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Recovering from Substance Abuse in Arkansas: The Accessibility and Affordability of Drug Treatment Programs

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Journalism

by

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Arkansas State University
Bachelor of Science in Communications, 2018

May 2021
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This thesis is approved for recommendation to the Graduate Council.

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Abstract

This thesis is going to examine how people recover from drug addiction and see if there are any similarities due to their socioeconomic statuses at the time of recovery. This research addresses the following questions: How accessible and affordable are drug addiction recovery programs and rehabilitation facilities in Arkansas for mid- to low-income individuals? What are the social costs for people who can't obtain drug rehabilitation services? The goal of this research is to explore whether there is a lack of affordable recovery programs in the state of Arkansas. This project utilizes survey responses as well as in-depth interviews with participants who remain anonymous. This study found that people with insurance often have "first-pick" when it comes to getting into rehabilitation programs and when the person does not have insurance, the costs can be about $1000 a day. This study also uncovered that some people that require low-cost or free drug rehabilitation resources, do not know that they exist.

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Introduction

This study examines the accessibility and affordability of drug abuse recovery programs for mid- to low-income individuals in the state of Arkansas. It is estimated that the average cost of an in-patient drug rehabilitation program is $42,700, $10 more than the average Arkansan makes in an entire year, and $18,400 more than a family of four below the poverty line earns each year. In Arkansas, the poverty rate is estimated to be 16.8%, or 1 in every 5.95 people, making Arkansas the sixth highest poverty-stricken state in the United States and Washington D.C. (Walkenhorst, E., 2020).

At the same time, there is great need for drug rehabilitation services in the state. According to the National Surveys on Drug Use and Health: Model-Based Estimated Totals (2018-2019), an estimated 73,000 Arkansans have used illicit drugs (other than marijuana) in the last month (p.12). This study will examine the underlying causes behind drug addiction, socioeconomic statuses of individuals addicted to drugs, as well as the costs associated with traditional drug treatments programs. Individuals and rehabilitation treatment centers were interviewed and later reviewed, compared and visualized on the website that accompanies this project.

One key finding is drug rehabilitation services, when they can be accessed, tend to be provided to people with some form of health insurance. While speaking to two representatives from two different drug treatment facilities, I was told that people with insurance are always “first-pick” when it comes to getting a room in a facility and people that want to go to an inpatient program that do not have insurance, “programs can range, with a detox… low-end, $12,500, but on average, about $25,000-$30,000 for 30 days. Basically $1,000 a day,” said

Andrew, an intake specialist at a national treatment center (Andrew, personal communication, March 11, 2021).

This project is aimed at exploring whether there is a need for more affordable options for people who are addicted to drugs in the state of Arkansas. This project also examines what happens to individuals after they attend drug treatment programs or after they are unable to attend a drug treatment program.

Background on Drug and Mental Health Treatment

"The issue of loss of control of the substance, heralding today's concept of addiction, was already being discussed in the 17th century" Croque, M., MD, p.355). Though drugs had been used for many years before the concept of addiction, treatment was not popularized until around 1750 in the United States and it was for alcohol abuse (Talchekar, A., 2020). During the late 1800s "Inadequate clinical technologies, exposes of ethical abuses in the field's clinical and business practices, economic depressions, and the larger stigmatization, demedicalization and criminalization of alcohol and other drug problems led to the virtual collapse of America's first era of addiction treatment" (White, W., 2002, p.1087). The 19th century was also the time period where wealth determined where you were treated. Poorer people were sent to "foul wards" which were in public hospitals, while wealthier addicts sought treatment in more discrete locations (White, W., 1998). In the early 20th century, drug clinics were opened by public health or police departments and they all closed due the federal government threatening to criminally charge these facilities after that treatment disappeared for almost everyone, except the more elite population (White, W., 1998).

In the 1950s through the 1970s a concept called "deinstitutionalization" began. People in mental health facilities, largely in public hospitals were moved to local facilities, in part due to

immense cost (Foley, H., & Sharfstein, S., 1983). This process seemed like a success because the number of hospitalizations decreased (Foley, H., & Sharfstein, S., 1983). However, there were some significant problems that came as a result of deinstitutionalization. These community mental health facilities had more rules to follow and major gaps in their services (Foley, H., & Sharfstein, S., 1983). These community centers also received less money because domestic spending was re-evaluated in the 1970s and the Nixon Administration wanted community based mental health to be stopped altogether (Foley, H., & Sharfstein, S., 1983 & Koyanagi, C., 2007).

Another movement for treatment was also rising during the mid-20th century. Alcoholics Anonymous, started in 1935 and gained national popularity by the early 1940s (Alcoholics Anonymous, 2021). This program type differs from its predecessors for several reasons, it is voluntary and free. Alcoholics Anonymous (A.A) was the birthplace for other therapy-based treatment such as Narcotics Anonymous, which was started in 1950s, by people who had attended A.A. meetings in the past (Narcotics Anonymous Eastern Area of Ireland, 2021).

The Hazelden Betty Ford Foundation also played a large role in the modern treatment of alcoholism and drug abuse. Since its inception in 1949, the Hazelden Betty Ford Foundation implemented A. A's 12-step program, modeled sober-living homes, published self-help books, specialized care for women, integrated psychology into treatment, family therapy, outpatient services, specialized care for teenagers, medication-assisted recovery, and genetic research (Hazelden Betty Ford Foundation, 2021). More genetic research on addiction has taken place in recent years. The National Institute on Drug Abuse (2019) says "Genes influence the numbers and types of receptors in peoples' brains, how quickly their bodies metabolize drugs, and how well they respond to different medications. Learning more about the genetic, epigenetic, and neurobiological bases of addiction will eventually advance the science of addiction" (p.4).

