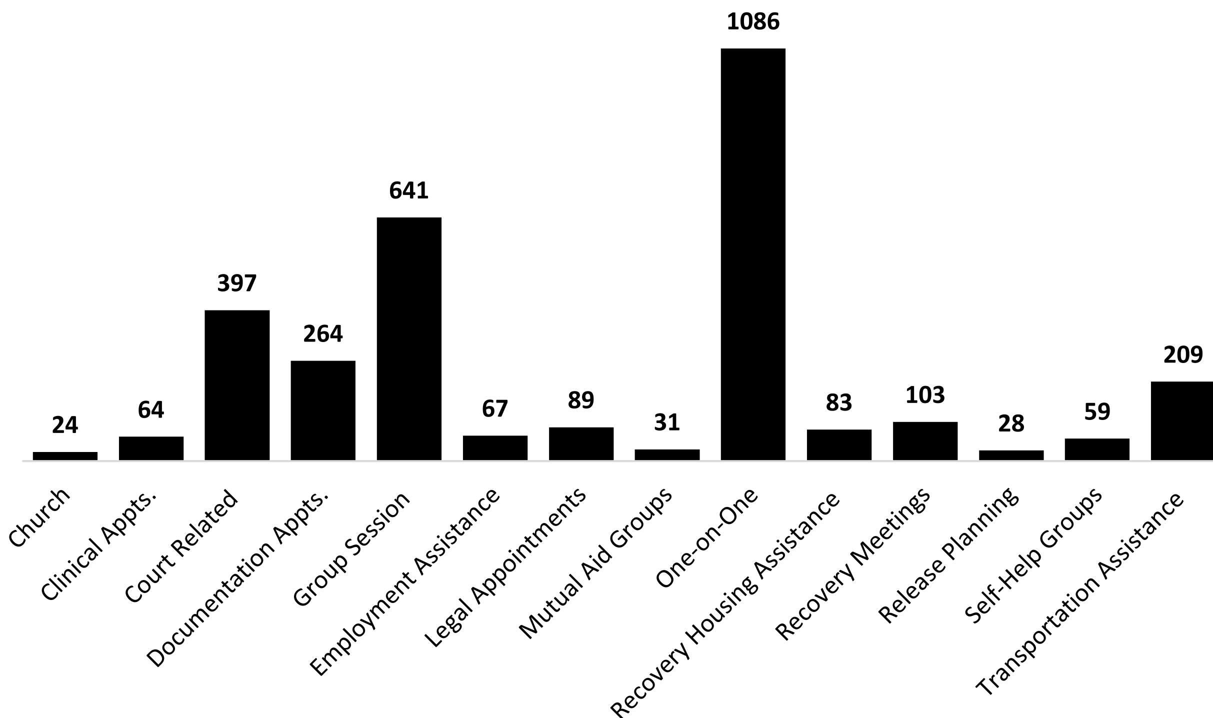
The most frequently reported drugs of choice were methamphetamine (459; 37%) and THC (352; 28%).

Fig. 32: AOC Peer Service Recipient Drug of Choice

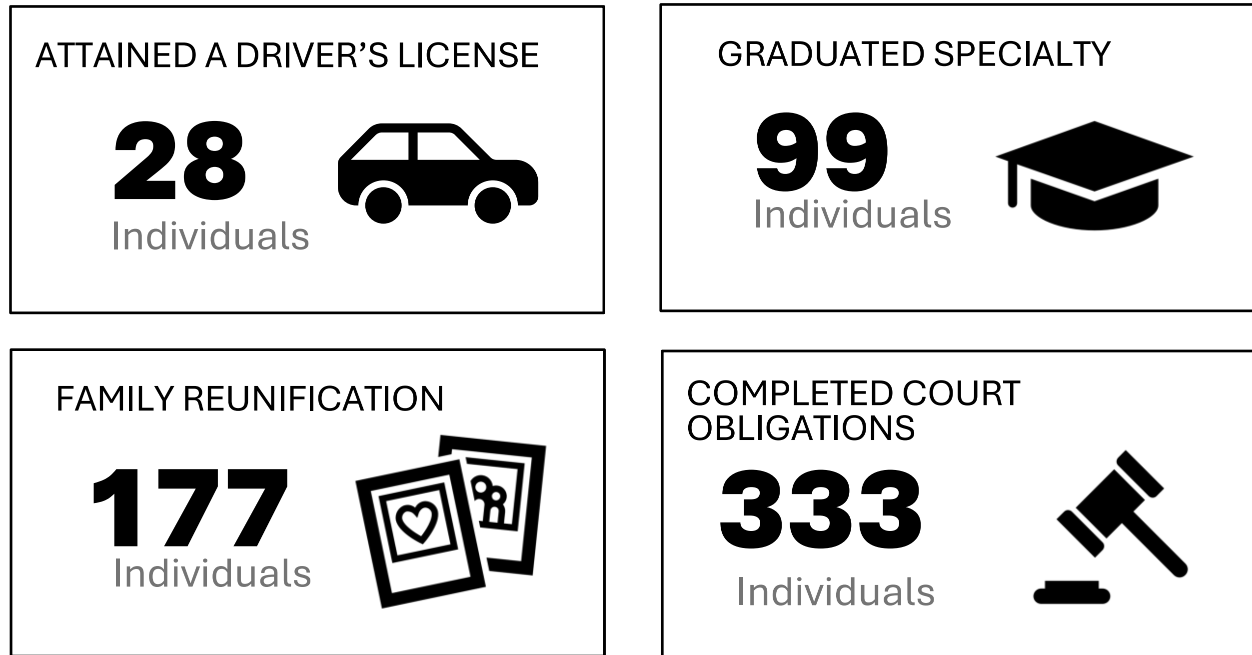


AOC Peer Workers reported peer services 2,403 times. The majority of peer services received were one-on-one sessions (1,086), 641 were group sessions, and 397 were court related.

Fig. 33: AOC Type of Service Received



During the reporting period, 28 individuals attained a driver's license, 177 individuals were reunited with their families, 99 successfully completed their programs and graduated from Specialty Court, and 333 fulfilled various court obligations, such as advancing to a new program phase or completing a court mandated class or training.



Negative Incidents

Peer Workers reported on some negative incidences experienced by the recipients. These included having a recurrence with substance use, receiving a sanction (such as a failed drug test, getting a new charge while enrolled, or missing an appointment with a parole officer), and court termination (occurs when the recipient has received too many sanctions).

Table 18: AOC Incident Totals*

Incident	Total
Received a Sanction	41
Court Termination	2
Had a Recurrence	252

*These values represent the number of times each incident was reported, not the number of individuals who experienced the incident

Sustained Recovery

Individuals in recovery may experience relapses in their sobriety. Sustained recovery is the length of time that an individual has refrained from misusing substances. The length of sustained recovery was reported in the months the recipient achieved the milestone and may be counted multiple times per year as they continue to sustain recovery or have a relapse. For example, if an individual achieved one month sobriety in February and maintained their sobriety through April, they would be counted for one month under February and again for three months in April.

Table 19: AOC Number of Peer Services Recipients Who Sustained Recovery*

	One Month	Three Months	Six Months	Nine Months	One Year	Multiple Years
Oct.-Dec. 2024	18	15	14	14	14	16
January 2025	8	10	5	6	11	6
February 2025	29	21	11	6	8	4
March 2025	0	27	22	17	32	3
April 2025	3	15	18	7	29	3
May 2025	23	7	8	4	6	0
June 2025	5	4	14	14	22	1
July 2025	54	21	18	8	27	2
August 2025	17	16	10	7	25	2

*Individuals fluctuate in their length of recovery and may be counted more than once

Arkansas Alliance of Recovery Centered Organization (AARCO)

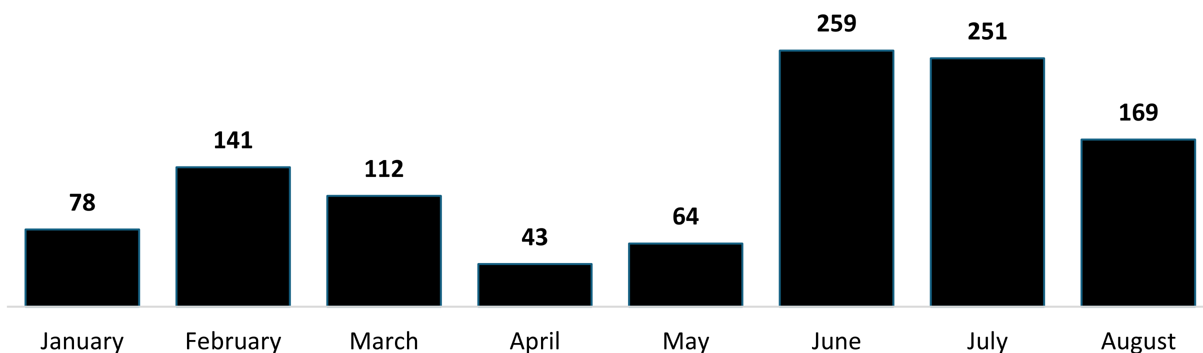
The Arkansas Alliance for Recovery-Centered Organizations (AARCO) is dedicated to uniting and strengthening the state's recovery community. It serves as an umbrella or coordinating body for designated Recovery Community Organizations (RCOs), which currently include entities like the Wolfe Street Foundation, Exodus.Life, NEA Divine Intervention, and PEARL. AARCO promotes peer recovery support services (PRSS) by encouraging agencies and providers to partner with local RCOs, and helps organizations prepare for meeting the national standards for RCO designation.

During this reporting period, AARCO partnered with four RCOs to employ ten Peer Workers to be deployed in healthcare, law enforcement, justice, and other similar settings.

Total Received Peer Services

Recipients of peer services were counted as unduplicated and were only counted the first time they received services. An individual may receive more than one service in a month, or may receive services in subsequent months, so the number of services will surpass the number of individuals. During the reporting period, 1,117 individuals received peer services.

Fig. 34: AARCO Received Peer Services by Month



Among peer service recipients, 49% were male, 42% female, and 8% unreported. Most identified as White (70%), with race unreported for 19%. The majority were ages 25–44 (55%) or 45–64 (35%). Methamphetamine (39%) and THC (20%) were the most frequently reported drugs of choice.

Fig. 35: AARCO Gender of Peer Services Recipients

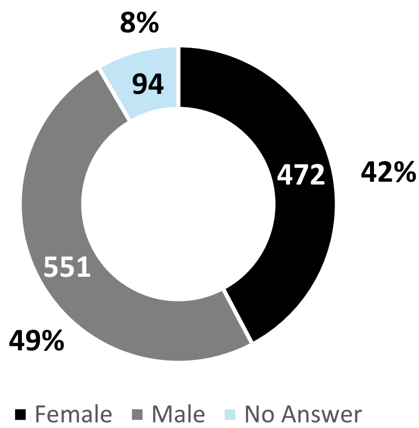


Fig. 36: AARCO Race of Peer Services Recipients

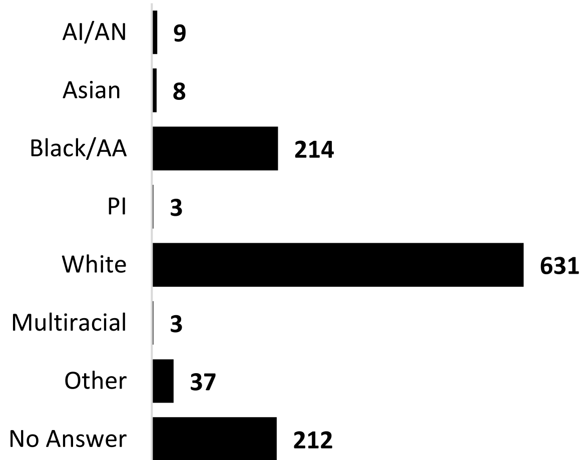


Fig. 37: AARCO Age of Peer Services Recipients

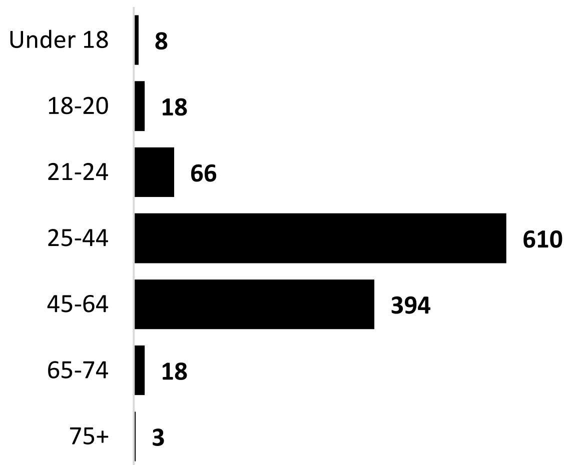
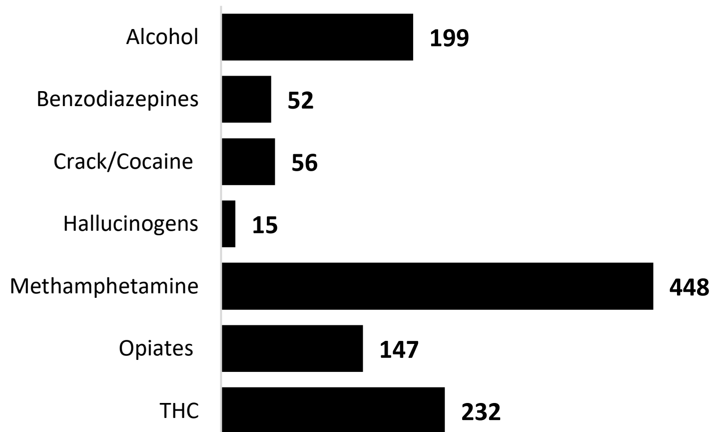


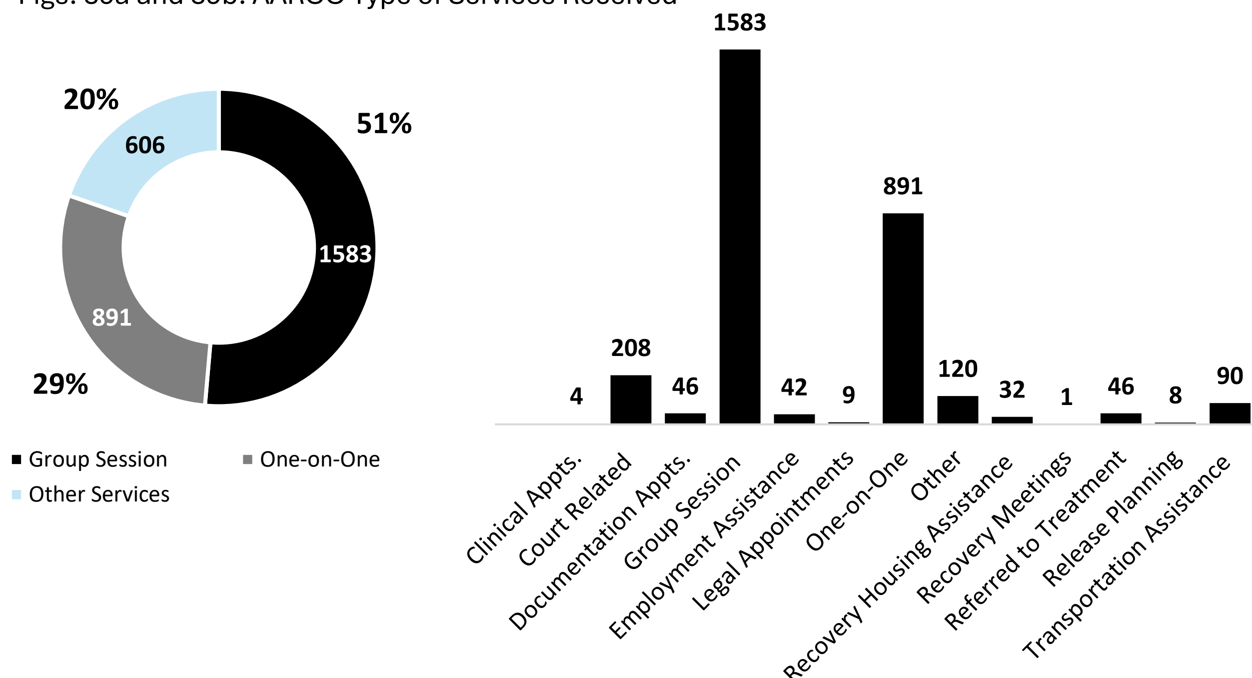
Fig. 38: AARCO Peer Service Recipient Drug of Choice



Type of Peer Services Received

AARCO Peer Workers reported peer services 3,080 times. The majority of peer services received were group sessions (1,583;51%), 891 (29%) were one-on-one sessions, and 606 (18%) were other services: clinical appointments (4), Court related appointments (208), documentation appointments (46), employment assistance (42), legal appointments (9), recovery housing assistance (32), recovery meetings (1), referred to treatment (46), release planning (8), transportation (90), and not specified (120).

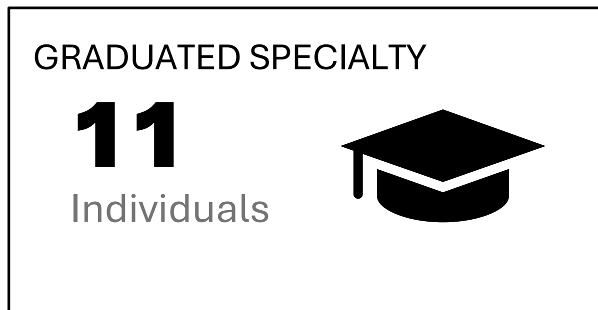
Figs. 39a and 39b: AARCO Type of Services Received

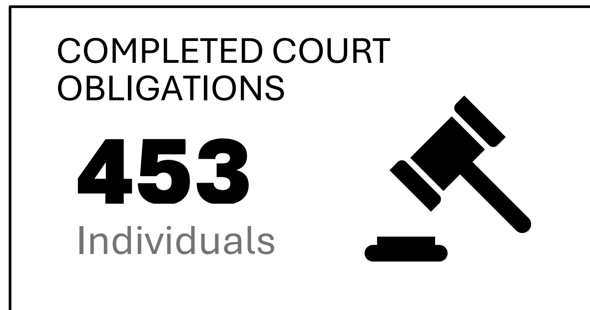


Achievements

During the reporting period, Peer Workers supported 12 individuals in obtaining a driver's license, while 53 individuals were reunited with their families. In addition, 11 participants successfully completed their program and graduated from Specialty Court, and 453 individuals fulfilled various court obligations, including maintaining employment or passing a drug test.

ATTAINED A DRIVER'S LICENSE	FAMILY REUNIFICATION
12 Individuals	**53** Individuals





Sustained Recovery

Individuals in recovery may experience periods of relapse as part of their sobriety journey. Sustained recovery refers to the length of time a person refrains from substance use, measured in months. This measure may be reported multiple times within a year, depending on whether recovery is maintained or relapse occurs. For example, if an individual reached one month of sobriety in February and continued through April, they would be counted as one month in February and three months in April. Sustained recovery was not reported for January and is therefore excluded from this table.

Table 20: AOC Peer Services Recipients Who Sustained Recovery by Month

	One Month	Three Months	Six Months	Nine Months	One Year	Multiple Years
February	5	11	2	6	5	7
March	0	41	16	5	23	14
April	5	11	4	0	1	4
May	10	22	7	3	4	3
June	38	76	55	13	2	70
July	29	83	103	231	107	87
August	29	29	53	36	22	12

*Individuals fluctuate in their length of recovery and may be counted more than once

Negative Incidents

Peer Workers documented several negative incidents experienced by recipients, including recurrences of substance use, sanctions such as failed drug tests, new charges while enrolled, or missed parole officer appointments.

Table 21: AOC Number of Negative Incidents Documented by AOC Peer Services Recipients

Incident	Total
Received a Sanction	5
Had a Recurrence	18

*These values represent the number of times each incident was reported, not the number of individuals who experienced the incident

CHESS Health

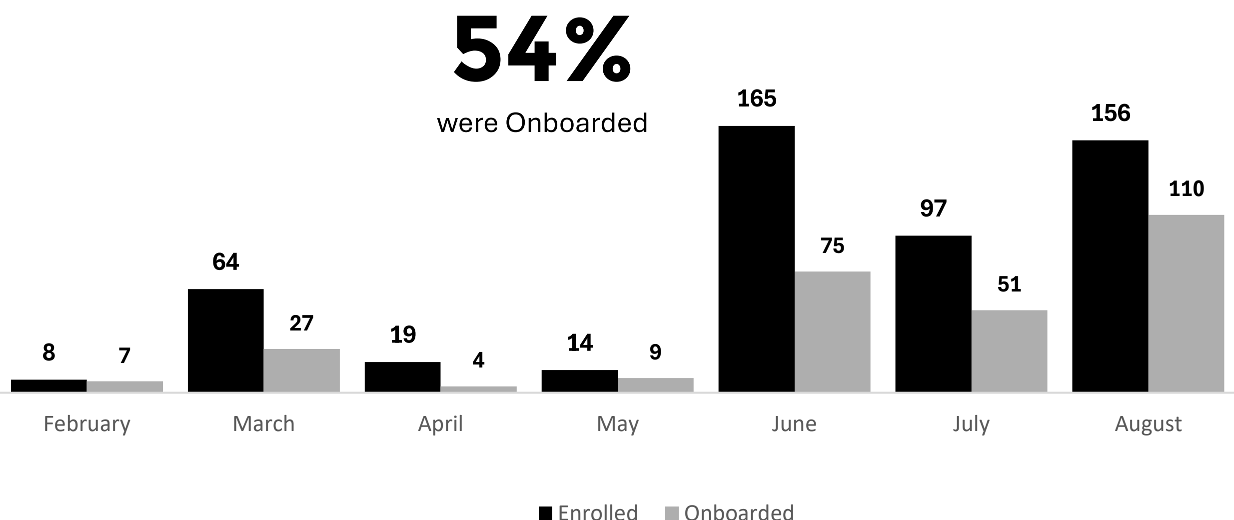
CHESS Health is a digital health company that supports long-term recovery from substance use disorder through evidence-based tools and continuous engagement. Its **eRecovery** platform includes the smart phone Connections App, Companion App, and a contingency management rewards system, offering peer support, virtual meetings, and 24/7 community connections to help individuals stay engaged in their recovery journey.

There are two ways for individuals in Arkansas to enroll in the Connections App.

- The Arkansas OSAMH-Public entity offers self-enrollment for individuals in recovery, either using a scannable QR code on a flyer or clicking on the Public Quick Enrollment Link (QEL).
- Staff at participating Recovery Community Organizations (RCOs) will scan their unique QR code or click their entity's QEL to enroll a client.

Once enrolled, the individual will receive a text message with a link to download the Connections App and a temporary password to create a profile and complete the onboarding process. During the reporting period, 283 individuals were onboarded out of 523 enrolled.

Fig. 40: CHESS Connections App Enrolled vs Onboarded by Month



Demographics of Onboarding Individuals

Among onboarded individuals, the majority self-reported as female (187; 66%), while 95 (34%) reported as male, and one declined to self-report or identified as a different gender. Most participants identified as White (228; 81%), with 29 (10%) identifying as Black or African American. Age distribution showed the largest group between 31–50 years old (186; 66%), followed by 57 individuals (20%) between 51–70 years old.

Fig. 41: CHESS Gender of Individuals

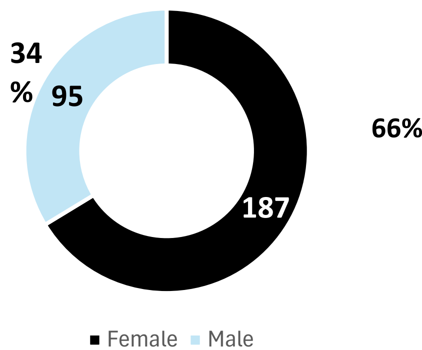


Fig. 42: CHESS Race of Individuals Using Connections App

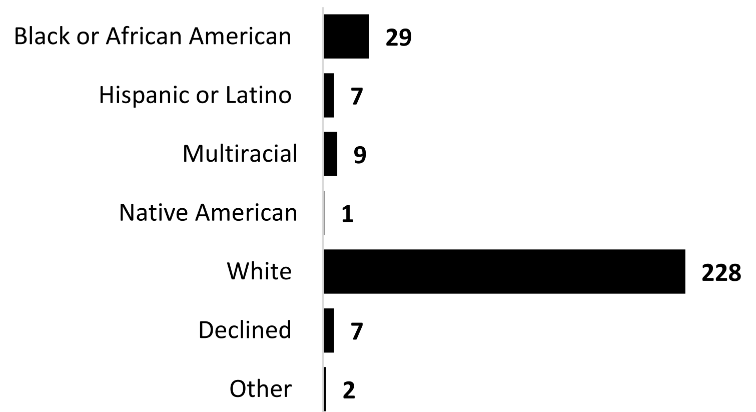
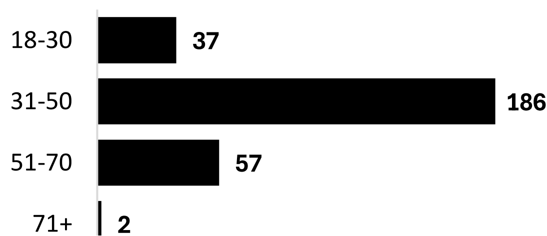
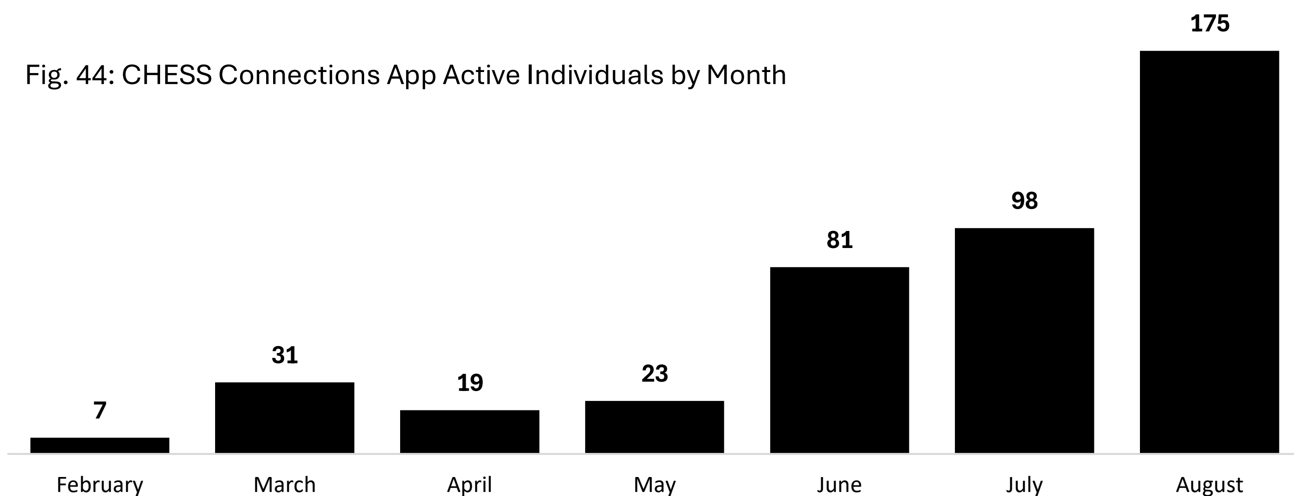


Fig. 43: CHESS Age of Individuals Using Connections App



Active Individuals: An active individual is one who has fully onboarded and is engaging with the features and tools offered by the app, such as attending in-app group meetings or answering the daily confidence survey.

Fig. 44: CHESS Connections App Active Individuals by Month



Community engagement refers to active participation within the Connections App, such as posting a reply to a discussion topic, while a community view measures how many times users opened and viewed a community discussion.

Daily Confidence Survey

Each day, users are asked to rate their confidence in their recovery. Out of 777 responses, 770 (99%) indicated "confident," while 7 (1%) indicated "not confident." When a user selects "not confident," a follow-up question appears offering the option to connect with a Peer for additional support.

Escalations

An escalation occurs when the Peer Team is alerted that an individual may require additional support. This can happen if the individual posts a concerning message, uses the "Help Button" to request contact, or selects "not confident" on the Daily Confidence Survey. In such cases, the Peer Team follows up the next day via direct message to check on the individual's well-being.

Table 22: CHESS Health Number of Escalations by Type

Escalation	Number
Concerning Post	0
Not Confident: Did Not Request Contact	10
Not Confident: Requested Contact	1
Reported Return to Use: Requested Contact	2
Help Button	0
Total	**13**

1:1 Contact and 1:1 Direct Messages

1:1 Contact refers to situations in which a user specifically requests to be contacted by a CHESS Peer. In contrast, 1:1 Direct Messages (DMs) represent the total number of messages exchanged with Peer Workers, whether or not they are related to an escalation. Users can use DMs to discuss their recovery journeys, averaging 2.6 messages per user.

Table 23: CHESS Health Number of Contacts and Direct Messaging

1:1 Contact and 1:1 DMs				
Month	**1:1 Contacts**	**1:1 Direct Messages**	**1:1 Individuals Utilizing DMs**	**Average DMs per User**
February	0	2	1	2.0
March	1	8	6	1.3
April	0	0	0	0
May	0	3	3	1.0
June	2	69	21	3.3
July	1	44	25	1.8
August	2	41	27	1.5
Total	**6**	**167**	**83**	**2.0**

Utilization of the Companion App

The Companion App is designed for family and friends of individuals using the Connections App. To enroll, they scan a QR code from flyers or posters provided by RCOs or the Arkansas DHS. After enrollment, they receive a text message with a download link and temporary password. Upon first login, they create a profile to complete onboarding and access the app, which allows them to engage in the community and view discussion topics.

National Association for Alcoholism and Drug Abuse Counselors (NAADAC)

NAADAC — The Association for Addiction Professionals — is a U.S.-based organization representing over 100,000 addiction counselors, educators, and other addiction-treatment professionals in the U.S., Canada, and internationally. Its mission is to lead, unify, and empower these addiction-focused professionals by providing education, training, certification, standards of practice, advocacy, and research — all toward ensuring high-quality, science-based prevention, treatment, intervention, and recovery support services for individuals, families, and communities affected by addiction. In Arkansas, NAADAC supported Peer Workers by promoting consistent standards and practices statewide, providing access to NAADAC memberships, offering training and test facilitation, and supporting national certification.

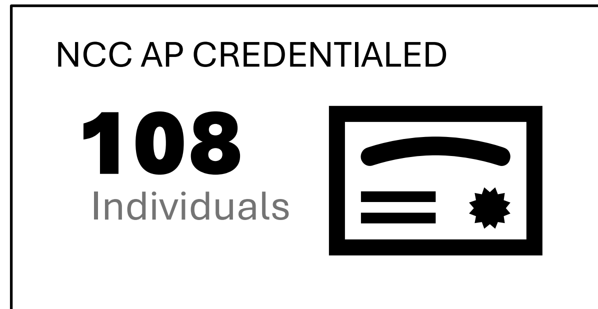
Active Peers

The NAADAC manages all the active Peer Workers in Arkansas. This includes approving and facilitating testing and training, approving continuing education, and issuing certifications and renewals. Peer types include Peer types: PIT-Peer in Training; PR: Core Peer Recovery Specialist; AIT-Advanced in Training; APR- Advanced Peer Recovery Specialist; SIT- Supervisor in Training; and PRPS-Peer Recovery Supervisor.

Table 24: NAADAC Active Peer Workers by Month and Type

Month	PIT	PR	AIT	APR	SIT	PRPS	Total
October-December 2024	299	77	43	16	25	22	**482**
January 2025	296	80	43	16	25	22	**482**
February 2025	309	79	52	18	21	24	**503**
March 2025	307	85	47	21	21	24	**505**
April 2025	289	102	45	20	24	24	**504**
May 2025	295	98	20	19	25	24	**511**
June 2025	300	102	49	19	25	24	**519**
July 2025	307	108	45	21	24	24	**529**
August 2025	297	114	45	17	25	24	**522**

NCC AP Credentialed Peer Workers



NAADAC received 111 applications for National Certification Commission for Addiction Professionals (NCC AP) credentialing as National Certified Peer Recovery Support Specialists (NCPRSS), of which 108 were approved. It is important to note that NCC AP certification and NAADAC membership are separate—membership is not required to obtain a credential, and certification does not automatically include membership. In the first year of SOR 4, the application fee for NCC AP certification was covered by the grant. To remain certified in Arkansas, Peer Workers must obtain NCC AP credentialing before their current certification expires. Arkansas recognizes three levels of state credentialing—Core Peer Recovery Specialist (PR), Advanced Peer Recovery Specialist (APR), and Peer Recovery Peer Supervisor (PRPS). The Core level now incorporates the NCPRSS, ensuring that all new peers in Arkansas will hold national certification moving forward.

STATE CREDENTIALED

Peer Type	Credentialed
PR	77
APR	18
PRPS	18
TOTAL	**113**

Peer Trained

The NAADAC Certification manager facilitated and approved trainings for Arkansas Peer Workers. These trainings prepared Peer Workers for later testing. A total of 171 Peer Workers were trained in Year-One of SOR 4.

Table 25: NAADAC Peer Workers Trained by Month and Type

Month	PIT	AIT	SIT	Total
October-December 2024	23	0	0	**23**
January 2025	24	0	0	**24**
February 2025	24	0	0	**24**
March 2025	24	0	0	**24**
April 2025	0	0	5	**5**
May 2025	25	8	0	**33**
June 2025	16	0	0	**16**
July 2025	18	0	0	**18**
August 2025	0	0	4	**4**
Total	**154**	**8**	**9**	**171**

Peer Tested

The NAADAC Certification Manager coordinated testing for Peer Workers, and upon successful completion, NAADAC granted approval and issued certification.

Table 26: NAADAC Peer Workers Tested and Passed by Month and Type

	Tested PR	Passed PR	Tested APR	Passed APR	Tested PRPS	Passed PRPS	Total Tested	Total Passed	% Passed
October-December 2024	5	4	0	0	0	0	5	4	80%
January 2025	5	5	0	0	1	1	6	6	100%
February 2025	2	1	1	0	1	1	4	2	50%
March 2025	15	12	4	3	1	1	20	16	80%
April 2025	22	18	2	2	0	0	24	20	83%
May 2025	0	0	2	2	0	0	2	2	100%
June 2025	1	1	0	0	0	0	1	1	100%
July 2025	2	2	1	1	1	1	4	4	100%
August 2025	7	3	1	0	0	0	8	3	38%
Total	**50**	**41**	**9**	**7**	**3**	**3**	**62**	**51**	**82%**

SOR 4 Qualitative Studies

WYSAC evaluators conducted interviews and focus groups to gather more detail and context in areas of the SOR 4 project of particular interest. Table 27 describes the topics of interest, participants, and method of qualitative data collection for Year-One.

Table 27: Topics of Interest, Participants, and Method of Data Collection Methods

Topic of Interest	Participants	Method of data collection
Year 1: Institutional		
Recovery Residences	Staff	Interviews
Juvenile Justice	Correctional staff	Interviews/Focus Groups
Drug Court	Staff	Interviews

Qualitative Studies

- Opioid Misuse and Recovery Residences: A Qualitative Exploration of Arkansas Recovery Residences
- Results from Interviews with Leadership and Service Providers on Juvenile Re-Entry of the Arkansas Department of Youth Services (DYS) Juvenile Treatment Facilities
- Results from Interviews with Arkansas Drug Court Staff in SOR 4-Funded Programs

Continuous Quality Improvement (CQI)

WYSAC evaluated three training modules using Continuous Quality Improvement (CQI) protocols in Year-One to assess content, delivery, and impact. Evaluations were conducted on May 23 (pilot rubric development), August 19, and September 3, using rubrics with 8–12 questions rated from 1 (not demonstrated) to 5 (expert). All sessions provided valuable and relevant information aligned with SOR 4 objectives. Detailed summaries of these sessions, including strengths, weaknesses, recommendations, and median rubric scores, are included in this report starting on page 127.