Some people that have undiagnosed mental health issues may misuse substances to cope with their underlying condition (MentalHealth.gov, 2019). When someone is using drugs and needs mental health treatment, both issues must be treated; health professionals must address the drug problem and the mental health disorder separately, or therapy may not be successful (MentalHealth.gov, 2019). About half of the people who experience a substance abuse disorder will also experience a mental disorder during their lives (National Institute of Mental Health, 2021).

In Arkansas, about 46.5% of people suffering from mental illness attend treatment centers (SAMHSA, 2015). The way mental health services are provided in Arkansas are like drug treatment facilities because insurance is involved. Mental health treatment in Arkansas has several types of facilities: public (which are provided by The Arkansas Department of Human Services), Medicaid-eligible facilities, and paid facilities (Gateway to Mental Health Services, 2021). Insurance plays a large role in whether people gain access to mental health treatment programs as well as rehabilitation programs.

We must also consider the demographics of the population of Arkansas. In Arkansas, there are about 30,000 people that are Native American alone (United States Census Bureau, 2019). People that are mixed race and have some native ancestry can also be eligible. If you factor in people that marked 2 or more races, which have the potential of having native heritage, the number of people that potentially have native descent in Arkansas over 96,000 people (United States Census Bureau, 2019). Through the federally recognized Indian Health Services (IHS) program, people of Native American or Native Alaskan descent can get free health care at an (IHS) approved facility (Indian Health Service, 2021). There are currently no IHS approved

facilities in the state of Arkansas, while there are about 50 in the border state of Oklahoma (Indian Health Service, 2021).

Background on Drug Use and Abuse

For thousands of years, people have been addicted to substances, which the United States government now classifies as illegal drugs. Drugs range from legal substances such as caffeine, alcohol and nicotine, to illegal substances such as heroin and methamphetamines.

Dating back to 3400 B.C.E. in Mesopotamia, Sumerians began using the "Hul Gil" or the "joy plant," more commonly known as opium (Public Broadcast System, 1998). The Sumerians passed this plant to the Assyrians, who passed it to the Babylonians, who passed it to the Egyptians (PBS, 1998). Around 1300 B.C.E, the opium plant made its way onto the trade route, which included The Phoenicians, The Minoans, The Greeks and all over Europe (PBS, 1998).

The documented modern history of what we now describe as illegal drug use and abuse in America has been recorded since the early nineteenth century. The popular forms and types of drugs have evolved since this time. The most popular drug of the 1800's was opium, which was prescribed frequently and most commonly taken by mouth, it's cheaper counterpart, morphine, is an opiate in another form with the ability to be injected (Musto, D.., 1999, p.1). These opium prescriptions were also very popular with doctors because it decreases gut motility, which was beneficial to people with dysentery and cholera, which was extremely present in nineteenth century America (Courtwright, D.T., 1982.) Around the turn of the century (1900), patents were unregulated, and companies were scrambling to stay ahead; the content of opiates was likely the highest in medicinal history; with no requirement that opiates be identified on patented medicines until 1906, It wasn't until 1915 that any restrictions were placed on opium, besides a tariff, which was nominal (Musto, D., 1999, p.2).

Another drug that was not new but gained popularity in the late nineteenth century was cocaine. The raw form of cocaine, the coca plant, had been chewed by Inca peoples for an estimated 5000 years (Van Dyke, C., Byck, R., 1982, p. 128-130). In the nineteenth century, America, cocaine was being ingested orally and topically, made popular by Sigmund Freud, as a cure for a multitude of illnesses. “Accordingly, I should say that the use of coca is definitely indicated in cases of atonic digestive weakness and the so-called nervous stomach disorders; in such cases it is possible to achieve not merely a relief of the symptoms but a lasting improvement” (Freud, S., 1884, p.214). Freud (1884) also mentions the use of coca to “cure” someone of sudden withdrawal of morphine, “There was no sign of depression or nausea as long as the effects of coca lasted...the patient was not bedridden and could function normally...the treatment of morphine addiction with coca does not, therefore, result merely in the exchange of one kind of addiction for another” (p.215).

Before the 20th century, there were no federal regulations on substances. The Pure Food and Drug Act of 1906 was the first piece of federal legislation passed (Institute of Medicine, 1992). The next phase of drug regulation in America was The Harrison Narcotic Act of 1914, which defined the properties of narcotics and “It required anyone who sold or distributed narcotics—importers, manufacturers, wholesale and retail druggists, and physicians—to register with the government and to pay a small tax” (Institute of Medicine, 1992, p.9).

The Rise of Drug Use in Modern America

Another rise in illegal drug use began in America in the 1950s and 1960s. After military drug testing had taken place “It was only a matter of time before the intensive testing of LSD by the military in the 1950s and early 1960s—as part of the CIA’s “

, 2000). Several different types of drugs became popular during this time. The American Chemical Society (2000) says “The demand for sedatives was profound, and the drug marketplace responded rapidly. Although Miltown (meprobamate), the first of the major “tranks,” was called the Wonder Drug of 1954, sedatives weren’t widely used until 1961, when Librium (a benzodiazepine) was discovered and marketed as a treatment for tension. Librium proved a phenomenal success. Then Valium (diazepam), discovered in 1960, was marketed by Roche Laboratory in 1963 and rapidly became the most prescribed drug in history.” There were even multiple generations utilizing different types of drugs during this time “While the youth of America were smoking joints and tripping on acid, their parents’ generation of businessmen and housewives were downing an unprecedented number of sedatives” (American Chemical Society, 2000).