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

November 19, 2025

Opioid Misuse and Recovery Residences

A Qualitative Exploration of Arkansas Recovery Residences

Matthew L. Wagner, PhD
Associate Research Scientist

Andria Blackwood, PhD
Senior Research Scientist

Miranda Greathouse, BA
Research Assistant

Wyoming Survey & Analysis Center
University of Wyoming
1000 E. University Avenue, Department 3925
Laramie, Wyoming 82071
307.766.2189 | wysac@uwyo.edu
www.uwyo.edu/wysac

Executive Summary

As part of the Arkansas State Opioid Response (SOR) IV grant, the Wyoming Survey & Analysis Center (WYSAC) implemented a qualitative study of recovery residences in Arkansas. The goal of this study is to better understand staff experiences working in a recovery residence, with a specific interest in the successes they have had and challenges they have overcome. Our qualitative work will address the following research questions:

- What are the interactions between residents and staff like?
- How do staff determine resident schedules?
- What challenges do staff face on a daily basis?
- What successes have the staff experienced within their facilities?
- What are the relationships between recovery residence staff and outside community organizations?
- What resources can be identified to better support recovery residences?

WYSAC evaluators relied on the Office of Substance Abuse and Mental Health (OSAMH) staff's existing relationships with stakeholders for recruitment of respondents. Respondents were selected based on one criterion: they must have direct experience with recovery residences in Arkansas. The respondents, two men and one woman, each held different positions and together averaged three years' experience related to recovery residences, with significant backgrounds in opioid misuse and recovery. To avoid re-identification, the respondents' ages, races, and ethnicities have been suppressed, and questions pertaining to their previous titles and experience have been omitted from the analysis and report. Two different facilities were discussed through data collection. Differences in facilities are summarized in Table 1 below, including facility age, size, and co-ed status.

Table 1: Facility Description*

	Year the Facility Opened	Beds for Men	Beds for Women
Facility A	1983	32	14
Facility B	2023	12	0

***The older facility is larger and is co-ed**

Data was derived from participant interviews with all three respondents. All sessions were audio-recorded and transcribed. A thematic approach to data analysis was used to identify themes and experiences common across all respondents. Informed consent was obtained from all participants, and no identifiable information will be included in any reports or presentations resulting from this project.

While this evaluation provides valuable insights into the operations and outcomes of these recovery programs, the findings are based on a limited sample of participants and programs. A larger, more comprehensive study would be necessary to confirm these results, clarify patterns in resident experiences, and explore how program characteristics, community engagement, and support services influence outcomes across a broader population. Expanding the study could also help identify best practices and inform strategies for addressing barriers such as stigma, transportation, and access to insurance.

Findings

Recovery residences in Arkansas experience multiple, nuanced challenges. Funding remains limited, with little direct financial support from local or state government, and Medicaid reimbursement for peer services is still underdeveloped. While faith-based housing may be an option for individuals who lack insurance, potential residents may not be comfortable with faith-based recovery due to their own beliefs or past religious experiences. Additionally, faith-based recovery centers may reject individuals who are a part of the LGBTQIA community. Community-based stigma compounds these issues: neighborhoods sometimes resist sober living houses, and even within the recovery field there is debate over the use of medication-assisted treatment. Most residents have a history with the criminal justice system, and directors and staff maintain strong partnerships with local courts, probation officers, and law enforcement.

Despite these barriers, recovery residences report notable successes. Many residents secure employment, maintain long-term sobriety, and move on to stable, independent housing, reuniting with family or returning as peer staff. Both facilities and associated recovery programs have grown in size and visibility, hosting community events and training thousands in overdose response. Yet, significant hurdles remain after discharge. Transportation and communication gaps—such as lack of cell phones, vehicles, or adequate public transit outside major cities—make it difficult for former residents to attend court dates, keep jobs, or continue outpatient treatment, underscoring the need for more coordinated and sustainable support systems. A general description of both facilities involved with interviews can be found in Table 1, including ages of the facility and the number of beds available.

What are the differences between men's and women's facilities?

Recovery housing for women appears to be far more limited than for men, with only a few programs available and some requiring prior residential treatment. Misconceptions about parenting needs add to the challenge, even though many women in recovery do not have custody of their children. Pregnant women and mothers often avoid services out of fear of losing custody or facing legal consequences, and the few houses that accept women with children are typically full, leaving many without safe options after treatment.

"There is a disparity. And that's one of the reasons why I'm focusing my next house on women. Here in [city], we've got another organization…She just opened a house for women. There's one other entity in [city] that has women transition living, but they they've created a barrier, because you have to go through the residential treatment program first to be eligible for their housing. So, it cuts out a lot of people."

"I think one of the challenges is that there's a big disparity in demand. It's kind of challenging to drive more resources to programs serving women. And then, obviously, I think there are a lot of complexities in the demand for women's housing. I think a lot of times, we operators make assumptions like, for instance, is part of the complexity that women are more likely to have parenting obligations and concerns? Well, that's an assumption that we make, you know, and actually, many, if not most, of the women who do have children that come into our program don't have custody and parental rights have been terminated anyway. So, there's not actually like they are a parent, a parent, but they don't have any parenting obligations or concerns."

"I think that we're seeing more women, pregnant women and children seek services. You know? I think the biggest fear for women, like there are some houses, not recovery residents, but transitional houses, or places they could go after treatment. But for the pregnant women, there's such a fear of losing their children, and also, you know, possibly getting charges, you know, for the unborn baby, and so they're not seeking out assistance. Women can go to a treatment center for 120 days. But the problem is, is when they go to get out of treatment, where are they going to go that's safe for them and their children? And so, we have one recovery house- it's in [city]. And so, she takes women and children under seven, and but it's full, you know, so that it's not really a resource when it's constantly full."

How many residents come and go per month? Per year?

There is variation in turnover and outcomes across recovery residences. One program reported a steady resident base with only two to three people leaving each month, while another saw eight to twelve departures monthly. Reasons for leaving ranged from positive transitions to independent housing to challenges such as return to use or financial difficulties, with staff often helping residents connect to alternative housing when needed.

"I've got a pretty low turnover rate, and we've got a pretty steady group of guys, I would say probably two to three per month, turnover, okay, sometimes not even that much. Per year, I would say…maybe 60 per year"

"We have people who leave on less than good circumstances. In a given month, we'll have probably about anywhere from 8 to 12 turnover for one reason or another. Typically, "return to use" is the top reason people leave…our policy is not to expel people for a reoccurrence of use, but sometimes people go all the way back out, and then we just lose them, and they're gone. In other cases, when it's not a return to use, sometimes we just have folks who cannot afford [to stay] or are not working, and that's kind of hard to say, because we have a lot of programs that support someone's first four weeks. We do a great job helping people get employed, but sometimes they just don't pay on time. In both of those situations: a return to use or a failure to pay their program fees, we always navigate them to a different housing provider. And honestly, anytime it's financial, most of the time, it's not that person saying, 'Well, I can't afford it', or just skipping out. It's us sitting down and saying, 'Hey, you have this debt that's hanging over you, and we could allow you to pay it out or work it off, but that would be doing you a great disservice, when you can start with a clean slate over here and not have to worry about this $900 over your head. So, yeah, I'd say, when it's like a negative discharge, it's either a return to use or that failure to pay program fees. When it's positive, a pretty good number of our folks complete their independent housing goal while they're with us. Some of them do it really quickly."

How long do residents typically stay?

Length of stay in recovery housing varies widely, with no set limits as long as residents meet program expectations. Staff report that some individuals remain for over a year, while others transition out in just a few months. On average, most programs report typical stays ranging from five to ten months, though the timeline depends on each resident's progress toward stability and independent housing.

"Typical stay is generally so I don't put a cap on how long they can stay there. I'll leave it open ended. They can stay as long as they want, as long as they're following the program directions and they're making their meetings, and they're staying sober, and they're paying their weekly fees and are working, or if they're not working, if they're on disability, then they're out volunteering, you know, throughout the week. Set number of hours so, but typically I would say, I mean, I've got guys that have been there for almost two years since we've been opened. I've got some guys that have been there for, you know, a year and a half a year. But I would say the average stay would probably be about 8 months, maybe, okay, yeah, 8 to 10 months."

"You know, I would say that our people stay with us on average for between five and seven months. Some people achieve their independent housing goals in 90 days. Some people don't achieve their independent housing goals for 18 months. But I think our average occupancy is between five and seven months."

What are the residents in your facility like?

Residents are generally grateful, humble, and proud to be in recovery housing, treating the homes with respect and care. They value living in a well-maintained environment and take pride in being part of it. Many also highlight the sense of brotherhood, generosity, and daily peer support as an important part of their recovery experience.

"Yeah, so the guys that come to my facility, the majority of them, are very grateful and humble to be there. I've got a really nice house. I took great care in making a nice facility, a nice house, you know. And so, they all, they love it there. They treat it with respect. But you know, a lot of people on the front end that didn't work in this field that I just knew, they're like, why are you spending so much money on this place? They're just going to tear it up. And I'm like, No, they won't. They're going to be proud of it, and they're going to be in a nice place, and they're going to take care of it, and that's exactly what's happened. So far as what they're like, they're very grateful, they're humble, they're very generous and kind. They enjoy the Brotherhood, they enjoy having peers surrounding them every day."

"Many of our participants come from reentry programs in county jails. We have a great partnership with Pulaski County Detention Center, so they have a recovery reentry program called CSI Academy, and we have an agreement with them, where first of all, we have through (SOR 4) we have a full time peer specialist inside that's working with folks doing, mostly Doing groups, because there's like 110 men in that program, and so it's really difficult to do one-on-one with that many people. And so [peer specialist] works with them inside and then he connects them to our peer team and housing team when they're preparing for release, and then we will

interview them and take them in. And when that happens, the county pays for the first four weeks of their participation or housing program that gives us time to help them find employment, become self-supporting. So, a number of them come there. Others will come from a lot of people, frankly, come to us from other housing providers who have really high-quality housing units."

Can you tell me what resident intake is like? What questions do staff ask?

Staff interviews indicate that intake is similar between organizations. Prospective residents complete an application that gathers information on their substance use history, recovery pathway, medical history, and any legal or social service involvement. The process helps staff understand individual needs and determine the most appropriate level of care. While no one is disqualified, the program may connect applicants to other resources if a higher level of support or accessibility is needed, ensuring everyone can access suitable recovery housing.

"On my website, there's an application to apply for services, and so they direct everybody to go on there, even if they're in treatment somewhere. I'll have their case manager to work with them to fill it out. And so that's kind of our screening process that they'll fill that out…substance abuse history, demographic information, if they have any legal matters right now that they're involved with, any DHS matters that they're involved with the. Often just a background, just to let us get to know them and see where they're at in their recovery, in their life. We'll take a look at it, if we have openings, then we'll contact them and do a phone interview with them, talk to them, explain the program to them."

"So, what we do is we have them fill out an application, obviously, and we asked them primarily about the structure of their recovery pathway. So, you know, do you have a recovery pathway? What does it look like? And what we hope is that they can articulate what that looks like. But also, a service we provide is connecting people to viable recovery pathways, whatever that looks like for them. So, we ask them about their recovery. We, in our application packet, we ask, you know, a lot of questions about medical history to make sure that we're the right level of care for that person. We ask about treatment history. We ask about any overdose history. We ask about primary challenging substances and pretty standard stuff, gathering that information, none of that's disqualifying. If you have experienced multiple overdoses and were unconscious for a period of time, you may have a traumatic brain injury and not know it. And we've had a lot of people, not a lot. We've had a couple of people come in with seizure disorders that did not

disclose those seizure disorders until they fell down the stairs...we do a lot of digging on that part, just to make sure that if someone needs a higher level of care or like in the case of a hypoxic TBI or seizure disorder, many of our units are up flights of stairs. So, do we have a closer to ground floor apartment for that person? Would it be better for them to be in our duplex? For example, and we're working on better accessibility…But we never tell someone no. We tell them, let us introduce you to our friends at x, y and z, this other housing program."

What substances are largely used by residents?

Interviews revealed the substances most often misused by residents are: methamphetamine, opioids, and alcohol.

"Typically, there's a lot of opiates. I would say that's the majority of it would be opiate use. And then I would say secondary would be meth and alcohol."

"Meth…we'll see people. I mean, a lot of people will disclose opioids too, but it's you know, anyone who tells you anything different in Arkansas is lying to you."

What are residents' programming schedules like?

Staff develop recovery programs emphasizing a structured and flexible approach to recovery and require residents to attend multiple meetings each week—both on-site and in the community. Peer support, recovery education groups, and various support meetings provide routine, while residents are encouraged to participate in any activities that contribute to their recovery, including 12-step, meditation, or faith-based groups.

"I require them to attend three meetings per week…I also require them to attend three meetings outside per week. And so, you know, I take a holistic approach to it. I don't believe there's one pathway to recovery, and so I count AA in a church, meetings with their therapist, pretty much anything that is, you know, directly involved with their recovery, that directly contributes to recovery. I'll count that as a meeting."

"We have a lot of structure in our program. People meet with a peer specialist once a week. They go to two recovery education groups a week, and they catch three support meetings a week. So that gives people a lot of structure. You know, we have a monthly all-house meeting. We do regular drug screens and inspections. We hold our recovery education groups at one o'clock and six o'clock every day, so people have different options on when they can catch those and then your three support meetings. I don't care what pathway that is. We have tons of 12-

step meetings here, but we also have recovery meditation groups that meet here. There are faith-based groups we're connected to that meet downtown. All of our units, by the way, are like two blocks away from here. So, you can walk down here for those meetings. You can walk to work right here downtown."

How often are residents employed?

Staff work with residents to develop a full-time plan, which is required to maintain residency. This plan typically involves employment, education, or volunteering. Those on fixed incomes, such as disability, are expected to fill their time through structured volunteering. Most residents find work locally, making it easy to meet program requirements and maintain a consistent, productive routine.

"It is a requirement. So, I give them two weeks to get a job. Once they get to the house, they've got two weeks to find employment."

"Yeah, we have a requirement for, well, I'll say that you have to have a full-time plan. We have some folks that are on disability, SSI, you know, or on some other kind of structured and planned income. But if that's the case, then you need to fill your time elsewise, you know, so you have to either be working, studying or volunteering full-time. And I can think of maybe, you know, a handful of people who have been on fixed incomes and could not work. Some of them volunteered with us full time. Some of them would volunteer elsewhere and bring us some documentation. You know, as long as you're doing that we're good….A lot of our folks work at [employer]. Some of them work at [employer] right there. Some of them work down at [employer]. So just about all of them work right here, you know. And everything is walkable for them. So that's super helpful."

How often have residents had encounters with the criminal justice system?

The majority of residents have had some involvement with the justice system, with most having at least a misdemeanor and many having felony convictions. Even those without extensive incarceration histories typically have prior legal encounters.

"I would say the majority of them at some point. They may not currently have any open cases, but I would say 90% of them had an encounter with justice system at some point."

"Almost everyone, yeah, almost everyone, even if, if they don't have, like, an extensive incarceration history, I can think of very few who have not had a felony conviction, I would be hard pressed to think of anyone who didn't at least have some misdemeanors."

How often do residents present with mental health problems?

Many residents have co-occurring mental health disorders. Staff work with external providers for therapy and treatment as needed. Residents must be able to manage their own medications, since the program does not provide dosing or higher-level medical care.

"Yes, they do. And so, I've worked with the [facility] here in [city], and also some private practices to refer out to get them therapy and treatment whenever there's a dual diagnosed, co-occurring disorder, you know."

"I think that a great majority of our folks have co-occurring mental health disorders. I think it is very rarely discussed. Sometimes it's on purpose, not disclosed. Probably 30% of our people have prescriptions for mental health medications. Many housing programs in Arkansas will not allow you to be there with mental health medications. Yeah, and so it's, it's not just like Suboxone or methadone, or it's like Lexapro, or they will not allow you to have any medications. You just don't do that now, depending on how many, what kind of medications you have, we may not be the right level of care, because we're not going to dose for you, you know, so you have to, you have to be able to independently administer your own medications, because we don't have that higher level of care."

"Some houses will take away all their psych meds, and that's like asking for trouble….The resident is trying to recover. Stay in recovery, they're taking their support away."

Do you, as staff, have relationships with local religious groups and faith-based recovery houses?

The programs support faith-based recovery options but does not require participation. Staff work with a variety of groups, including non-Christian programs, to provide equitable access, while recognizing that some individuals, such as transgender residents, may face exclusion or discomfort in certain faith-based settings.

“I do that's, that's something that I love seeing them involved with, just because of my personal beliefs. However, I don't make them or force them.”

“Yeah, we work with faith-based recovery groups. We don't have a lot of direct programming with faith-based churches. We used to have a refuge recovery group here, which is a Buddhist program, which was really cool, because, you know, when we say faith-based in Arkansas, we mean Christian, but there are non-Christian faith-based recovery pathways and groups that are active in the area. So, I feel like we do a pretty good job of equitably engaging with faith-based groups.”

“There are a lot of faith-based places which can be good for somebody who's willing to go and doesn't have insurance. You know, I'm also glad that there's multiple options, because some people have had bad experiences with religion and don't want to go that route, even though it's an option for them. And the challenge is, is for, you know, our transgender population. They won't take them. And I say that they won't take them like they'll find them a resource, and then the churches will like, well, we'll pray that out of you.”

What is your organization’s relationship with the local government like?

One program reported a strong, consistent partnership with courts and law enforcement, while the other described limited, intermittent engagement and little government support.

“I've got a very good, close working relationship with the local government, with the mayor, and with the judicial system here. I've got a partnership with Sebastian County Drug Court, Sebastian County mental health court with Crawford County mental health court with the local DHS system. I've got a very good, close relationship with all them that I've established that long time ago. I mean, the police chief came on grand opening, and so, you know, we work directly with them. They've got a mental health unit that I work with, sometimes when needed. And obviously the probation officers that are here in town, Arkansas, Community Corrections (ACC), I have a very good working relationship with them. So yeah, the entire judicial and court system and law enforcement, I've got a good relationship with all of them.”

“It’s off and on…. Our city director has been by here. Our elected folks have been by here. So, the city is like, they're pretty lukewarm. You know, we partner up with them from time to time on some things, but we've never received any financial support from the city. I mean, it's okay, the county government is a little better than the city government, honestly, but even that is like not significant, especially in terms of funding. There's no funding support.”

What is your organization's relationship with the state government like?

Staff of one program reports developing a strong, ongoing relationship with state government, including regular weekly communication, while the other reports experiencing a more inconsistent and challenging relationship, with ups and downs that require continual effort to maintain alignment.

"I've got a very good, close relationship with them as well.…I've worked with the state government very closely. I've got into a phenomenal relationship with them, and I speak with them weekly."

"State government is really hard to work with just, you know, transparently, it is really hard to work with the state government, but, you know, things kind of up and down with that working relationship. I think they're actually in a much better place now than they have been in months. But it just is a struggle to remember and help people realize that our goals are actually aligned, you know, and we are not adversarial to your goals, and you are not adversarial to ours. We're trying to do this together."

In what ways could government agencies provide better support for your organization?

Both programs encounter barriers in working with local authorities, but the nature of the challenges differs. One program faces regulatory limits from fire marshals and city officials, such as occupancy caps, which the director is actively working to address. The other program notes broader systemic issues, including fragmented coordination between law enforcement, courts, and peer support initiatives, leading to siloed resources and limited alignment with recovery efforts.

"There's been a there's a barrier that has come up with particularly fire marshals and mayors across the state. So, where there's a barrier, where they'll come in and it'll minimize, or put a cap on the number of people that they can have in their house unless they put a fireplace system in. And that's one of the fights that well, one of the, I should say that's one of my goals as director is to get some sort of understanding across the state where we can break down that barrier and stop putting that undue burden on some of these houses."

"Counties and cities could work harder to align law enforcement with recovery support. They just don't align them for peer support. You know the courts here, we have peer support specialists in the courts. I honestly don't know how that's going, because I haven't talked to AOC in a while and but why aren't we working more closely together? Why is that funding not combined? The police departments here have gotten some opioid money here and there to do some peer support. Why aren't we working more closely together with that? And so, all of these things are just kind of scattered and siloed. I think the law enforcement agencies want to control the peer support, and that's just not great. Could work better to align law enforcement and EMS, for that matter."

Does your facility work with other agencies and organizations?

Staff of one program reports receiving significant grant support from philanthropic partners, such as Blue Cross Blue Shield's foundation, often exceeding government funding. The other program indicates it relies on partnerships with residential treatment centers and local employers to connect residents with housing and job opportunities, highlighting a more community- and workforce-driven approach.

"Blue Cross, Blue Shield. They are a great sponsor of ours and their philanthropy organization, the Blue and You Foundation for a Healthier Arkansas, we get quite a bit of grant support from them. We actually get more grant money from them than our government partners."

"So, I work with some residential treatment centers here in [city], or actually outside of [city] and [city], I work with a couple in Northwest Arkansas, where they'll refer me individuals after they complete treatment. I work with a couple companies here in town where we have an MOU, it's a workforce initiative to where they'll give my guys jobs when they have spots open."

What challenges do staff face at their job?

Staff of both programs describe challenges in managing their recovery houses, though the nature differs. One program faced initial difficulties with financial and administrative responsibilities, such as taxes, while the other emphasizes balancing personal relationships with residents and the stigma surrounding battling substance misuse.

"There was a lot to it that I didn't know that I would need to do, just on the back end of things, I mean stuff I kind of had to get accustomed to just avoid wage taxes and stuff like that….a lot of

the financial aspect of it, taxes and just stuff that I didn't really know I was gonna have, but I'm handling it just fine now. But that was kind of a challenge early on."

"I would say keeping the balance between, when it comes to the guys in the house, on a personal level, maintaining rapport with the guys and also holding up the integrity of the house, you know, not letting my emotions get involved and get in the way of decision making. And so, there's sometimes where I have to make difficult decisions that I don't want to make , but I have to, you know, to uphold the integrity of the house."

What are the challenges of MAT in Recovery Residences for staff?

Staff of both programs report challenges related to medication-assisted treatment (MAT), but in different ways. One program expressed frustration with community-based stigma toward medications like Suboxone, emphasizing that such discrimination violates national standards. The other program notes practical concerns, including potential triggers for other residents and conflicts over medication, which have led some operators to avoid providing MAT services.

"Somebody said we need to develop a limiting liability statement for houses that don't want to have people on MAT. And I was like, why would we need to do that? It is a violation of the national standard to discriminate against people who use medication, right? And I was like, flabbergasted by the level of stigma inside the community against medication. I think that's one of the biggest problem areas in the housing conversation. I can't believe we're still talking about whether or not you allow people to come to your house who are using medication for opioid use disorder. It's insane and they want people to have Vivitrol, but not Suboxone, you know, that's wild to me."

"A lot of them shy away from doing MAT services, you know, because of the danger that it puts other individuals in in harm's way. Because most people that are trying to recover are triggered by Suboxone, you know, because some people have used it. And so, if there's even if they were to have a lock box, it's the what it brings to the to the home. So, if somebody that's a trigger for them and it's in the house, then it creates a whole bunch of problems. Yeah, triggers and maybe return to use arguments. Could fight over the box, steal the ball, you know, all of this, all kinds of problems. So, I think that's what kind of why the operators have shied away, you know."

What types of stigma has your organization faced in regard to residential recovery?

Staff of both programs report facing community opposition and outdated local rules that limit recovery housing, often driven by stigma rather than actual problems. Even well-run homes encounter political pressure and restrictive requirements despite positive outcomes.

"It's typically because the neighborhood has been fighting and saying, Hey, we support what they're doing, but we don't want in our neighborhood. And so, they'll raise concern with that. And so, then the local government will come in and say, Okay, well, you can't operate this house like this, unless you put a $50,000 or $60,000 fire sprinkler system, you know. And so, it limits their beds to four people, right….I'm very familiar with the fair housing laws and ADA and they can't do that. If they're not going to treat the house next door, who has seven family members living in the house, or eight, you know, the same, right? So, a single-family dwelling, the definition of that is, is that the individuals are sharing common living spaces, you know, sharing common bathrooms and stuff like that, and living areas. And so just because they're not related doesn't make them a family. So, a lot of what's happening is discrimination, and they're crossing the federal criminal line, and they don't know it, and they just don't care. So, that's one of the things that I'm kind of trying to tackle right now."

"Just some places do not want recovery. They're afraid they're gonna trash the neighborhood. Maybe they have experiences with a family member that just hardened their heart on it, you know, and like, you're never gonna recover. So, they they'll be town meetings and stuff that will prevent them."

"It's kind of nuts, because there's a whole other case happening right now in Little Rock where there's a fantastic operator and, and they've been operating for five years, six years, something like that. No problems, not a single issue. No police reports, no nothing. While all of a sudden, the neighbors found out it was a sober living house, and they complained to the city, and then the city said, "Well, you have to have this special use permit in order to have a group home. None of us knew that. You know and they and they haven't enforced it. It's so dated that it required you to have a license from the state. The state does not issue licenses. It's in a nicer part of town, as you might imagine. And so, the neighbors got all pissed off. So, we've been fighting that they try to shut the homes down. We've done open houses, we've gone door to door, we've gone to the neighborhood association. None of that mattered. They're pissed. They use political processes to shut it down. Of course, they got a really great attorney who told them that they needed to stop using stigmatizing language. And so, they just said, "Well, we're not worried

about the kind of people that are there. We're just worried that there are so many of them in that single family house."

What could be done to improve access to physical and mental health services for residents?

Staff of both programs identify access to insurance, particularly Medicaid, as a key barrier to care. Faster enrollment and the ability to bill for peer and community services are seen as critical for sustaining programs and expanding access to treatment.

"We need to be able to get people into treatment using Medicaid. We need to be able to bill for peer services and other community supports using Medicaid. We need to be able to sustain these programs with Medicaid dollars. The number one obstacle to people getting care is what kind of insurance do they have? You know, I wish that I could sit down with you and say, Well, gosh, what's your primary challenge so it's math. Oh, there's a great stimulant use disorder program at such and such place. That's not what we do here. Do you have insurance? You don't? Oh, well shit. I guess we're going faith based, you know? I mean, that's, that's just it. So, yeah, I think that tapping into actual Medicaid expansion will be huge. Other than that, I think that more coordinated points of entry for people would be huge."

"I would say, probably a faster path to insurance coverage, because a lot of times they, you know, don't get signed up, and it is a long time before they can get coverage with Medicaid. And so, I think a fast-track insurance coverage would be the main thing."

What successes have you had?

Staff of both programs indicate strong outcomes for residents and the community. Residents typically achieve employment, stable housing, and long-term sobriety, with family reunification also noted. Programs have grown in capacity and reach, including community engagement, training initiatives, and hiring alumni as peer support staff.

"I would say the majority of the guys that come through the house stay there long enough to get a job, maintain their long-term sobriety, whether that's eight months a year, you know, six months whatever, and able, to able to go out and get a find their own housing and keep their job. You know, that's obviously an immediate success. I've seen a lot of family reunification happen. That's been a major success."

"Well, for as much as I'm bitching about money. We've gone from a tiny budget to an almost $2 million budget. We've gone from basically shutting down during covid to 80,000 door swings a year. We have encountered thousands of people in the community because we've been going out to festivals and events, not just holding our own, but going out to festivals and events. We've trained a couple thousand people a year on Narcan. We got to start hiring some of our alumni. So, three of our staff, peer support specialists, are graduates of our program, which is fantastic."

Do staff connect residents with resources after their stay in your facility?

Staff of both programs report providing ongoing support for residents after they leave housing. One program offers continued, cost-free peer support regardless of housing participation, while the other emphasizes structured exit planning to ensure residents have safe housing and access to necessary resources.

"Oh, yeah, our peer support is not contingent on participation in our housing program. Even when someone leaves our housing program by their choice or ours, they continue. They can continue with peer support. Not everyone does, but, yeah, receiving cost free peer support is not contingent on participating in housing. So, we can continue working with someone, matter of fact, yeah, a couple days ago, last week, one of our former housing participants stopped by, and she was asking for a recommendation letter for a job, and she exited our housing program like almost two years ago, like she was one of our first folks. So yeah, we serve people, whether they're in our housing program or not."

"So I've got a policy that if they, if the guy, any of the guys, are wanting to move out, I asked, I asked them to come to me at least a week in advance so they can, we can put together an exit plan, make sure that they have a safe place to go, make sure that they have any outside resources set up that they need, whether that's, you know, obviously Housing First, you know, they wouldn't be leaving if that wasn't set up. Sometimes they just, they just leave and that's not set up. Sometimes they don't come to me a week in advance to tell me, but officially, and you know, on policy, I ask that they come a week in advance so that we can have everything set up. And so, if there's resources that need to set up for therapy, for anything, we make sure that all that's set up before they go."

What do staff need to do their job better?

Staff of both programs identify the need for additional support, though in different forms. One program could benefit from more staff, while the other highlights the value of stronger strategic leadership and coordination from funding partners.

"I could probably use a couple more staff members that that that would help. You know, my house manager takes a lot off me, but a couple more staff members certainly wouldn't hurt, you know."

"Well, aside from money, I think more strategic leadership from our funding partners. We are funded by the Blue and You Foundation, and they do a great job of having like synergy meetings. We meet at least once a quarter with all grantees so that we can talk about coordinating our service delivery. The Blue and You Foundation has like a strategy, but even they could do a little better job, honestly."

What problems do residents face when transitioning out?

Staff of both programs identify transportation and communication as major barriers for residents, especially those transitioning from incarceration or treatment. Limited access to vehicles or phones can hinder access to work, healthcare, and court obligations, with public transportation providing only a partial solution.

"Huge issue with transportation and communication. A lot of folks that are transitioning to us from incarceration or from treatment do not have a cell phone. They do not have vehicles. Thank God we live in [city] and there's decent public transportation here, it's okay. Um, not so elsewhere. There's no other community with decent public transportation in the state of Arkansas. So, you know, it's one thing. If you're releasing to [city] and you wind up in our housing, and you can walk to work, and you can, you can walk to a health clinic and you can walk to blah, blah, blah, blah, blah. But transportation is a huge issue. And even when you do, if you have a court case pending in Northwest Arkansas, that's three-hour drive, right? You know? So, transportation and communication are huge barriers."

"Um, transportation, transportation, yeah, that's a that's a big one, a big one that a lot of them lack transportation so they go on the bus system."

Do staff often see the same people returning?

Staff of both programs report that residents rarely return to the housing program, with most transitioning successfully to other housing or treatment options. When returns do occur, it is often after a relapse or completion of additional treatment, and these cases are infrequent.

“I really don't. I see it every now and then, but I generally don't see people returning. And a lot of times, you know, I stay pretty full. And so, a lot of times when people call, I'll get people that you know, want to return, and I'll have to refer them somewhere else, because I'm full.”

“Returning to our housing program? No, I can think of a handful of folks coming back. Some of those folks had a return to use. We helped them get to treatment. They completed treatment, they went to some other intermediary program, either for treatment or housing, and then they wind up back with us. That's happened a handful of times, but we typically don't see folks coming back into housing”

Summary Conclusion

The two recovery residences featured in this report differ in age, size, and approach, yet both share the central goals of stability and sobriety. The first, a long-established facility opened in the early 1980s, houses nearly 50 men and women, while the second, opened in 2023, accommodates a dozen men. Despite these differences, the facilities share several key characteristics.

Both residences offer open-ended stays, typically lasting five to ten months, with low monthly turnover and few residents returning after exit. Many residents have histories of incarceration and co-occurring mental health conditions, and are generally described as humble and grateful. They participate in structured recovery activities—including peer support meetings, therapy, and community service—while maintaining employment or full-time volunteer commitments.

Respondents highlight persistent gender disparities, structural barriers, and community stigma as major challenges. Women’s housing is limited and often subject to extra eligibility requirements, and pregnant women face fears of losing custody. Neighborhood opposition, zoning rules, and enforcing fire-safety mandates can cap occupancy or even threaten closure, despite federal fair-housing protections. Medication-assisted treatment remains contentious, with some houses restricting its use despite clinical recommendations. Financial constraints and fragmented public support add pressure: local and state governments offer little funding, and

Medicaid billing for peer services is limited. Yet these programs also report strong partnerships with courts, employers, and health providers, as well as successes such as family reunification, residents achieving long-term housing and employment, and former participants returning as peer staff.

Recommendations

Strengthen Funding and Sustainability

- **Expand Medicaid Coverage**: Advocate for policy changes to allow Medicaid billing for peer services and community supports, ensuring long-term financial sustainability.
- **Diversify Funding Sources**: Develop partnerships with private foundations, healthcare systems, and corporate sponsors to reduce dependence on unpredictable grants or donations.
- **Leverage Government Opioid Settlement Funds**: Work with state and local agencies to earmark opioid settlement dollars for housing and peer-support services.

Continued Staff Success

- **Expand Education and Training:** Work with existing organizations to provide both targeted and general education programs to staff members focused on housing and substance misuse.
- **Enhance Staff Leadership and Coordination:** Both programs identified the need for more staff, and one identified the need for stronger strategic leadership from partners.
- **Expand Support for Staff Well-Being;** To avoid burnout and improve facility retention, invest in local community resources to better support physical and mental health of recovery residence staff.

Improve Access and Equity

- **Increase Women's Housing**: Support development of women-specific and family-friendly recovery residences, addressing the unique needs of pregnant women and mothers.
- **Inclusive Practices**: Ensure housing policies protect transgender and other marginalized residents and promote evidence-based acceptance of medication-assisted treatment (MAT).

- **Insurance Navigation Support**: Offer staff training and case management to help residents enroll in Medicaid or marketplace plans to expand care options.

Reduce Stigma and Build Community Support

- **Neighborhood Education Campaigns**: Host open houses, community meetings, and success-story events to counter stereotypes and clarify fair-housing rights.
- **Collaborative Advocacy**: Form a coalition of recovery operators to engage city councils, fire marshals, and zoning boards to standardize and simplify occupancy and safety requirements.

Enhance Post-Discharge Support

- **Transportation Solutions**: Partner with transit agencies, ride-share companies, or local nonprofits to provide vouchers, shuttle services, or low-cost car-share programs.
- **Communication Tools**: Provide departing residents with prepaid phones or connect them to discounted wireless plans to maintain contact with courts, employers, and healthcare providers.
- **Extended Peer Support**: Formalize alumni programs and aftercare check-ins to sustain recovery momentum.

Strengthen Data and Continuous Quality Improvement

- **Track Long-Term Outcomes**: Implement standardized follow-up measures (e.g., employment, housing stability, relapse rates) to document impact and guide program improvements.
- **Share Best Practices**: Encourage cross-training and peer learning among houses to spread effective strategies for reducing turnover, improving mental health support, and integrating MAT.

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

November 19, 2025

Results from Interviews with Leadership and Service Providers on Juvenile Re-Entry of the Arkansas Department of Youth Services (DYS) Juvenile Treatment Facilities

Carisa Dwyer, Med
Senior Research Scientist

Matthew Wagner, PhD
Associate Research Scientist

Andria Blackwood, PhD
Senior Research Scientist

Wyoming Survey & Analysis Center
University of Wyoming
1000 E. University Avenue, Department 3925
Laramie, Wyoming 82071
307.766.2189 | wysac@uwyo.edu
www.uwyo.edu/wysac

UNIVERSITY OF WYOMING

Executive Summary

The Wyoming Survey & Analysis Center (WYSAC) conducted an evaluation of the Arkansas Department of Youth Services (DYS) Juvenile Re-Entry, which assessed the experiences of treatment staff at three juvenile treatment facilities. Participants included staff from two Community-Based Providers (CBPs)—covering both Community Reintegration and Family Centered Treatment programs—as well as DYS leadership, DYS and OSAMH staff, and a juvenile probation officer (JPO).

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 re-entry services could be enhanced to better support overall outcomes for youth across Arkansas.

Background

The Arkansas Department of Youth Services (DYS) maintains five secure facilities for youth committed to their authority. Rites of PASSEage (ROP), an independent contractor, staff all the facilities. The Office of Substance Abuse and Mental Health (OSAMH) within the Arkansas Department of Human Services (DHS) reached out to DYS to evaluate the needs of youth in DYS care to assess the needs surrounding successful re-entry into the community upon release. This evaluation is part of the State Opioid Response 4 (SOR 4) grant managed by OSAMH and is supported through funding by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT).