Heroin use was the main focus of lawmakers in the 1960s and 1970s. “According to the admissions records of treatment programs monitored by New York State drug officials, heroin was the primary drug of 92% of those treated for addiction in 1970, peaked at 95% in 1972, then slid to 46% by 1978” (Gardiner, S., 2009). People were gaining access to this drug via international channels and by the late 1970s, heroin use was declining, but arrests and felonies for possessing or selling heroin rose (Gardiner, S., 2009).

In the 1970s, politics and President Nixon focused on the “War on Drugs,” passing the Controlled Substances Act, which made some substances (some plants, drugs, & chemical substances controlled by federal jurisdiction. (Sacco, L., 2014, p.5). This legislation is what started drug scheduling (mentioned above) that ranks drugs based on their addiction likelihood, how dangerous they are & if they have legitimate medical use (Sacco, L., 2014, p.6). President Nixon also founded the Drug Enforcement Administration (DEA) in 1973, which would enforce

the Controlled Substances Act of 1970 exclusively (Sacco, L., 2014, p.6). The "War on Drugs" had several major flaws. First, this effort focused on criminalization, rather than health-based initiatives (Leadership Conference and Education Fund, 2019). The Leadership Conference and Education Fund (2019) also states "The criminalization of drug use in the U.S. has led to tragic consequences and mass incarceration, with a disproportionate impact on lower-income and minority communities."

Fast forward to the 1980s in America, and a new "drug epidemic" is arising. The United States General Accounting Office (1991) says "the socioeconomic characteristics of crack users are unclear, (p.16). The typical crack user changed throughout the 1980s. According to the United States General Accounting Office (1991), the National 1-800-COCAINE hotline, which is operated by a New Jersey Hospital, callers changed significantly (p.16). In 1983, more of the callers to the hotline were white males, employed, in 1985, the callers were broader, and the hotline workers speculated that this is because new forms of cocaine (crack) were cheaper (United States General Accounting Office, 1991, p.17). In 1987, the majority were unemployed and only 16 percent were college educated, the hotline works believed this was because crack use had moved to inner cities, and in 1989, people that were college-educated that called in rose while the unemployed rate remained the majority; the hotline workers believed this shift happened because crack had become more popular in the suburbs (United States General Accounting Office, 1991, p.17). Fischer, B., & Coghlan, M. (2007) explains that "crack use is one of the largest and most destructive pieces in the overall picture of our cities' illicit drug problem, and is likely going to be around for some time" (p.1340).

Specifics of the Study

This study focuses on illegal substances, drugs that are banned under federal law. These illegal or "street" substances were partially identified using "schedules." Schedule 1 consist of drugs that have "High abuse potential with no accepted medical use; medications within this schedule may not be prescribed, dispensed, or administered" ranging from heroin to ecstasy. Schedule 2 consists of drugs having "high abuse potential with severe psychological or physical dependence; however, these medications have an accepted medical use and may be prescribed, dispensed, or administered" such as morphine, codeine, methadone & oxycodone (Gabay, M., 2013). Schedule 3 consists of drugs that have "intermediate abuse potential (i.e., less than Schedule II but more than Schedule IV medications)" such as hydrocodone or anabolic steroids (Gabay, M., 2013). This study will focus on people with a myriad of substance abuse issues, not just people who use marijuana or alcohol exclusively.

When an individual is addicted to an illegal substance, quitting or stopping the drug use can be difficult (NIDA, 2020). The National Institute on Drug Abuse (2020) says that when someone stops using a drug, common symptoms include sickness, urge to use again, and fear. There are several popular or common ways people stop drug use, including: in-patient rehabilitation (long-term & short-term residential treatment), day treatments or partial hospitalization, out-patient rehabilitation, N.A. (Narcotics Anonymous), sober living communities (commonly known as halfway houses), individualized drug counseling, group counseling, and more (NIDA, 2020.).

While recovering from drug addiction is difficult, the above-mentioned recovery methods have been successful for people in the past. According to Joseph A. Califano, a former Secretary of the U.S. Health, Education and Welfare Department, in-patient and out-patient treatments

have a success rate of about 30% (Califano, J., & American Addiction Centers, 2020). The other 70% to 80% have dropped out of treatment between the three- and six-month mark (Califano, J., & American Addiction Centers, 2020).

The Reason Behind Addiction in America

The larger question is why? Why do Americans develop drug addictions? Does financial standing have anything to do with addiction?

To examine this further, I am considering environmental factors that could play a non-linear role in the development of a drug addiction. Let's consider the socioeconomic status of people and their children. According to NIDA (2020) there are risk factors that can make a person more likely to use drugs. Some of these risk factors are: Lack of parental supervision and community poverty (NIDA, 2020). According to Chalk, R. A., & Phillips, D. A. (1996) "These conditions include the decline in economic security for poor and middle-class families, the increase in the number of single-parent households, and the rise in the number of neighborhoods with concentrated poverty that are spatially and socially isolated from middle-and working-class areas" (p.9). While these risk factors do not guarantee that someone will end up addicted to drugs, there is a higher chance of children & people in poverty being exposed to more of these risk factors than those who do not live in impoverished neighborhoods.