DYS operates five facilities:

1. Arkansas Juvenile Assessment & Treatment Center (AJATC) serves not only as a treatment center, but also as the primary intake and assessment center for all youth committed to DYS custody.

2. Dermott Treatment Center houses serious offenders contained within a security fence because of its proximity to the Delta state adult correctional facility. This site only house male offenders only, primarily older ages 17 to 21 years of age.

3. Harrisburg Treatment Center houses only female offenders.

4. Lewisville Treatment Center houses offenders with a minimum residential length-of-stay of six months.

5. Mansfield Treatment Center also houses serious offenders.

Alternative Placement and Step-Down Programs include:

1. Civilian Student Training Program (CSTP) is open to juvenile court-ordered male participants ages 13-17 years old. It is an eight to nine-week residential program modeled after military structure teaching youth behavioral management, criminal behavior deterrence, citizenship, physical fitness, academic and life skills, and community service. This is a short-term placement with a longer-term aftercare process of one year to divert youth out of commitment to one of the 5 primary treatment facilities.

2. Community Reintegration is a new program that opened in June 2025, allowing youth to transition into a non-secure environment where they can continue to receive the structure provided in the treatment centers while taking on more responsibility.

In September of 2022, DHS/OSAMH contracted with the University of Wyoming, Survey & Analysis Center (WYSAC) to evaluate the SOR 4 program. The evaluation of the re-entry process of youth committed to the Arkansas Juvenile Treatment facilities under the authority of DYS is part of the overall SOR 4 program. The University of Wyoming granted WYSAC researchers an IRB exemption, determining that individuals would experience less than minimal risk for participating.

Key Entities and Roles

A clear understanding of the roles and interactions of the primary entities involved in the care of court-involved youth is fundamental to analyzing the system's effectiveness. This section defines the functions of the DYS, Community-Based Providers (CBPs), the juvenile court system, and the Provider Affiliated Shared Savings Entity (PASSE) program, while also highlighting the systemic friction points that emerge from their interactions.

DYS is the state agency with legal custody of all youth committed by the juvenile courts. As the central authority, DYS is responsible for overseeing all aspects of a youth's treatment, from initial assessment upon commitment to managing the re-entry process. The agency contracts with ROP to operate state facilities, provides in-direct services, and contracts with a network of community providers to deliver care across Arkansas. DYS leadership views its contracted Community-Based Providers as "an arm of extension from DYS", tasked with managing and supporting youth as they transition back to their home communities.

CBPs are non-profit organizations contracted by the state to deliver a wide array of services to court-involved youth. These services span the entire justice continuum, including diversion and prevention for at-risk youth, delinquency services for those on probation, and re-entry/aftercare support for youth returning from DYS facilities. As described by providers, core services include mental health and limited substance abuse treatment, life skills training, Moral Reconation Therapy (MRT) classes, and electronic monitoring. A key feature of the CBP model is its flexibility; services are tailored to meet the specific needs and requests of the local courts within each provider's designated catchment area.

The juvenile courts and their probation officers (JPOs) play a central and decisive role in the system. Judges adjudicate cases, determine dispositions, and order commitments to DYS custody. Notably, the courts maintain jurisdiction over youth before their commitment to DYS custody, in approving release, and subsequent re-entry period. Upon a youth's return to the community, the court determines whether aftercare services are required and is ultimately

responsible for holding both youth and their families accountable to the established treatment plan. This dynamic creates a key point of tension in the system. Stakeholders noted that inconsistency in ordering and enforcing aftercare can weaken the therapeutic work conducted by DYS and the support provided by CBPs, potentially reducing the effectiveness of the state’s investment in a youth’s rehabilitation.

The Provider Affiliated Shared Savings Entity (PASSE) program is the state's managed care organization for Medicaid. For Medicaid-eligible youth, the PASSE program provides an additional layer of care coordination upon their release from a DYS facility. A dedicated care coordinator works with the family to connect them with necessary services, such as ongoing counseling and specialized family-centered treatment. While this provides a valuable link to community resources, stakeholders noted a potential challenge in this model: the PASSE care coordinator is often a "whole new" person introduced to the family at the critical moment of the youth's return home, which can disrupt continuity and there are often delays in accessing services due to Medicaid coverage being turned off while at the DYS facilities. Understanding these distinct but interconnected roles is essential for examining the specific interventions that occur during a youth's re-entry to the community.

Methods

WYSAC evaluators developed an interview instrument (Appendix A) containing prompts to help guide reflection of the juvenile re-entry process 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 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. All participation was voluntary, and participants could refrain from answering any or all questions and could leave the interview at any time.

The interview research instrument included questions asking for the opinions and experiences of staff and administrators working with youth at juvenile treatment centers and upon discharge from DYS custody. Interview questions asked participants about their role in working with youth involved in the juvenile justice system, credentials and/or training required for their position, description of the treatment services available to youth in and outside of the treatment facilities, their thoughts and experiences about the treatment services made available, preparation for re-entry and following re-entry, the challenges and barriers related to the re-entry process, notable successes, and their recommendations for improvement. Interviews lasted between 30-60 minutes and were held at 3 of the 5 juvenile treatment facilities, the community re-integration program, and with community-based providers and other key stakeholders including relevant state and community staff.

Demographics of Respondents

A total of 12 individuals, 9 women and 3 men, were interviewed to discuss their experiences and observations surrounding the juvenile treatment services and re-entry process, and recommendations for making improvements. The following table lists the key positions for those directly interacting with youth involved in the juvenile justice system and required certifications and/or training. Demographic variables such as age, race, and gender were not collected to help preserve confidentiality.

Key Positions	Required Credentials	Required Training
Clinical staff in facilities	Master's Degree and unrestricted licensing including LMSW, LADC, and LPC	CEUs for licensure, Clinical Supervision and any modality specific training.
Juvenile Justice Case Managers in the community	Bachelor's Degree	Mandatory annual in-person trainings and online platforms.
Vocational and Career Coordinators in the community	Bachelor's Degree and Qualified Behavioral Health Provider certification	Specific curriculum certifications such as MRT, Botvin's Life Skills and Strengthening Families.
Family Intervention Specialists in the community	Bachelor's Degree, some Master's Degrees working toward clinical licensure and certification in Family Centered Treatment	Intensive training in curriculum and application and field observation in mastery of 10 skills over a year before certification. Weekly training and monthly all-staff training.
Peer Support Specialist in facilities	Peer Support Specialist certification at core level, advanced or supervisor	Core peer support specialist training, work experience, supervision hours and CEUs

Analysis

Interviews were audio recorded, transcribed, and themes were identified using a rapid analytic approach. Findings were summarized to identify patterns and divergences across participant responses. Identifiable information was not included to preserve confidentiality.

Findings

In your opinion, what are the biggest challenges youth face when they go back home?

Most interview respondents said the biggest challenge youth face is returning to the same home and community environment. The primary challenges being deeply rooted in family dynamics, peer influence, and the stark reality of resource availability, particularly in rural areas.

Family and Community Environment: A recurring and significant hurdle is the reality that youth often return to the same dysfunctional family environments they left. Caregivers may not have received their own treatment, often lack effective parenting skills, and may be struggling with their own substance use, trauma, or mental health challenges. These dynamics task youth to succeed in an environment where the caregivers themselves lack the necessary tools or stability to support recovery.

"When they go back home, these kids have spent whatever amount of time it is since their commitment, receiving all this treatment and redirection and services, but nothing has changed in the home environment."

Negative Peer Influence: As noted by many participants, youth face immense difficulty in separating from the same peer groups that contributed to their initial involvement in the justice system. Upon returning home, youth gravitate back to familiar social circles, making it exceptionally difficult to apply new skills and avoid old habits.

"They are going back to the same environment, so same peer group in their neighborhood or whatever they that's a that's a real challenge for them is knowing that they're not good influences for them, but being able to step away from that and utilize all of the growth that they've had while they were in."

Rural Resource Deserts: The lack of resources in Arkansas's rural communities is an acute and persistent challenge. This scarcity creates significant barriers to accessing the fundamental

support needed for a successful transition. Stakeholders specifically highlighted the following shortages:

- **Services:** A profound lack of accessible mental health and substance abuse services.
- **Opportunities:** Limited employment options and minimal or no pro-social or recreational activities for young people.
- **Support:** Scarcity of formal mentorship programs, which are critical for providing positive role models and guidance.

"One of the biggest challenges that they have, I think, for smaller areas, rural areas, there's not a lot of opportunities. And I think what happens, because their minds are not busy, they go back to the same environment, and those environments, unfortunately, don't, don't have a lot of services, and so it's difficult for us to connect and find services and mentors and things of that in the community that would be most helpful for the students, also parents, family members as well."

In your experience, which supports are needed to ensure youth have a successful reentry?

The post-release period is a critical juncture that often determines whether the gains made during commitment translate into long-term success. A youth's ability to navigate the challenges of their home environment, school, and peer groups is heavily dependent on the quality and consistency of support they receive.

Following their release, all court-involved youth are typically placed in a standard aftercare program for 180 days, delivered by a contracted CBP. This model provides a foundational level of support aimed at ensuring a smooth transition. Core components of standard aftercare include:

- **Vocational Services:** Connecting youth with the Arkansas Department of Workforce Services to identify continued training and/or employment opportunities.
- **Educational Support:** Collaborating with the youth's school to facilitate re-enrollment and academic progress.
- **Independent Living Skills:** Reinforcing practical skills such as money management and job readiness.
- **Behavior Modification:** Providing continued individual therapy to continue reinforcing healthy coping skills and pro-social behaviors.
- **Family Engagement:** Conducting regular "parenting check-ins" to support the family unit.
- **Mentorship:** Pairing students with mentors for a minimum of six months and up to one year post release.

While these services form a structured continuum of care, their effectiveness is often compromised by significant systemic barriers and the opportunities for enhanced and/or specialized support services vary across the state.

The most notable supports repeated by nearly all the interview participants are the need for family support and engagement, residential substance abuse treatment and/or recovery support and continued vocational and/or education support.

"Family support, recovery support, I would say are the two biggest….(supports needed)."

Family Support and Engagement

For youth with more complex needs, Arkansas utilizes an Intensive In-Home Services program based on the Family Centered Treatment model. This program, used as both a preventative strategy and re-entry support service, represents a more robust, wrap-around approach. Trained practitioners work with the entire family system, conducting sessions in the home two to three times per week. The goal is to address the underlying family dynamics that contribute to a youth's challenges. As one provider emphasized, the success of this intensive model hinges on "that family's buy in and their willingness to participate." The family's willingness to engage in the re-entry plan is critical for successful re-entry into the community. Youth rely on their family for support in complying with court orders to continue treatment, participate in urinalysis testing, meeting with their JPO and accessing medication. The Intensive In-Home Services provides a way to engage the family and provides another resource to support the family in helping the youth to successfully re-enter the community.

Vocational and Educational Support

Beyond standard services, DYS and the CBOs have developed targeted partnerships to provide youth with tangible credentials and pathways to success. Notable initiatives include a partnership with the **Saline County Career Center**, which allows youth to earn trade certifications in, for instance, forklift operations. Another key collaboration is with **Graduate Arkansas**, a virtual charter school that enables youth to complete their high school diploma. A Student Success Coach from Graduate Arkansas provides ongoing, location-flexible support, traveling to a youth's home or another agreed-upon location to ensure they finish their coursework and earn their diploma. These programs give youth a "sense of hope" and a vision for a future defined by employment, often for the first time. However, these are needed once the youth return home as they provide continued education and/or gainful employment and connection and commitment to their community.

How are youth and families supported after release?

Upon release, youth enter a formal 180-day aftercare period where they are connected with a network of community-based support designed to ensure a successful transition.

- **Standard Aftercare Services:** Community-Based Providers (CBPs) are the primary source of aftercare support. Their services include vocational assistance, coaching on independent living skills, and regular check-ins with parents to offer support and guidance. A key challenge, as noted by DYS Leadership, is that aftercare workers often cover large geographic areas and may not be physically located in the youth's community, which can limit the frequency and depth of contact.
- **PASSE Care Coordination:** For youth with Medicaid, a PASSE (Provider Affiliated Shared Savings Entity) care coordinator is assigned to their case. This individual's role is to help the youth and family navigate access to medical and mental health services. While beneficial, this adds another new professional to the youth's support team at the critical moment of release. As one PASSE Liaison described, after dealing with DYS staff and aftercare workers, "...they get a whole new care coordinator added to the mix... now we add another person to the mix the day they come home."
- **Accountability and Engagement:** The courts and Juvenile Probation Officers (JPOs) provide an essential layer of accountability. JPOs monitor compliance with court orders and the aftercare plan. However, stakeholders noted inconsistent enforcement regarding parental engagement in services. While some courts actively require and monitor parental participation, others may not enforce these requirements or may dismiss the need for aftercare services altogether, creating a significant gap in support.

Beyond these standard services, several innovative and targeted approaches are showing significant promise in addressing the core challenges faced by youth and families which are described in more detail under unique approaches.

What happens with youth and families before they are release? How are youth and their families prepared for reentry?

The Arkansas juvenile justice system provides a continuum of services designed to prepare youth for re-entry while in a residential facility and to support them upon their return to the community. These services are delivered through a partnership between DYS, its contract providers, and community-based organizations.

In-Facility Preparation for Re-entry

While in DYS facilities, youth receive a range of evidence-based therapeutic and skill-building services. The core therapeutic approach includes individual, family, and group therapy sessions designed to help youth process trauma, challenge criminogenic thinking, manage emotions, and develop healthy coping skills.

This in-facility treatment culminates in a re-entry planning process. The aftercare plan is developed by the youth's designated Community-Based Provider, which is then reviewed by the DYS Re-entry Specialist. This plan is discussed with both the youth and their family prior to discharge to ensure all parties understand the expectations and support available upon their return to the community and is a continuation of the initial treatment plan developed upon commitment to DYS.

What types of treatment are available to youth while they are here, for example can you list the types of common treatments?

Interview respondents provided examples of numerous types of treatments including, but not limited to individual, family and group therapy; educational and vocation support; life skills; and peer support services.

Individual Therapy
Individual therapy is provided to all youth using evidence-based modalities.

Group Therapy
Group therapy is provided to all youth based on their individual treatment plans based on need. These can include focuses on anger management, substance abuse groups, life skills and sexual offense and trauma.

Family Therapy
Family therapy is provided to youth based on their individual treatment plans based on need. These are done virtually with the family participating online, except in some cases where the family can travel to one of the treatment centers.

Educational/Vocational Support
All youth are provided either educational support or vocational support based on their individual needs as outlined in their treatment plan. For those still working toward graduation, they participate in online school through a partnership with Arkansas EDU with teachers coming in person 2 days a week. For those that have graduated or completed their GED, there are numerous vocational training opportunities, however these vary widely across the different

treatment centers with the most diverse opportunities at the AJAC. Students' achievements and progress in various areas, including career goals and parenting skills are tracked through the I Validate and I Achieve program.

Peer Support Services

For youth in recovery from substance use or abuse, there are peer support services available. These are provided in group settings for those interested in groups but are also provided with the opportunity to meet one-on-one with a Peer Support Specialist. All peer support services are voluntary. For those over 18, they can receive help identifying residential substance abuse treatment opportunities.

The following table outlines the common evidence-based treatment modalities and programs available to youth in DYS facilities.

Treatment/Program	Description
Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT	An evidence-based therapy modality used in individual and group therapy to help youth process trauma and develop skills for managing trauma-related symptoms.
Aggression Replacement Training (ART)	An evidence-based group curriculum that teaches youth skills to manage anger, reduce aggression, and improve moral reasoning.
Eye Movement Desensitization and Reprocessing (EMDR)	A psychotherapy treatment that is designed to alleviate distress associated with traumatic memories. Only youth with longer commitment periods can participate due to the lengthened treatment period.
Dialectical Behavioral Therapy (DBT)	A structured therapy that focuses on teaching four core skills (mindfulness, acceptance & distress tolerance, emotional regulation, and interpersonal effectiveness).
Seeking Safety	A group modality designed for youth with a history of trauma and/or substance abuse, focusing on developing safe coping skills.
Life/Independent Living Skills	Case management and group sessions focused on practical skills such as budgeting, career exploration, hygiene, and communication.
Peer Support Services	A voluntary, substance-abuse-focused service where youth meet with certified Peer Support Specialists who have lived experience with the justice system and recovery, providing a unique and relatable perspective.
Gender Specific Services	Voices for girls and Mastery for boys

How do youth get connected to these treatments?

Upon commitment, DYS staff initiate a comprehensive assessment process to guide a youth's treatment. They review the field evaluation, examining background information from the family, school, and community. Concurrently, assessments such as the Substance Abuse Subtle Screening Inventory (SASSY) and the Structured Assessment of Violence Risk in Youth (SAVRY) are used to develop initial treatment plan goals. Once a youth is placed in a facility,

ROP clinicians work directly with them to create specific, measurable objectives designed to meet those overarching goals throughout their commitment.

Are certain treatments in more demand than others?

Many respondents spoke about anger management and substance abuse treatment being in high demand, based on clinical evaluations and commitment orders coming from the local courts. However, internal staff felt there's not necessarily a demand for certain types of treatment, rather, the ever-changing influx of youth at any given time may increase demand. DYS must accept youth at any time and cannot release youth without local court approval which means they have to maintain staffing levels and adjust available services to meet the number of students coming in and out of the facilities.

"I feel like substance abuse is one of our largest needs, but we do not have a residential substance abuse treatment facility for you in the state at all, so that is one of the main things."

"Anger management is a really big one. Substance abuse is another really big one that is really in demand as well."

Is there enough capacity to serve all the youth that need these treatments?

While staff felt facilities have enough capacity to meet the needs of students while in their care, most participants unanimously identified the lack of adequate SUD treatment for adolescents.

- **No Residential Facilities:** There are no residential SUD treatment facilities for youth in the state of Arkansas. This means youth with primary SUD issues have no appropriate placement option and often end up committed to DYS as a last resort.
- **Secondary Diagnosis Model:** SUD is typically addressed as a secondary diagnosis within mental health treatment programs (e.g., Psychiatric Residential Treatment Facilities, or PRTFs). Medicaid will not currently pay for standalone residential SUD treatment for youth.
- **Outpatient Limitations:** While Medicaid covers outpatient SUD services for youth, access is limited, especially in rural areas. There is also a shortage of providers with specialized SUD credentials.

"There's already a shortage of mental health providers, and then there is an even greater shortage of those who want to work with this population."

Are there any unique approaches you have seen facilities take to support youth and prepare them for successful reentry? What are the strengths of these approaches? Which areas need improvement?

Identifying and understanding successful initiatives is strategically important for shaping the future of juvenile re-entry services. Across Arkansas, several innovative programs and high-impact strategies are demonstrating positive results and offering valuable lessons for the broader system. These approaches stand out for their focus on tangible skills, family-system intervention, and practical, real-world preparation.

Vocational and Educational Training

Providing youth with marketable, career-focused skills has proven to be a powerful tool for improving self-esteem and creating a tangible sense of hope. Facilities like the Arkansas Juvenile Assessment and Treatment Center (AJAC) have developed robust vocational programs through partnerships with local institutions like the Saline County Career Center and Shorter College. These programs offer youth the opportunity to earn valuable certifications in high-demand fields.

- Forklift Operation
- Welding
- Commercial Driver's License (CDL)
- Tower Climbing
- ServSafe (Food Handling)

The key strength of these initiatives, as articulated by participants, is that they provide youth with "real world job skills." This not only equips them for immediate employment upon release but also offers a concrete pathway to a stable and productive future, fundamentally shifting their perception of what is possible.

Improvements needed are ensuring availability for all youth across the state both while in DYS care and after release. This included mention of better engagement from Arkansas' businesses, particularly in rural communities.

Intensive In-Home Service Model

The Intensive In-Home Services program, which utilizes the Family Centered Treatment (FCT) model, is a powerful approach that addresses one of the system's most profound challenges: family dysfunction. Its primary strength is its focus on treating the entire family system rather than just the identified youth. Therapists work directly in the home two to three times per

week, fostering family buy-in and addressing the underlying dynamics that contribute to a youth's behavior.

A central pillar of the model's success is the collaborative pre-discharge staffing. As described by an FCT provider, these meetings bring together the family, DYS staff, and the provider before the youth is released. This process creates "transparent, open, honest communication up front" that fundamentally shifts the family's mindset from punitive to collaborative, building the trust and engagement essential for success.

"Flexibility, meeting families where they are and helping them get back to connectedness, because that's half the battle, treating the whole family, not just the kid, because that's the biggest part of the battle."

While the primary limitation of this high-impact service is capacity; insufficient funding means the service cannot be offered to all families who need it, particularly on the re-entry side, the primary strength is its wraparound approach encircling the whole family in services where they're at and has proven positive outcomes.

The following table illustrates the success of this model with data highlighting the percentage of youth who have benefited from this program. This provides a glimpse of the success in using this as a prevention strategy to keep youth from progressing through the juvenile justice system, as well as via aftercare to lower recidivism.

	Prevention	Aftercare
# of Referrals	435	365
# of discharged cases due to all goals met	146	132
# of youth committed to DYS or went AWOL during service or before services started	30	52
#Other (closed early or did not open due to various reasons: residential placement, moved out of the area, in detention, family refused)	259	181
# of youth avoiding commitment and/or recommitment to DYS custody	34%	36%

Community Reintegration Program: "The Cottages"

The new Community Reintegration Program is a 90-day, home-like, step-down program designed to bridge the critical gap between a secure DYS facility and the community. Its innovative structure addresses several key systemic and practical barriers to re-entry.

- **Reactivating Medicaid Pre-Discharge:** Youth's Medicaid is turned on the day the youth transfer to the program and PASSE gets assigned. This is unique to this program as they are still in DYS custody, but able to receive additional services covered by Medicaid in addition to the services DYS provides.

- **Practical Life Skills:** The program focuses heavily on essential life skills such as budgeting, grocery shopping, cooking, and money management, preparing youth for the practical realities of independent living.
- **Educational Partnership:** A collaboration with Graduate Arkansas allows youth to continue their high school education virtually. Crucially, this partnership includes a success coach who continues to work with the youth *after* they leave the program, providing ongoing support.
- **Engaging PASSE Coordinators:** The program proactively brings PASSE care coordinators into the discharge planning process while the youth is still in residence, establishing a relationship and a plan for medical and mental health care well before the youth return home.

The primary strength of this program is to provide youth with an opportunity to continue working through their treatment plan while increasing their independence and responsibility both to themselves and the other youth they are housed with, leading to a more seamless re-entry process. Improvements are still unknown as the program just started.

Peer Support Services

Peer Support Specialists offer a unique and highly effective service for youth struggling with substance abuse. This voluntary program connects youth with certified specialists who share the lived experience of both justice system involvement and substance use recovery. The effectiveness of this model lies in its authenticity. As one specialist noted, youth relate differently because they are "working with someone that's been through the same lived experience," which breaks down barriers and fosters a level of trust and openness that can be difficult to achieve in traditional therapeutic relationships.

The strength of this approach is inherent in its description; youth are offered the additional support of a trusted adult who they can relate to and are given the choice to participate, which differs from the other treatments that are mandatory.

The limitations are that these services are mostly provided while youth are in DYS care, because they can only be provided to youth after release if they are 18 or older.

Which of these do you think would make the biggest impact on successful reentry?

Most respondents spoke to the need to expand successful reentry programs and strategies such as intensive in-home services, community reintegration or step-down opportunities for youth to transition between DYS custody and returning home. And all participants highlighted the need to better engage the family to ensure youth can complete their reentry requirements and hopefully continue to apply the skills they've learned while in DYS

custody. Mentorship being a key component of this to provide additional resources for the youth and families that are often more approachable than staff.

Many participants spoke about the need for community partner engagement in a variety of ways from identifying and engaging mentors to opportunities for employment and vocational training to providing basic needs like clothing and transportation for youth to become and stay employed.

Additionally, some participants spoke to the need to increase funding and support to prevent high turnover and ensure continuity of service providers. As well as a consistent them in providing the resources to support more preventative approaches to keeping youth out of DYS care in the first place.

How can the state and community support these changes?

Interview respondents listed a variety of strategies and approaches the state and community can do to further support youth as they reenter the general community, including residential substance abuse treatment for youth, additional support in securing employment, community support and involvement in becoming mentors, additional training to support peer support specialist expanding their work to include families post release, access to additional funding, expanded education at all levels of state government to understand levels of care, need and after-care, supporting the whole family through services like Intensive Home Services, step down opportunities or transitional living situations for youth who need alternative placement to support continued change, more prevention and early intervention including parenting education and family support.

Across all interviews, several consistent recommendations emerged for strengthening the juvenile justice system and improving outcomes for youth.

- **Invest in Early Intervention and Prevention:** A consensus exists that resources must be shifted to the "front end" to address behaviors before they escalate. This includes providing services in elementary schools and engaging families as soon as risk factors are identified, well before court involvement.
- **Increase Funding and Resources:** More state funding is deemed essential to raise salaries for mental health professionals, reduce caseloads, expand the capacity of proven programs like IIHS and the Community Reintegration Program, and develop solutions for the SUD treatment gap.
- **Strengthening Family-Centered Approaches:** There is universal agreement that treating the family system is paramount. This includes expanding access to programs like FCT and Strengthening Families, and finding ways to better incentivize or, if necessary, have courts mandate parent participation in treatment.
- **Foster Robust Community Partnerships:** Building stronger relationships with employers, trade schools, and community organizations is vital for creating pathways to

employment and pro-social engagement for youth. This also includes finding committed, long-term mentors to provide guidance and support.

"I think the mentorship is a really big advocate in the smaller rural areas. And that's the hardest thing is finding when you live in a smaller area.

- **Improve Systemic Coordination:** Continued efforts are needed to streamline processes between DYS, the courts, and Medicaid to eliminate bureaucratic barriers, such as the delay in service access caused by Medicaid suspension, and to ensure all stakeholders are working collaboratively toward the common goal of supporting the youth.

Conclusion

The evaluation of Arkansas's juvenile re-entry system reveals a core truth: while dedicated professionals are implementing innovative and effective strategies on the ground, their efforts are often undermined by systemic gaps related to family dysfunction, rural resource scarcity, and a critical void in substance abuse treatment. There is a promising way forward that builds on these findings. A combination of increased investment in what works, such as hands-on vocational training and family-centered therapeutic services, along with targeted policy reforms to school re-entry and family engagement is essential. By addressing these foundational issues, Arkansas can create the conditions necessary for lasting, positive change for its most vulnerable youth.

Recommendations

Strengthen Family-Centered and Home-Based Interventions

- **Expand Intensive In-Home Services (IIHS)** so that every family with a youth returning from DYS custody can access wrap-around support.
- **Mandate and support parental participation** in treatment and aftercare, using court orders and incentives (e.g., transportation assistance, flexible scheduling) to reduce non-engagement.
- **Provide family education and coaching early**—at the point of first court involvement or even earlier—to reduce the likelihood of later commitment.

Close the Youth Substance Use Disorder (SUD) Treatment Gap

- **Establish in-state residential SUD treatment options for adolescents.** Lack of residential care is a critical barrier; developing Medicaid-reimbursable, youth-specific programs would help divert youth from DYS custody.
- **Expand outpatient and recovery supports**, especially in rural areas, and train additional providers with adolescent SUD credentials.

Build and Sustain Community-Based Supports

- **Develop and fund community mentorship programs,** with a special focus on rural areas, to provide long-term positive adult connections.
- **Formalize employment partnerships.** Formalize partnerships with local employers, trade schools, and career centers to offer paid internships, apprenticeships, and job placements.
- **Invest in pro-social activities and safe spaces.** Invest in recreation centers, youth clubs, and transportation so young people have healthy outlets and structured leisure.

Ensure Smooth School and Service Re-Entry

- **Reform school re-entry policies** to prioritize inclusion in mainstream schools and extracurriculars instead of defaulting to Alternative Learning Environments.
- **Pre-activate Medicaid and PASSE coordination** before discharge (building on the Community Reintegration "Cottages" model) so medical and mental-health care continue without interruption.

Invest in Prevention and Early Intervention

- **Offer elementary and middle-school supports.** Offer evidence-based family programs, behavioral health services, and parent training well before court involvement.
- **Develop targeted rural strategies.** Create mobile or telehealth teams and local service hubs to overcome geographic and resource barriers.

Stabilize and Grow the Workforce

- **Increase salaries and reduce caseloads** for DYS and Community-Based Provider staff to lower turnover and maintain continuity of care.
- **Offer advanced training and career pathways** (e.g., clinical supervision stipends, tuition support) to attract and retain qualified mental-health professionals and peer specialists.

Improve System Coordination and Data Use

- **Streamline communication** among DYS, juvenile courts, Medicaid/PASSE, and schools to eliminate service delays and conflicting requirements.
- **Use shared data systems** to track youth progress from commitment through aftercare and early intervention, enabling more responsive, evidence-based policy.

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

November 19, 2025

Results from Interviews with Arkansas Drug Court Staff in SOR 4-Funded Programs

Tashina Lemons, MPH
Associate Research Scientist

Matthew Wagner, PhD
Associate Research Scientist

Andria Blackwood, PhD
Senior Research Scientist

Wyoming Survey & Analysis Center
University of Wyoming
1000 E. University Avenue, Department 3925
Laramie, Wyoming 82071
307.766.2189 | wysac@uwyo.edu
www.uwyo.edu/wysac

Executive Summary

Adult Drug Courts (ADC) in Arkansas provide voluntary, multi-phase programs designed to support adults involved in the criminal justice system with substance use disorders. Lasting 14 to 18 months, ADCs combine frequent court appearances, intensive supervision, case management, and evidence-based treatment. Treatment can include individual and group counseling to promote recovery, family reunification, and community reintegration. ADCs serve high-risk, high-need populations, and many of their participants have co-occurring mental health disorders or prior unsuccessful probation experiences.

Interviews with five ADC staff highlighted the increasing prevalence of opioids, particularly fentanyl, across urban and rural communities, often in combination with other substances. Successes included expanded eligibility, robust peer support, team-based approaches, and statewide networks that improve access to treatment and supportive services. Staff emphasized that walking alongside drug court participants, leveraging lived experience, and providing person-centered care have driven meaningful recovery outcomes.

Despite these successes, challenges persist. Staff turnover, housing and transportation barriers, funding constraints, stigma toward substance use and Medications for Opioid Use Disorder/Medication Assisted Treatment (MOUD/MAT), and limited access to treatment facilities were cited as key obstacles. Resource shortages, particularly in rural areas, further constrain program effectiveness.

Background

Adult Drug Court is a voluntary, multi-phase intervention program in Arkansas, typically lasting fourteen to eighteen months, designed for adults involved in the criminal justice system due to underlying unmanaged substance use disorders and who are at elevated risk of reoffending (National Association of Drug Court Professionals, 2018). The program employs evidence-based treatment and supervision measures to support participants in achieving sustained recovery. Key components include frequent court appearances, random drug and alcohol testing, intensive community supervision, case management, and comprehensive substance use disorder treatment, encompassing both individual and group counseling (AllRise, n.d.).

In addition to clinical treatment, Adult Drug Courts connect participants with community services and supports, promoting life-saving interventions, family reunification, and long-term

stability while also preserving public resources. The overarching goals of Adult Drug Courts are to enhance public safety, reduce incarceration among individuals with substance use disorders, and improve the quality of life for participants, their families, and the broader community.

Consensus in use of best-practices and program participation considerations are built into the evaluation process. Adult Drug Courts typically begin formal evaluation at 125 participants to ensure sufficient resources and attention are available to meet program objectives (National Association of Drug Court Professionals, 2018). In Arkansas, there are currently 104 specialty courts administered under the state supreme court system. Drug courts represent the largest subset, comprising approximately half of all specialty courts, with additional courts serving veterans, mental health needs, juveniles, and families.

These courts serve high-risk, high-need populations, many of whom have previously participated in probation programs without success. Participants often present with co-occurring conditions, including mental health disorders alongside substance use disorders. Mental Health Courts, for example, require participants to have a chronic DSM-5-recognized diagnosis. Collectively, Arkansas' Adult Drug Courts represent a structured, evidence-based approach to addressing complex needs within the criminal justice system, with the dual aim of promoting recovery and safeguarding communities.

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 respondents were informed of their rights, and each signed a consent form (Appendix B) explaining the goals for 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 respondents 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 Adult Drug Court participants. Interview prompts asked respondents about their experiences and interactions with Adult Drug Court participants throughout Arkansas, their thoughts and experiences surrounding opioid use, challenges and successes in Adult Drug Court, perceived stigma around opioid use disorder, and any further

information they wanted to share about their experiences. Each interview lasted approximately 40 minutes and was held virtually in private settings.

Respondent Demographics

A total of five individuals participated in the interviews. Respondents were on average 45 years old, with ages ranging from 39 to 51. All participants identified as white and reported non-Hispanic/Latino ethnicity. Two participants were male, and three were female.

All respondents served populations considered high-risk and high-need, reflecting the complex challenges faced by individuals involved in substance use and recovery programs. Among the five interviewees, one held the dual role of staff attorney designated to specialty courts and statewide coordinator for those courts. The remaining respondents were peer support specialists assigned to county-level drug courts, who also carried additional responsibilities within their respective agencies.

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. Data was analyzed using thematic analysis. Transcripts were coded into notable categories of significance that describe the experiences, opinions, thoughts, and recommendations of the interview participants.

Findings

How prevalent is opioid use among the clients you serve?

All interview respondents highlighted how opioid use has increased and is an emerging concern across all demographic groups with prevalence in both urban and rural communities.

"Antidotally, fentanyl wasn't a thing when I first started in [this work] and now it's about in everything."

"It's meth and opioids are the primary substances."

"It's very, especially now a days [it may not even be their drug of choice] but it's in everything."

"Every single one of them."

Have you observed any trends in opioid use among the clients you serve?

All interview respondents discussed how illicit substances are often adulterated with fentanyl or it's analogues, with or without the knowledge of the user.

"Within the last five years, fentanyl is in everything."

"It's definitely increased."

"Frequency in use is rising and the population that uses is getting younger."

Are there specific opioids (e.g., fentanyl, heroin, prescription opioids) that are more common?

All interview respondents emphasized the pervasiveness of opioid misuse. At the same time, they highlighted that the specific profile of other problematic substances differed by urbanicity, with variations emerging between urban and rural settings.

"Hydrocodone, oxycodone, very common."

"Higher use of fentanyl and suboxone, before that it was heroine, fentanyl, morphine and other opioids."

"Meth is the number one drug of choice, but fentanyl and opioids are a close second."

Multiple substance use is very common.

"Fentanyl is more prevalent (now) and widely used. Most drugs today are mixed; there's a little bit of everything within them.

What aspects of your work with clients have been most successful? Are there specific interventions, treatments or support systems that have worked particularly well?

All interview respondents consistently identified how improved resources shifted from a scarcity model to one of greater stability allowed stakeholders to focus directly on the recovery ecosystem. This includes the value of lived experiences and growth of peer support.

"Finding funding, it used to feel like I was looking and trying to find [funding] for later days, now I have the funds, and I just need to find the best sources for [courts] to utilize it."

"Being able to share my lived experience because I do have that lived experience with opioid use as well and just knowing how that feels to be a slave to that being able to come out on the other side and having empathy for that… being able to see that light click on in participants eyes and being able to see them get jobs and family reunification, drivers licenses and get their lives back on track in their recovery. "

"Finally seeing people lean into peer support, they finally realize what peer support is and what it can do, then it has worked out really well."

"Having someone around who is also in recovery with them and having more accesses to more meetings and groups of people."

"Best thing I can do is just walk beside them. Helping people with the simple things in life and being there to help guide them through that."

What aspects of your work with clients have been most successful? Are there specific interventions, treatments, or support systems that have worked particularly well?