Why are the risk factors more likely to occur to someone living in a poorer neighborhood than a wealthier neighborhood? There are factors that discourage drug use, such as parental monitoring and support and neighborhood resources (NIDA, 2020.) To explain a possibility of why poorer communities are more susceptible to these risk factors, we must examine the social disorganization theory, developed by the Shaw & McKay at the Chicago School. The social disorganization theory is defined as "the breakdown or disruption of community social

organization resulting from low economic status, ethnic heterogeneity and residential mobility" (Moriarty, L., 1992, p.230). The social disorganization theory was developed by scholars to explain that crime happens as a result of weakened social relationships (Moriarty, L., 1992). There are certain points that are pivotal in the social disorganization theory: "1) Humans are a product of their environment 2) Cultural values govern behavior 3) Communities are characterized by many cultural values 4) As different cultural values compete, traditional values break down 5) Deviant behavior results when one acts in disregard to the dominant cultural values 6) Deviant behavior, delinquency, and crime are more prevalent in inner cities" (Moriarty, L., 1992, p.231). This theory summarizes that communities that are more socially disorganized tend to have higher crime rates and unstable social environments, which can lead to people being exposed to more risk factors.

People in poverty are, in fact, more likely to have a substance abuse issue than people with higher incomes, but they are not necessarily related (Foundations Recovery Network, 2021). Rather, "substance abuse is more of a byproduct of the lifestyle led by people of limited financial means" (Foundations Recovery Network, 2021). People in poverty are not guaranteed to have a substance abuse issue, but they are more likely to be exposed to risk factors that may lead to a drug addiction.

St. Joseph Institute for Addiction (2018) says there are several reasons people in poverty are more likely to have a drug abuse problem, "worrying about how to afford shelter, food, and other basic needs causes a tremendous amount of stress. When you're struggling to make ends meet, there is a great temptation to turn to drugs or alcohol to temporarily escape from your problems." Further, St. Joseph Institute for Addiction (2018) says feelings of hopelessness,

decreased self-esteem, decreased social support and no access to healthcare are elevated in low-income households.

While drug use may not be more prevalent in low-income communities, the cessation of using illegal substances may be related to the accessibility and affordability of healthcare. According to Majerol, Tolbert & Damico (2016) “Low-income households allocate limited resources to competing necessities”. “The majority of spending among low-income households is devoted to housing, food, and transportation...spending even small amounts on health care can crowd out other necessities or require low-income families to go further into debt” (Majerol, M., et. al., 2016). With limited or no income to spend on healthcare, people with lower incomes have less access to medical assistance than those with higher incomes. This limited amount of money for healthcare could be a reason why people turn to drugs or are unable to stop using after an addiction has formed.

Affordability and Insurance

The cost of recovery methods is a barrier for many individuals. Most recovery methods have some cost associated with them, ranging from lodging, medical care, medication, therapy to transportation. For many drug-addicted people, working or keeping a job is difficult, and in some cases, impossible. For others, even when they are working, they fall below the national poverty line and have extremely limited income set aside for medical purposes. Considering this, the cost associated with recovering excludes a portion of people that may want and need to recover from drug abuse and addiction. “The inability to afford rehab is the number one reason why addicts who need and want help didn’t receive treatment at a specialty facility” (OneCare Media, 2019 & SAMHSA, 2013). The data in this set was collected at a national level between the years of 2010-2013. According to SAMHSA (2015), the percentage of people that did not receive

treatment for illicit drugs (who were dependent on drugs) was 78.5% from 2007- 2014 (SAMHSA, 2015, p.17).

OneCare Media (2019) and their brand help.org estimate the cost of rehabilitation as follows: Outpatient: $3,000- $10,000 for 90 days, Inpatient: $5,000- $20,000 for 30 days and Luxury: $30,000-$100,000 for 30 days. According to the Arkansas Occupational Employment and Wage Survey (2020), the average middle-class Arkansas citizen makes $42,690 per year (p. 9). According to American Addiction Centers (2020), the “Most addicted individuals need at least three months in treatment to get sober and initiate a plan for continued recovery. Research shows that the best outcomes occur with longer durations of treatment.” If we take the average cost from OneCare Media’s estimations (2019) for inpatient treatment, this puts the cost for a three month stay at $37,500, only $5,190 less than the average yearly median income. According to the Arkansas State Epidemiological Outcomes Workgroup (2017), Arkansas was the 3rd lowest in the United States for household income in 2017 (p.18).

According to the results from the 2013 National Survey on Drug Use and Health: Summary of National Findings (2013), “Among adults aged 18 or older, the rate of current illicit drug use was higher for those who were unemployed (18.2%) than for those who were employed full time (9.1%), employed part time (13.7%), or "other" (6.6%)” (p. 28). This would put the number of Arkansas residents who are using illicit drugs that are also unemployed at approximately 21,165 people by using the estimates of the Executive Office of the President of the United States (2013).

In Arkansas, the poverty rate is estimated to be 17.4% (Kaiser Family Foundation, 2020). This makes Arkansas the 6th highest poverty-stricken state in the United States, including Washington D.C. (Walkenhorst, E., 2020). The poverty line in Arkansas is an income under

$11,880 for one person, and under $24, 300 for a four-person household (Arkansas Legal Services Online, 2021). If we then use the same calculation for rehabilitation as above, $37,500 for a three month stay, the Arkansan in poverty is making $13,200 less than the cost of a 90-day stay in rehabilitation per year (OneCare Media, 2019 & SAMHSA 2013).

Some may argue that people who can support a drug habit, can support the cost of treatment, but the two are not equal. The Council of Economic Advisors (2019) says, "to put this in perspective, a person on Medicare would only pay $9.78 per gram, or between $1,785 and $3,570 per year (in 2007 dollars), to fund an opioid addiction in the same year" (p.6). Using the above-mentioned figures, we can estimate that a three month stay in rehabilitation would be $33,930 more expensive than funding an opioid addiction for an entire year (OneCare Media, 2019 & SAMHSA 2013). "Expansions in insurance coverage that reduce out-of-pocket prices can make misused prescription opioids more affordable, consumed either by the patients for whom they are prescribed or when supplied via the secondary market" (The Council of Economic Advisors, 2019, p.6).

Further, the price stated for treatment plans does not cover any medications associated with the treatment. For example, opiate addicts usually require long-term medication, such as methadone and buprenorphine, to control the body's reaction to detoxing. According to OneCare Media (2019), these medicines are usually taken over the period of one year and the cost associated with one year or medicine is up to $5,200. Not only are addicts paying up to $37,500 on the treatment facility, but they are also paying up to $5,200 for medication to aid in their treatment. That puts the cost of treatment at $42,700, $10 more than the average Arkansan makes in an entire year, and $18,400 more than a family of four below the poverty line earns each year.

Drug Abuse in Arkansas

According to the National Surveys on Drug Use and Health: Model-Based Estimated Totals (2018-2019), an estimated 73,000 Arkansans have used illicit drugs (other than marijuana) in the last month (p.12). The Substance Abuse and Mental Health Services Administration estimates that in 2008-2010, there were 40,200 Arkansans using illicit drugs, other than marijuana, in the past month (SAMHSA, 2012).

By using the statistics provided through SAMHSA and National Surveys on Drug Use and Health, the amount of people in Arkansas that have used illicit drugs in the last month, other than marijuana, has increased from an estimated 40,200 people, to 73,000 people. Some of the difference is because newer methamphetamine items were not included on the older estimates, therefore, it is impossible to give an accurate representation of the drug climate prior to 2010 in Arkansas, but with the data we do have, there has been a significant increase.

There have been several attempts to discuss the reason for drug addiction, in modern times, we have seen an increased dependency on opiates. Today, "The first wave of the opioid crisis has previously been attributed to the pharmaceutical industry's marketing efforts, which downplayed the risks of opioid use disorder, and to changes in physicians' prescribing norms, which encouraged the prescription of opioids for pain management. Both factors were likely important, although their roles have yet to be quantified (The Council of Economic Advisors (CEA), 2019, p.1). "The CEA (examines an additional factor that, in the setting of manufacturer over promotion and changing prescribing norms, may also have played a role: falling out-of-pocket prices for prescription opioids. Out-of-pocket prices for prescription opioids declined by an estimated 81% between 2001 and 2010" (The Council of Economic Advisors, 2019, p.1). Experts say falling out-of-pocket prices effectively reduced the price of opioid use not only in

the primary market but also in the secondary (black) market for diverted opioids, from which most people who misuse prescription opioids obtain their drugs (The Council of Economic Advisors, 2019, p.1).

The American Opioid Crisis swept the nation in the late 1990s. Since then, over 760,000 people have died from a drug overdose, and in 2018, two-thirds of those overdose deaths involved an opioid (U.S. Department of Health and Human Services, 2021). Opioids are characterized as "substances that work in the nervous system of the body or in specific receptors in the brain to reduce the intensity of pain" (Centers for Disease Control & Prevention, 2020).

Part of the increase we see in the estimates of drug users in Arkansas may be due to the opioid crisis. "In 2018, Arkansas providers wrote 93.5 opioid prescriptions for every 100 persons compared to the average U.S. rate of 51.4 prescriptions" (Centers for Disease Control and Prevention. U.S. Opioid Prescribing Rate Maps, (2019). Opioid prescription dispensing rates in Arkansas are the 2nd highest in the nation, only less than Alabama. From 2006- present, Arkansas has remained one of the highest opioid prescription dispensing rates in the country (U.S. State Opioid Dispensing Rates, 2006-2018.) The rate of which opioids have been prescribed and dispensed in Arkansas has been declining in recent years, but rates are still very high compared to other states (U.S. State Opioid Dispensing Rates, 2006-2018.) According to Brown (2017) "a new study shows the Arkansas prescription drug problem is so serious there are enough pills on the street for each of Arkansas' almost 3 million citizens to have a full bottle".

Since 1999, the number of opioid-related deaths in Arkansas has steadily increased. In 2017, there were 188 deaths in Arkansas involving opioids, this includes prescribed medication and illicit substances (National Institute on Drug Abuse, 2019). There have been years that the

opioid deaths have spiked and fallen, including 2008-2010 & 2015, but there was an increase from 2016-2017 (National Institute on Drug Abuse, 2019).

Mental Health in Arkansas

According to the National Institute on Drug Abuse (2020), “Many individuals who develop substance use disorders (SUD) are also diagnosed with mental disorders, and vice versa. Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.” In Arkansas, the percentage of serious mental illnesses in adults who live in Arkansas has remained higher than the national average since 2010 (SAMHSA, 2015). According to SAMHSA (2015), “about 115,000 adults ages 18 or older (5.2% of all adults) per year in 2013-2014 has SMI (serious mental illness) within the year prior to being surveyed. The percentage did not change significantly from 2010-2011 to 2013-2014” (p.10).