Interview respondents highlighted several key elements driving success in opioid related interventions like program innovation and expansion, building strong state-wide networks of support, using collaborative and team-based approaches. These themes also ensure there is compassionate and person-centered care for the ADC participants.

"The sheriff's office has developed a program to provide drug treatment, mental health treatment, and life skills training to candidates… they take some of the individuals that are not

seen in drug court and [those individuals] were doing really well and it led to the expansion of eligibility for drug court. Another great tool has been transitional housing."

"I Built a really good network of supports throughout the state, if [I'm] not finding the support that is needed [within the county] then there's the ability to reach out a little bit further, whether it be detox or something a little bit more for treatment, [I] have those connections."

"All of drug court is a team, the counselors, the peer support specialists etc.; schedule conflicts or link ups happen but there isn't anything (anyone on that team) wouldn't do to help each other or let something like that stand in a person's way."

"Faith based programs have been very successful within [the area].

Can you share a story or example of a successful case?

All interview respondents could highlight multiple successes of how ADC has benefited the program participants.

"I can think of dozens and dozens of cases where people who pled into drug court and went into transitional living; huge difference."

"There's often times where [I] had a young lady in my office that had nowhere to go, she was unhoused, and I was able to get her into treatment services immediately….because of the network that [I] have built working within this field."

"A participant with mental health and substance disorder issues, but [this participant] has used the program as a whole and has surprised everyone."

"There's a lady who has been in drug court for a while and she is in the last phase and she has come into [drug court] with a positive attitude and she has been asking for more materials and more information on things, and we've gotten her into book clubs, and she wants to now go to school to be a counselor."

"I was able to walk someone who was going through the system and you could tell (she) was ready to get back out there. But I was there with her and kind of helped guide her through things and now she is a peer support specialist."

What are the biggest challenges you face in working with clients who use opioids?

Interview respondents described several persistent challenges in the implementation and sustainability of ADC and related services. Major themes were specific to staff turnover, participant expectations, stigma towards treatment approaches, housing barriers, transportation, and funding constraints.

"Turnover (within the court system), it makes it hard to make sure everyone is adhering to standards."

"The main thing is when we get a new participant in [ADC] and they hear "oh we're going to let you out if you go to drug court" and of course they want out of jail…but then they start and they're like [I didn't sign up for this] but they literally did, I watched (you) do it."

"Resources like housing, most people want to rent to someone who isn't in recovery or don't have a court case."

"Stigma surrounding things like MOUD/MAT treatment because those are things that have to be handled with sensitivity because not everybody is as accepting to those types of treatment services, and it took a little while to get everybody on board and [we're] still working on that. You have to meet everyone where they are at and it's a chiseling it down and slow process."

"Drug court specific housing is a high need for many participants; charges can dictate if a person can or cannot get into different housing areas or meet criteria for specific transitional housing areas."

"Sometimes when you're trying to find housing for people, you hit a wall."

"Those who are addicted to [prescription based] opioids get out and go to a doctor and end up coming right back.

"Funding types for treatment can put people into a hardship; sometimes it means uprooting and moving people to find means that work."

Are there systemic or structural barriers that impede your work (e.g., policy, staffing, treatment access)?

Interview respondents identified multiple systemic challenges that limit the effectiveness and reach of opioid-related programs like fragmented funding structures, policy and staffing

constraints, limited resources and legal barriers, as well as restricted access to treatment facilities and recognition of peer support.

"Funding, (for instance) probation officers are funded through a different system [we can] spend money and time training them and then they can be moved as needed somewhere else within the state."

"[We] have come along with policy and staffing; we are chipping at way at treatment and housing and that is where we are hitting some stigmas along the way."

"Stigma towards [peer supporters] and understanding of what we do."

"We [as a county] don't have access to as many resources as we would like to have. Sometimes it's a problem with the courts, like we can get them letters for treatment facilities, but I have problems with some of the prosecutors opening up to me."

"We have three treatment facilities here, but it's hard to get people in if they don't have the funds or insurance. Most of those places, unfortunately, only take people if they have the ability to fund things, we frequently have to send people out of the county."

How has stigma related to opioid use affected your clients or your work?

Stigma emerged as a persistent barrier affecting both individuals in recovery and the systems that support them. In rural areas, barriers such as limited access to treatment and persistent social stigma remained prevalent, while urban areas showed shifting public perceptions and more active efforts to reduce stigma.

"No, actually… we [Arkansas] is a small state, it's to the point now where everybody has somebody that they know who has struggled with substance use; a cousin, a brother, a parent, whatever, most people would have a story or have a connection if you look at meth (that was really big here twenty years ago) and most recently opioids, that has helped."

"Getting into treatment facilities and those kinds of things [that are not so much in your control] that's where we're hitting the stigma."

"Sometimes it will, and it's something that I am trying to talk to people about; I bring up the word stigma a lot."

"I get the stigma a lot, I am trying to change that I show up every day, but we have housing issues, jobs are hard to find for people who are in recovery."

What resources or supports are currently lacking in your program?

Most interview respondents identified resource shortages that limit program effectiveness and participant success such as insufficient personnel, funding, housing shortages and transportation issues.

"Personnel, I wish there were five of me…there hasn't been someone like me in this role and navigating that has been challenging."

"When you plead guilty or are found guilty of a drug offense within Arkansas, your license gets suspended for six months, when you go to these rural counties and you don't have a license, it makes it very difficult to make you specialty court obligations…every morning a participant has to dial a number and it tells them if they have to come [to court] or not for a drug screen, it makes it hard for people to comply with that if they don't have transportation. Even though best practices say that you should never turn away somebody because of transportation issues, in reality our courts are having to because there's no fixing that in some places."

"We are missing a lot of resources like housing and stuff like that, there are people who want to come into the drug court program, but they don't have a place to live, and they can't get into the program without having a place to live."

"The only funding we have is the grant that I'm paid on for this, we don't have any additional funding."

"If I had the ability to, I would open a sober-living within my area; we have lots of treatment programs but no sober-living facilities…most people end up living in a hotel or renting a room and that isn't always the best scenario for them."

"I don't get paid for fuel for transportation, I'll take people to go do things and I don't get reimbursed for transportation."

"It's hard to find housing for those in recovery within my area."

What kinds of training, services, or tools would help you be more effective in addressing opioid use?

Interview respondents emphasized the need for expanded services and tools to strengthen program effectiveness and participant outcomes thought enhanced training for practitioners, greater availability of support groups and meeting as well as broader resource access.

"I wish I had more resources to tap into to train our practitioners within the state, that has been hard lately."

"Trainings for like MOUD and crisis intervention, [I] could come up with an entire list that we could get some help on."

"Anything that would be offered."

"Sometimes I feel like I struggle with things that I may need to help with groups or meetings for participants and there isn't a lot of resources for meetings or groups."

If you had additional funding, what would be your top priorities?

With additional funding, respondents emphasized hiring more staff, additional training, materials, and housing and treatment resources.

"Depends on the kinds of funding, I don't want to hire someone that is grant dependent because those positions are time fixed, if I had an endless amount of funding I would hire staff though."

"We don't have any additional funding…we don't have money to pay for anything, so we don't have additional trainings or anything else."

"More materials, it would also help to be reimbursed for the support that I give like driving people to and from places."

"Housing and treatment."

Summary Conclusion

Adult Drug Courts in Arkansas serve a critical role in addressing substance use disorders among high-risk, high-need populations involved in the criminal justice system. The program's multi-phase, voluntary structure, combined with evidence-based treatment, intensive supervision, and comprehensive case management, provides participants with opportunities for recovery, family reunification, and reintegration into their communities. Interview findings underscore the pervasive presence of opioids, particularly fentanyl, across both urban and rural populations, highlighting the complex and evolving challenges faced by program participants.

Interview respondents identified multiple successes, including the expansion of program eligibility, the integration of lived experience through peer support, and the development of statewide networks that enhance access to treatment and other supportive services. Team-based, compassionate, and person-centered approaches were consistently emphasized as key drivers of positive outcomes. At the same time, participants face persistent challenges, including staff turnover, housing and transportation barriers, funding constraints, stigma surrounding opioid use and MOUD/MAT treatment, and systemic limitations in treatment accessibility. These barriers underscore the need for targeted resources and ongoing support to ensure that the program can sustain and expand its impact.

Recommendations

Based on interview findings, the following recommendations are proposed to strengthen Adult Drug Court outcomes and address current gaps:

1. **Enhance Workforce Capacity:**
    - Increase personnel dedicated to drug court programming, including peer support specialists, case managers, and court staff, to reduce turnover impact and improve service continuity.
    - Provide ongoing training for staff in evidence-based practices, MOUD/MAT, and crisis intervention to enhance program effectiveness and practitioner confidence.
2. **Expand Housing and Transportation Supports:**
    - Develop additional transitional and sober-living facilities to support participants who lack stable housing.
    - Provide funding or reimbursement for transportation to ensure participants can comply with court obligations, treatment sessions, and support meetings.
3. **Increase Resource Accessibility:**
    - Establish or expand statewide networks to connect participants to treatment services, detox facilities, and other recovery resources, particularly in rural areas.
    - Offer broader access to materials, support groups, and community-based programming to strengthen participant engagement.

4. **Address Stigma and Promote Awareness:**
    - Implement educational initiatives targeting the community, court personnel, and participants' families to reduce stigma surrounding substance use and recovery.
    - Promote understanding of peer support roles and the benefits of MOUD/MAT to enhance acceptance of evidence-based interventions.
5. **Sustain and Diversify Funding:**
    - Secure long-term, flexible funding streams that reduce reliance on time-limited grants and support core program operations, training, housing, and transportation needs.
6. **Monitor and Evaluate Program Outcomes:**
    - Continue rigorous program evaluation using census data and participation benchmarks to ensure resources are sufficient and program objectives are met, particularly as opioid prevalence and polysubstance use trends evolve.

Implementing these recommendations will enhance the capacity of Adult Drug Courts to provide effective, equitable, and sustainable interventions for individuals with substance use disorders, ultimately improving public safety, reducing recidivism, and supporting recovery in Arkansas communities.

References

AllRise. (n.d.). *About Treatment Courts*. AllRise. Retrieved September 19, 2025, from https://allrise.org/about/treatment-courts/

National Association of Drug Court Professionals. (2018). *Adult drug court best practice standards* (Vol. 2, Text Rev.). National Association of Drug Court Professionals. https://arcourts.gov/sites/default/files/Adult-Drug-Court-Best-Practice-Standards-Volume-2_Standard-IX_Text-Revision-December-2018-1.pdf

Wyoming Survey & Analysis Center
UNIVERSITY OF WYOMING

November 19, 2025

Continuous Quality Improvement (CQI)

Year-One Assessments in Training Implementation for SOR 4

Matthew L. Wagner, PhD
Associate Research Scientist

Tashina Lemons, MPH
Associate Research Scientist

Wyoming Survey & Analysis Center
University of Wyoming
1000 E. University Avenue, Department 3925
Laramie, Wyoming 82071
307.766.2189 | wysac@uwyo.edu
www.uwyo.edu/wysac

ABOUT THIS REPORT
This publication was produced for the Department of Human Services and the Office of Substance Abuse and Mental Health through the 2024 State Opioid Response grant award number 231419A0004.

© 2025 WYOMING SURVEY & ANALYSIS CENTER

CQI Evaluation Year-One

As part of a series of continuous quality improvement (CQI) assessments, WYSAC evaluated two separate training modules over the course of the first year of SOR 4. A CQI assessment is a structured method used to assess and improve processes, services, or outcomes in a systematic and data-driven way. CQI assessments help organizations identify inefficiencies, understand root causes, test solutions, and track improvements over time. These assessments are a continuous process that help programs evolve, improve performance, and deliver better results over time.

The first assessment, on May 23, 2025, was used as a pilot to develop the rubric, and the second on August 19, 2025. The first rubric has twelve questions, the second rubric has eleven questions, and eight questions specific to virtual (online) training sessions. Answers range from 1 (not demonstrated) to 5 (expert) (See Appendices A and B for rubrics).

Both the training modules had positive and impactful elements to them, provided salient information, and were within the scope of the SOR 4. Summaries of each training session, including strengths, weaknesses, and recommendations, are found in this report.

Important to note, the CQI rubric was changed after the first training module to accommodate a more holistic evaluation, to include a specific section for virtual trainings, and to shift focus from training content to training implementation. Answers to the revised version of the first training is found in Table 2 and Zoom-specific indicators are found in Table 3. Both rubrics are found in the Appendix.

Training Evaluations

American Society of Addiction Medicine (ASAM) Training Observation May 23, 2025 (Pilot)

The training session provided a high-level and comprehensive overview of the updated ASAM criteria, with particular focus on its integration within the Medicaid 11-15 billing standards. The training instructor emphasized the importance of the fourth dimension of care (time), the chronic care model, and holistic and integrated approaches for improving patient outcomes. A notable highlight was the new requirement for weekly patient assessments, now billable for insurers to ensure care remains aligned with individual needs. The session also addressed subdimensions of care and incorporated key themes such as cultural competency, social determinants of health, and diversity, equity and inclusion.

The training instructor demonstrated expert-level understanding and consistently used standardized ASAM terminology, clearly outlining the full spectrum of ASAM levels and emphasizing the integration of psychosocial and behavioral health support. However, several key clinical components – such as assigning risk rankings per dimension, integrating OUD pharmacotherapy, and justifying level-of-care decision – were not adequately demonstrated due to time limitations and content misalignment with the audience. While individualized treatment planning and care adaptation were addressed at a competent level, the content often assumed a high baseline of knowledge and lacked practical examples relevant to the attendees' professional roles.

The training also fell short in engaging participants through shared decision-making practices or demonstrating culturally responsive, patient-centered approaches. The session ultimately shifted toward a discussion rather than an interactive learning experience, revealing the need for improved alignment between training content and audience needs.

Overall, the instructor effectively conveyed the regulatory implications of ASAM updates and aimed to support providers in maintaining compliance and improving care quality. However, participant feedback highlighted a broader need for better knowledge-sharing across facilities and called for a more coordinated community care model supported by standardized EMR systems statewide.

Training Implementation Summary

Training Positives

- The training demonstrated expert-level understanding and consistently used standardized ASAM terminology
- The training provided Arkansas-specific content that is directly applicable to local communities.

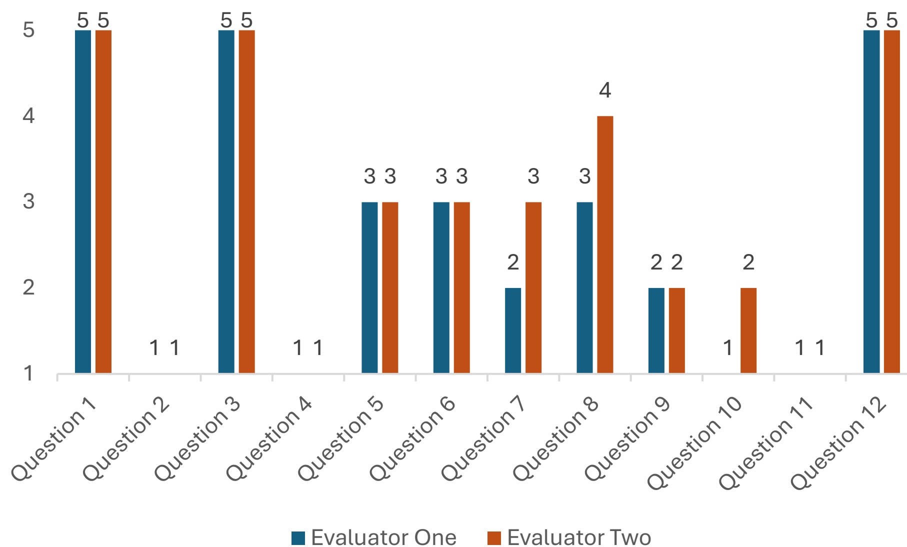
Needs Improvement

- Key clinical components, for instance justifying level-of-care decisions, were not adequately demonstrated due to time limitations. A longer training period would be helpful.

A comparison of rubric answers for the evaluators of the training is found in Table 1 below.

Table 1. ASAM Training Evaluation Rubric Answers

The evaluators were generally in agreement across all dimensions of the evaluation.



Medication for Opioid Use Disorder (MOUD) Training Observation August 19, 2025

The training was intended to provide a clear, evidence-based overview of medications for opioid use disorder (MOUD), covering the opioid epidemic, recent developments, and practical approaches for clinical and community settings. However, the session fell short in several key areas. It began without a proper introduction of the training module, leading to confusion. Furthermore, the trainer's initial explanation of opioids was overly complex and framed awkwardly given the audience and topic, including inappropriate language such as referring to individuals' "love of opioids," which lacked sensitivity and clarity.

The presentation included numerous graphs and statistics that were poorly cited, leaving participants unsure of their sources or relevance, particularly to Arkansas. For example, CDC Wonder data from 1999 to 2023 was used to describe trends in opioid-related overdoses in both Minnesota and the United States. However, the selection of specific ICD-10 codes (e.g., T40.0–T40.4, T40.6 for opioid involvement) were not made clear and can significantly affect the data retrieved. More importantly, the Center for Disease Control changed their data collection process in 2018, updating how multiple causes of death were collected and coded, and emphasizing self-reported multiracial demographics data in their releases.

This transition can cause inconsistencies in race-based mortality trends, especially when comparing long-term data. Earlier data suppressed multiracial identities, while later data increasingly reflects them. Finally, there has been a shift in how some jurisdictions report and certify drug overdose deaths, particularly regarding the specific drugs involved. All of these changes in data collection practices would influence the accuracy of the data used in the presentation.

Attempts to discuss the political determinants of health lacked depth and accuracy, creating further confusion. The trainer's background as a Licensed Professional Clinical Counselor in Minnesota created a mismatch, as the scope of practice differs from that in Arkansas. This mismatch added to the disconnect between the training content and the local context of the audience. While MOUDs were briefly covered, the information lacked proper sourcing, and the alignment between the content and referenced materials was unclear.

Training Implementation Summary

Training Positives

- The training demonstrated excellent use of presentation slides and visual aids.
- The presentation offered a very holistic view of opioid use disorder.