From 2010-2014, the annual average of Arkansans who did not receive mental health treatment or counseling was 53.5% (SAMHSA, 2015, p.11). Another study is needed to determine the factors that lead to over half of the people with mental health concerns to not receive treatment in 2015. Unemployment or financial concerns may be a contributing factor to people not receiving mental health care. In 2014, unemployed adults who received treatment in the Public Mental Health System in Arkansas made up 47.4% of the served population (SAMHSA, 2015, p.12). Only 20.2% of the adults served in the Public Mental Health System in Arkansas were employed and the other 32.4% of the population was not in the labor force (SAMHSA, 2015, p.12).

In the last century, the amount of public psychiatric facility beds available have diminished, “The result has been a transfer from the old psychiatric hospitals to prisons and the

streets of a population suffering not only from severe mental disorders, but also from substance abuse, poverty and, at times, despair" (Messias, E. 2014). Arkansas has the third lowest ratio of public psychiatric beds to the population in the nation with the national average being 11.2 beds per 100,000 people and Arkansas' average being around 5.2 beds per 100,000 people; in some areas, such as Fort Smith, the number of psychiatric beds per 100,000 people is even lower, at about 3.2 (Messias, E. 2014). "The short-term effects of our shortages are long wait times to get care, untreated conditions yielding co-occurring disorders like alcohol and drug use (sometimes used as self-medications) and use of emergency rooms as stop-gap measures" (Messias, E. 2014).

"People with mental disorders are at much higher risk of descending into poverty than other people" (Funk, M., Drew, N., Knapp, M., 2012, p.9.) "Other chronic diseases can also lead to poverty, but in the case of mental illness there is the additional challenge of stigma and discrimination, and their additional negative impacts which further increase the risk of illness, relapse and poverty" (Funk, M., et. al. 2012, p.9). With inadequate public psychiatric care in Arkansas, people may turn to illegal substances when their condition could be managed with proper treatment and medication (Messias, E. 2014).

Research Methods

This research study seeks to investigate the relationship between socioeconomic status and the accessibility and affordability of drug recovery programs in the state of Arkansas, the cost of attending each facility in the state of Arkansas, the accessibility and affordability of drug addiction recovery programs and rehabilitation facilities in Arkansas for a mid to low-income individual, and the social costs for people who can't obtain rehabilitation services for their

addictions. This project will present a publicly facing site, to be distributed through the Razorback Reporter and the School of Journalism's website for journalism coursework.

While this study is primarily a qualitative study, there will be several quantitative aspects that are utilized to develop a clearer picture of common ideas and statistical information. The success and failure will be determined by a general survey of rehabilitation.

The other quantitative portion of this study will consist of a survey and it will be available from 11/1/2020 to 12/10/2020. The target population for this survey are people that have had or currently have drug abuse problems in Arkansas. The target population has also been to or wants to attend some type of rehabilitation center or program in Arkansas. These individuals will be recruited largely from rehabilitation centers (in-patient and out-patient), groups like N.A (narcotics anonymous) or religious-based organizations. Directors of facilities and programs will be contacted initially, and asked for references to people that fit the criteria for this study. Institutional Review Board approval from the University of Arkansas was obtained before this study was conducted. Per the Institutional Review Board's recommendations, all participants were given pseudonyms to remain anonymous.

Research Questions

1. What is the relationship between a person's socioeconomic status and their ability to gain access and afford drug recovery programs in the state of Arkansas?
2. How accessible and affordable are drug addiction recovery programs and rehabilitation facilities in Arkansas for mid- to low-income individuals? Are rehabilitation facilities in Arkansas designed only for mid- to high-income individuals?

3. What are the social costs for people who can't obtain drug rehabilitation services? Do a large portion wind up homeless or in prison? Do they lose their jobs and require public assistance?

The survey will consist of several types of questions, including yes/no or true/false, Likert scale and multiple choice. Online survey forms will be distributed by email to potential participants. The participants of the survey will undergo a screening survey that will only advance if the participant answers the screening questions with the qualifying correct answers. If someone answers screening questions with an answer that disqualifies them, the survey will stop, and the person will be informed that they are not eligible to participate in the research. If the individual answers these questions with the correct qualifying responses, the survey will automatically advance to these body questions. The survey will consist of these screening questions: See screening questions in Appendix 1.

If the individual answers these questions with the correct qualifying responses, the survey will automatically advance to the survey's body questions: See survey's body questions in Appendix 1.

The highlighted answers (shown in Appendix 1) will be the answers that must be chosen in order to participate in the survey. The people who will participate in the individual interviews will be chosen from the participants who are eligible for this survey.

The number of participants of this survey will not be limited, with a goal of 150 participants. This goal was determined with a 17% response rate expected and a goal or 7 participants in in-depth interviews.

This study also consisted of virtual or in-person interviews. The interviews were conducted from late February 2021 to mid-March 2021. The participants were selected for the individual interviews by using the responses to the above survey.

Participants were also actively recruited by making connections with recovery program leaders and asking for suggestions. The participants were screened by socioeconomic status. This screening was entirely self-reported and asked for data that correlates to the time of their individual addiction and recovery. An average of the data will be calculated, this number will be used for this study's purposes. An approximately even amount of people from each social class will be sought out. There will be 7 participants from each socioeconomic standing (low, middle, high). The interviews will be semi-structured. The questions will be closed and open-ended and the recorded interviews will last approximately 30 minutes.

These methods have been chosen because of the nature of the study. This study heavily relies on qualitative research because recovery is different for each person, which requires individualized analysis. This study also heavily relies on perception and opinions.

Drug addiction and recovery is an unbelievably sensitive and difficult topic to discuss, and one-on-one interviews are the best option for this case. Individual interviews allowed for the interviewer (Whitney King) and the participants to build some rapport before the interviews and the virtual focus group.

Interview Questions for Individuals

1. Can you tell me about your drug of choice? What was the method of ingestion?
2. Can you expand more on why you began to abuse substances?
3. Can you talk about your stay at a rehabilitation facility or lack thereof? Why didn't you go to rehabilitation?

4. Was the cost the largest reason why you didn't go to rehabilitation? (This question will only be asked to individuals who reported not going to drug rehabilitation.)
5. Why couldn't you attend a low-cost or free facility? Did you attempt to attend a low-cost or free facility?
6. Can you describe your care at the facility?
7. Ultimately, how did you recover from your addiction? How long have you been sober?
8. Did you have multiple stays or treatment plans? Why? Why didn't it work the first time?
9. Is there anything else about this topic that you would like to mention?

During the interviews, these questions were used as a framework. Some further questions were asked to specific individuals that had unique circumstances and other questions were omitted to participants that did not fit the criteria for those questions.

Interview Questions for Rehabilitation Facilities

1. How long have you been in business?
2. What types of addictions do you treat here?
3. Do you accept all individuals or is it a case-by-case basis?
4. What types of programs do you offer here? Can you explain the differences of each?
5. Which program is best? Worst?
6. What is the average stay for an individual doing in-patient treatment?
7. How long does an outpatient treatment program usually last?
8. What is the cost associated with these treatment programs? Is insurance collected? What if someone doesn't have insurance?
9. Will people be turned away if they cannot pay?
10. What are the success/failure rates of treatment?

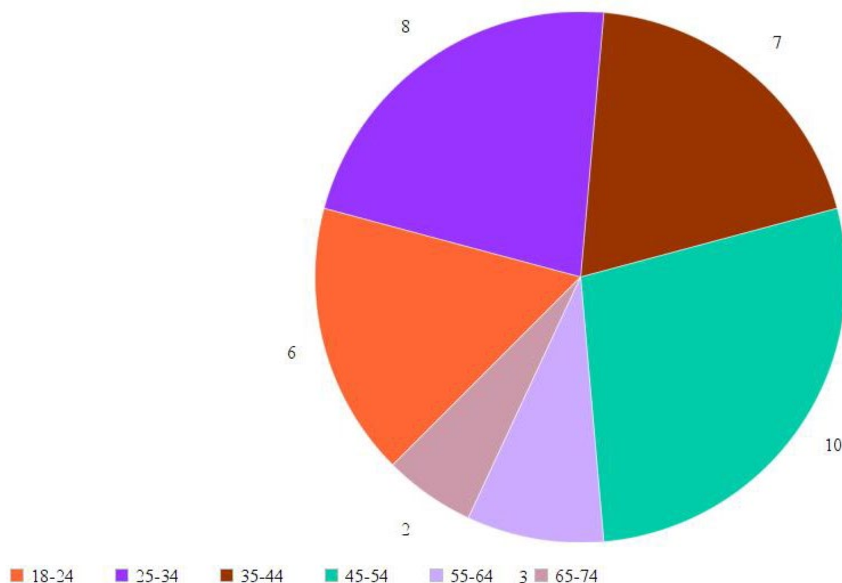
11. Do you believe there are enough low-income or free treatment centers in your area?
12. Do you accept public assistance? Why or why not?

During the interviews, these questions were used as a framework. Some further questions were asked that were specific to their job titles. (Ex. for profit rehabilitation workers vs. non-profit rehabilitation workers.)

Demographics of the Survey Participants

Thirty-nine participants either completed or partially completed the survey portion of this study. The partially completed survey responses were used in the full sample only if they answered a specific question. For example, if a participant did not answer question 30, that lack of response was not used in the calculation for that question, if they did answer question 25, their response was included in the calculation of percentages for that question. The partially completed survey respondents generally skipped questions that required a written response or exited the survey and did not complete the remainder of the questions. Of the 39 participants, 36 of them reported that they were white or Caucasian. This study was conducted in Northwest Arkansas, where the population is approximately 72% white or Caucasian (United States Census Bureau, 2019). Considering the population of the area, the percentage of white participants in the survey was anticipated.

Number of Participants By Age



N=39

FIGURE 1.1- NUMBER OF PARTICIPANTS BY AGE

Seventeen of the participants were male and 16 of the participants were female, the other 6 participants declined to answer that question. Lastly, seven participants did not disclose their income during their addiction, 10 participants reported having no income during their addiction, and the other income reports ranged from $8,000 per year to $70,000 per year.

Twenty-four participants reported having been to a rehabilitation facility and 9 reported not attending a rehabilitation facility. The reported substances that were abused included: Methamphetamine or other amphetamines (27 participants), cocaine (18 participants), non-prescription opioids (16 participants), hallucinogens (10 participants), inhalants (8 participants), heroin (7 participants), crack (4 participants), prescription opioids (4 participants), salvia (3 participants), mdma (3 participants), prescription stimulants (2 participants), ketamine (1 participant), bath salts (1 participant), p.c.p. (1 participant), benzos/valium (1 participant),

barbiturates (1 participant), methaqualone(1 participant), cough medicine (1 participant) and kratom (1 participant).

Findings

There were 32 participants who were asked about why they began using illegal substances. Approximately 31% of the participants reported that they began using drugs because of peer pressure. There were 9% of users that reported they began to use drugs due to chronic pain or mental health issues and almost 19% reported using drugs due to curiosity or fun. Another 12.5% of participants reported they began to use drugs because of stress, and nearly 19% reported using drugs because of parental or family influence. Participants could select more than one option on this question; therefore, someone could have attributed their first usage to more than one factor.