Needs Improvement

- Using content specific to Arkansas and accurate data collection methods, for instance CDC Wonder data would provide better audience engagement.

Table 2. MOUD Training Evaluation Rubric Answers

The training provided a holistic view of opioid use disorder

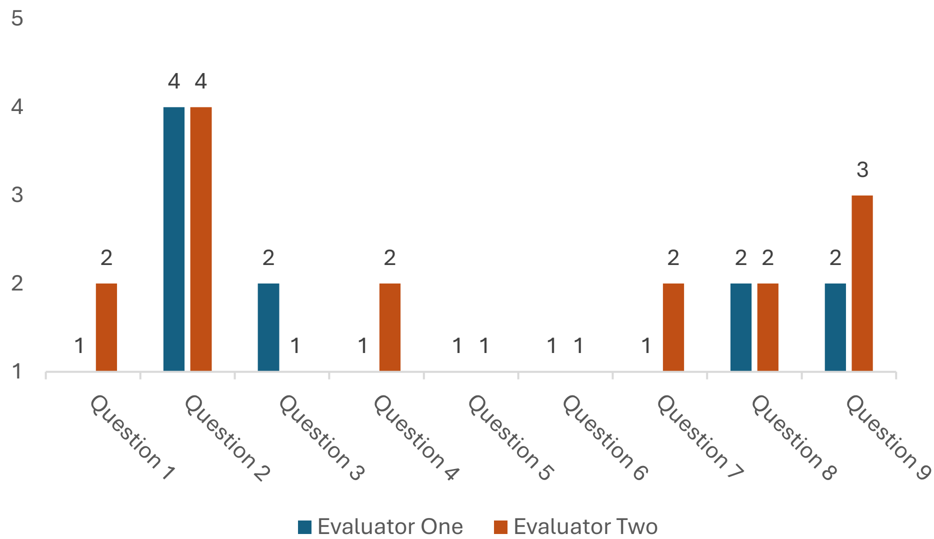
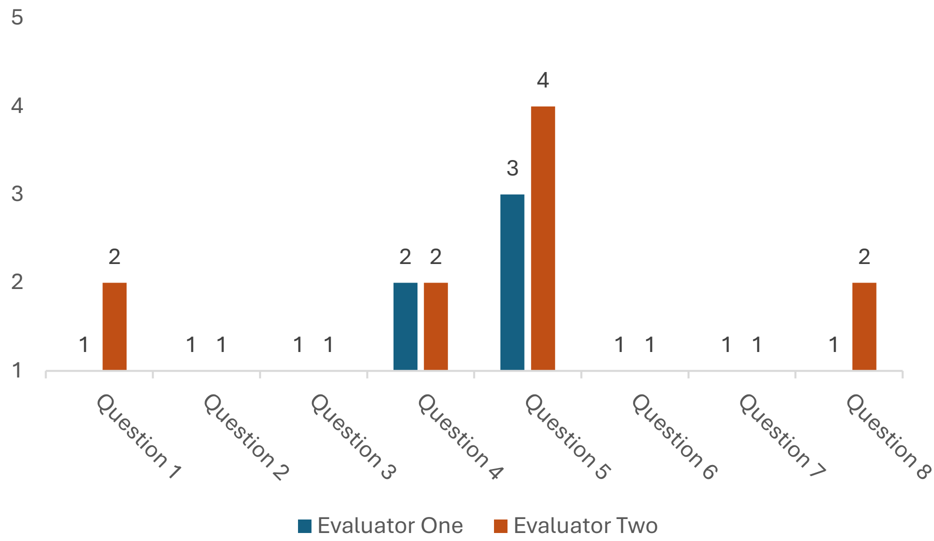


Table 3. Zoom-Centric MOUD Training Evaluation Rubric Answers

The training consistently presents a multi-dimensional view of opioid treatment



Training Assessment Summaries

American Society of Addiction Medicine (ASAM) Training Observation
May 23, 2025 (Pilot)

Strengths	Needs Improvement	Recommendations
Expert-level presentation by instructor with consistent use of ASAM terminology	Key clinical components (risk rankings, OUD pharmacotherapy, level-of-care justification) not fully demonstrated	Use pre-event surveys to align content with participants' roles and knowledge levels
Comprehensive overview of updated ASAM criteria and Medicaid 11-15 integration	Content assumed high baseline knowledge; limited practical, hands-on examples	Extend training to two full days to allow for interactive activities and knowledge checks
Emphasis on holistic, integrated care and cultural competency	Limited participant engagement; training leaned toward discussion rather than interactive learning	Incorporate case studies, role-plays, and culturally responsive practice demonstrations
Highlighted new billable requirement: weekly patient assessments	Missed opportunities to model patient-centered approaches	Provide practical tools for implementing cultural humility and individualized treatment planning
Clear explanation of regulatory implications and compliance support	Training content misaligned at times with audience needs	Develop tailored modules for different professional roles within the care system
		Facilitate statewide knowledge-sharing and encourage adoption of standardized EMR systems for coordinated community care

Medication for Opioid Use Disorder (MOUD) Training Observation
August 19, 2025

Strengths	Needs Improvement	Recommendations
Training intended to provide an evidence-based overview of MOUD, opioid epidemic, and practical approaches	Session began without proper introduction, creating confusion and awkwardness	Begin with a clear agenda, objectives, and introductions to set expectations
	Explanation of opioids was overly complex, poorly framed, and used insensitive language (“love of opioids”)	Use sensitive, patient-centered language and frame concepts in accessible terms
Use of national datasets (CDC Wonder, ICD-10 codes) to present overdose trends	Graphs and statistics were poorly cited; data sources and coding decisions *ICD-10) not explained; relevance to Arkansas unclear	Provide clear citations, explain coding choices, and tailor data to Arkansas-specific trends
Coverage of long-term overdose mortality data and race-based trends	Data interpretation issues: lack of clarity on CDC coding changes (2018), race category transitions, and jurisdictional variations in reporting	Include data caveats; contextualize methodological changes; explain implications for interpreting racial and temporal trends
Social determinants of health were marginally addressed	Content would have benefited from greater depth and precision, as some portions left participants uncertain	Incorporate vetted, evidence-based resources; ensure trainers are prepared to address structural/political determinants meaningfully
	Mismatch between trainer’s Minnesota scope of practice and Arkansas content	Select trainers with local expertise or pair outside trainers with Arkansas-based co-facilitators
MOUDs were briefly discussed	Content lacked depth, clarity, and proper sourcing; unclear alignment with referenced materials	Expand MOUD discussion with clearly sourced evidence; provide Arkansas-specific policies, regulations, and case examples
	Overall, training might have been more effective with greater focus, stronger contextual relevance, and clearer delivery.	Conduct pre-event needs assessments to align content with audience expectations and local context

Recommendations

To strengthen future training sessions, the following recommendations are offered:

1. **Improve Session Design and Engagement**
    - Begin with clear objectives, agendas, and expected outcomes.
    - Incorporate interactive elements such as case studies, role-play, or knowledge checks to reinforce learning.
    - Extend training duration when covering complex material, ensuring time for application and participant questions.
2. **Enhance Content Relevance to Arkansas**
    - Use state-specific data, policies, and examples to increase applicability.
    - Pair national experts with local practitioners to ensure contextual alignment.
    - Provide practical tools, templates, or scenarios that participants can implement directly in their work.
3. **Ensure Accuracy and Transparency**
    - Clearly cite all data sources and explain methodological choices, particularly for mortality and billing data.
    - Present technical information in plain language, avoiding jargon or insensitive phrasing.
    - Incorporate structured approaches to cultural humility, equity, and patient-centered care.
4. **Strengthen Trainer Preparation**
    - Conduct pre-event needs assessments or surveys to better understand participant roles, knowledge levels, and expectations.
    - Provide orientation for trainers on Arkansas-specific regulatory frameworks and cultural considerations.
    - Align trainer expertise with the clinical and policy context of the intended audience.

5. **Foster Ongoing Coordination and Knowledge Sharing**

    - Encourage participant collaboration through shared decision-making activities.
    - Support statewide efforts toward standardized tools (e.g., EMR templates, care coordination frameworks) to enhance consistency.

Appendix A

Training Evaluation Rubric One

Mission Statement:
To improve the quality and impact of ASAM training by implementing a continuous quality improvement approach that strengthens participant outcomes and enhances training effectiveness.

Goals and Objectives:
Overall Goal: Improve participant knowledge and improve training efficiency related to opioid use and misuse.

Goal 1: Increase the total number of scores from emerging and competent to proficient and expert by September 29, 2025.

Goal 2: Decrease the total number of scores of not demonstrated or emerging by September 29, 2025

Observation Notes

ASAM Training Observation Checklist

Observer Name: ________________________

Trainer/Instructor Name: _______________________

Observation Date: ______________________

Setting: ☐ In-Person Training ☐ Online Training over Zoom

Observation Criteria	1 Not Demonstrated	2 Emerging	3 Competent	4 Proficient	5 Expert	Comments / Examples
Identifies/applies appropriate ASAM Level of Care based on multidimensional assessment	☐	☐	☐	☐	☐	
Assigns risk ratings (0–4) based on patient data per dimension	☐	☐	☐	☐	☐	
Uses standardized ASAM terminology consistently	☐	☐	☐	☐	☐	
Integrates OUD pharmacotherapy options (e.g., buprenorphine, methadone, naltrexone)	☐	☐	☐	☐	☐	
Demonstrates individualized treatment planning linked to ASAM dimensions	☐	☐	☐	☐	☐	
Considers psychosocial needs and co-occurring conditions in planning	☐	☐	☐	☐	☐	
Engages clients in shared decision-making about treatment, including medications	☐	☐	☐	☐	☐	

Adapts care plans responsively to clinical changes (e.g., withdrawal, adherence)	☐	☐	☐	☐	☐	
Links treatment interventions to specific ASAM dimensions and client priorities	☐	☐	☐	☐	☐	
Clearly justifies level-of-care decisions in documentation or verbal case reviews	☐	☐	☐	☐	☐	
Demonstrates awareness of safe prescribing practices and overdose risk	☐	☐	☐	☐	☐	
Emphasizes integration of psychosocial support and behavioral treatment	☐	☐	☐	☐	☐	

Appendix B

Training Evaluation Rubric Two

Mission Statement:
To improve the quality and impact of SOR-related training by implementing a continuous quality improvement approach that strengthens participant outcomes and enhances training effectiveness.

Goals and Objectives:
Overall Goal: Improve participant knowledge and improve training efficiency related to opioid use and misuse.

Goal 1: Increase the total number of scores from emerging and competent to proficient and expert by September 29, 2025.

Goal 2: Decrease the total number of scores of not demonstrated or emerging by September 29, 2025

Observation Notes

Virtual Training Observation Checklist

Observer Name: ___________________________

Trainer/Instructor Name: __________________________

Observation Date: _________________________

Setting: ☐ In-Person Training ☐ Online Training over Zoom

Observation Criteria	1 Not Demonstrated	2 Emerging	3 Competent	4 Proficient	5 Expert	Comments / Examples
Identifies/applies appropriate assessment based on training	☐	☐	☐	☐	☐	
Assigns risk ratings (0–4) based on patient data per dimension	☐	☐	☐	☐	☐	
Uses standardized terminology consistently	☐	☐	☐	☐	☐	
Discusses appropriate OUD pharmacotherapy options (e.g., buprenorphine, methadone, naltrexone)	☐	☐	☐	☐	☐	
Considers psychosocial needs and co-occurring conditions in planning	☐	☐	☐	☐	☐	
Engages clients in shared decision-making about treatment, including medications	☐	☐	☐	☐	☐	
Discusses care plans responsively to clinical changes (e.g., withdrawal, adherence)	☐	☐	☐	☐	☐	

Links treatment interventions to specific dimensions and client priorities	☐	☐	☐	☐	☐	
Clearly justifies level-of-care decisions in documentation or verbal case reviews	☐	☐	☐	☐	☐	
Demonstrates awareness of safe prescribing practices and overdose risk	☐	☐	☐	☐	☐	
Emphasizes integration of psychosocial support and behavioral treatment	☐	☐	☐	☐	☐	
Virtual Trainings						
Course is organized	☐	☐	☐	☐	☐	
Plan adheres to training topic	☐	☐	☐	☐	☐	
Encourages audience participation	☐	☐	☐	☐	☐	
Delivery is effective	☐	☐	☐	☐	☐	
Trainer technically proficient with Zoom	☐	☐	☐	☐	☐	
Content is relevant and clear	☐	☐	☐	☐	☐	
Trainer implements engaging learning activities	☐	☐	☐	☐	☐	
Trainer uses appropriate tools for training and engagement	☐	☐	☐	☐	☐	

SOR 4
Program Recommendations

Prevention

To further strengthen the effectiveness and reach of statewide prevention initiatives, the following recommendations are offered:

The Arkansas Department of Higher Education

- We recommend that (ADHE) expand its outreach and technical assistance efforts to increase institutional participation in the collegiate prevention and recovery program. Early communication of application timelines, informational webinars, and individualized proposal support would likely result in a greater number of high-quality submissions.
- In addition, we recommend ADHE incorporate structured peer-to-peer networking opportunities among funded campuses and adopting a standardized evaluation framework. This structured approach will enhance sustainability and allow for consistent measurement of outcomes across institutions.

End Overdose™

- We recommend that **End Overdose™** refine its training delivery models by integrating preferred instructional approaches, such as hands-on and gamified learning, into both online and in-person formats.
- In addition, we recommend **End Overdose™** expands outreach to rural communities, increases educational content on stimulant and emerging drug overdoses, and strengthens partnerships with housing providers to address gaps in service.

MidSOUTH SOR-P (Agreement 2)

- We recommend **MidSOUTH SOR-P** prioritize the development of targeted educational materials and training modules on lesser-known substances identified in provider surveys, including GHB, U-47700, synthetic cathinones, carfentanyl, and xylazine.
- In addition, we recommend **MidSOUTH SOR-P** incorporate interactive, scenario-based training approaches to better prepare providers for real-world challenges.

Treatment

To further strengthen the impact and sustainability of Arkansas's treatment programs, several key recommendations are proposed:

Arkansas Community Corrections (ACC)

- We recommend that **ACC** strengthen retention by expanding individualized case management, addressing scheduling barriers, and diversifying group content.
- In addition, we recommend pursuing stronger community linkages and adding compliance incentives post-release to support long-term recovery.

Family Centered Treatment–Recovery (FCT-R)

- We recommend that **FCT-R** enhance provider capacity-building and ongoing technical support. Developing a structured follow-up process after Readiness Assessments will help track and resolve gaps more effectively.
- In addition, we recommend broader engagement of community partners, including child welfare agencies, primary care providers, and peer support organizations to enhance adoption and integration of family-centered approaches.

MidSOUTH SOR-T (Agreement 4)

- We recommend that **MidSOUTH SOR-T** build on its strong training infrastructure, prioritizing increasing access for rural and underserved providers by offering more hybrid and asynchronous options. Expanding training content to include emerging treatment modalities, stigma reduction, and culturally responsive practices would further strengthen provider capacity.
- In addition, we recommend establishing mechanisms to evaluate how training is translated into practice will help demonstrate impact beyond participation metrics.

River Valley Medical Wellness (RVMW)

- We recommend that **River Valley Medical Wellness (RVMW)** integrate structured aftercare in its youth program, expand mobile health services for women, and collect long-term maternal and infant health outcomes to guide improvements.

UAMS MATRIARC/Project ECHO

- We recommend that **UAMS MATRIARC/Project ECHO** continue expanding rural access, encourage more case presentations, and add content on methamphetamine and dual diagnosis.

- We also recommend evaluating the impact of methadone services and Concrete Support to strengthen accountability.

Recovery

To enhance the effectiveness and long-term sustainability of Arkansas's recovery programs, the following key recommendations are offered:

Arkansas Alliance for Recovery Residences (AARR)

- We recommend that **AARR** expand outreach to additional recovery homes, provide structured mentorship for new residences, and implement periodic refresher trainings to maintain compliance with NARR standards and enhance sustainability.

Arkansas Administrative Office of the Courts (AOC)

- We recommend that **AOC** continue tracking outcomes for peer-supported individuals, incorporate enhanced relapse prevention strategies, and expand peer support services to reach underserved populations and younger participants.

Arkansas Alliance of Recovery-Centered Organizations (AARCO)

- We recommend that **Arkansas Alliance of Recovery-Centered Organizations (AARCO)** strengthen collaboration among RCOs, increase peer service capacity, and implement standardized reporting to better measure program impact and sustained recovery outcomes.

CHESS Health

- We recommend that **CHESS Health** increase user engagement through targeted onboarding strategies, expand monitoring of Companion App usage for family support, and integrate additional content addressing high-risk substances such as methamphetamine.

National Association for Alcoholism and Drug Abuse Counselors

- We recommend that **NAADAC** continue facilitating national certification for Peer Workers, enhance ongoing professional development opportunities, and monitor certification success rates to ensure uniform quality and effectiveness of peer services across the state.

Appendix A – Acronyms\Abbreviations

Acronym	Definition
AARR	Arkansas Alliance of Recovery Residence
AARCO	Arkansas Alliance for Recovery Centered Organization
ACC	Arkansas Community Corrections
ADHE	Arkansas Department of Higher Education
AOC	Arkansas Administrative Office of the Courts
CAC	Central Arkansas Community Corrections Center
DHS	Arkansas Department of Human Services
ECAC	East Central Arkansas Community Corrections Center
FCT-R	Family Centered Treatment Foundation-Recovery
GPRA	Government Performance and Results Act
MAT	Medication-Assisted Treatment
MATRIARC	UAMS MAT Recovery Initiative for Arkansas Rural Communities
NAADAC	National Association for Alcoholism and Drug Abuse Counselors, Inc.
NWAC	Northwest Arkansas Community Corrections Center
OUD	Opioid Use Disorder
PDO	Prescription Drug/Opioid Overdose
PRSS	Peer Recovery Support Specialists
REDCap®	Research Electronic Data Capture
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response
STR	State Targeted Response
SWAC	Southwest Arkansas Community Correction Center
UAMS	University of Arkansas for Medical Services
RVMW	River Valley Medical Wellness

Appendix B – SOR 4 Logic Model