There were 31 participants that answered the question about illegal drug use, and they could select more than one rehabilitation type, therefore one person may have gone to several different forms of treatment. Participants were asked about what types of rehabilitation treatments they attended. Approximately 52% of participants reported attending an inpatient program, while 26% of participants reported attending an outpatient treatment program. Approximately 16% of participants reported living in a sober community and nearly 42% reported attending Narcotics Anonymous or like programs. Almost 10% of the respondents reported going to drug court and nearly 13% reported going to day treatment or partial hospitalization. Lastly, approximately 16% of the respondents said they did not attend any type of rehabilitation.

Further, 31 participants were asked if the rehabilitation programs they attended were successful. Approximately 39% reported that rehabilitation program(s) were successful for them,

while approximately 45 % reported that rehabilitation was not successful & approximately 16% said some rehabilitation programs were not successful, while others were. Participants were not allowed to select more than one answer choice.

A total of 26 participants reported the number of times that they attended a rehabilitation facility. Half of the participants (50%) reported going to rehabilitation one time. Nearly 27% reported going to rehabilitation two times, just over 19% reported going to rehabilitation between 3-5 times and approximately 4% reported going to a rehabilitation between 5-7 times.

There were 29 respondents who responded to a question about cost associated with their rehabilitation programs, and 62% said they had “no cost or insurance paid” for their treatment from private insurance, Medicare or Medicaid and 14% of respondents were unsure of how much they paid. Another 24% said they paid between $1,600 to $20,000 for their rehabilitation programs.

Five participants reported leaving or not attending a drug rehabilitation treatment program due to cost issues. The survey showed 21% said they were uninsured and 60% of respondents said they might have stopped using drugs sooner if rehabilitation facilities were less expensive. Another 37% of participants said they were unaware of low cost or free resources available for people struggling with addiction.

Approximately 72% of respondents reported being unemployed for a length of time during their addiction or recovery, about 53% respondents reported being homeless at some point during their addiction or recovery and about 63% respondents reported being incarcerated at some point during their addiction or recovery. Thirty participants answered the survey questions pertaining to homelessness, unemployment and incarceration.

Interviews

I conducted interviews with seven individuals that have either been addicted to illegal substances or are currently addicted to illegal substances. To keep the participants anonymous, their legal names are not going to be used. Pseudonyms have been assigned for each person. First, the most common trend that arose was the importance of finances during recovery. Four of those interviewed mentioned the high cost associated with drug treatment. Angela, who had Medicaid at the time, went to a rehabilitation treatment that was paid for through her insurance. However, she claimed that there were a lot of other costs that were not covered by insurance, while she was unable to estimate how much she paid out of pocket, she did say it was substantial. "I think if it [rehabilitation] was more accessible to everybody who... didn't have to worry about what they were charging and all that I think that people might be more prone to going" said Angela (Angela, personal communication, March 8, 2021.).

There was only one person of the seven people interviewed who said the costs associated with treatment were not an issue, and coincidentally, this person was not in a low-income bracket.

Second, four participants said they did not want to associate with Narcotics Anonymous due to lack of comfort with members of this group. Some also mentioned a social stigma associated with attending Narcotics Anonymous meetings. "I didn't like N.A [narcotics anonymous] because you know I- you know I didn't want to be around druggies" said Angela (Angela, personal communication, March 8, 2021.) There was only one respondent that reported feeling comfortable with going to Narcotics Anonymous or Cocaine Anonymous. "I kinda got this gist of, you know, people trying to change their lives" said Aaron, "that really helped me kinda get the understanding that it's just normal people like me just trying to change their lives"

(Aaron, personal communication, March 12, 2021.) Further, four out of the seven reported attending A.A. because the structure and environment was better suited for their needs. One participant said she felt uncomfortable with Alcoholics Anonymous because she was much younger than a lot of the participants and she felt like she was being judged by other members of the group. Marilyn said she was about 18 years of age when attended Alcoholics Anonymous and felt uncomfortable since other members were compelled to attend due to a court order. Marilyn, by contrast, said she attended the sessions voluntarily (Marilyn, personal communication, March 11, 2021.)

Third, six participants reported having mental health problems that contributed to their subsequent illegal drug use. Dakota said he had issues with mental health as a young person "later on found out in life that I had borderline personality disorder," (Dakota, personal communication, March 8, 2021.) Dakota was also diagnosed with a brain tumor, which altered the part of his brain that controls emotions. One participant reported having mental health issues after using drugs changed their life circumstances. "I just couldn't live with myself. I'd go up to his [father's] grave with a gun, drunk, and I'd put it [the gun] in my mouth and [I] just didn't have the guts to pull the trigger," said Frank (Frank, personal communication, February 24, 2021). More than one of the participants mentioned suicide and self-harm that accompanied their addictions.

Lastly, two respondents said they didn't reach out for additional help because they thought they would be a burden to others. "The main factor[s] was just money and feeling like there was a correct person, a correct person to reach out to without disappointing anyone or putting an extra burden on someone else, like my parents," said Steve (Steve, personal communication, March 11, 2021). The social costs of not being able to attend a rehabilitation

facility extend further than criminal costs, for some, it can strain personal relationships, leaving those affected by drug abuse feeling alone. “I did reach out, I tried, I asked family for help, I reached out and I have some friends that really care about me, I have a friend who’s a counselor, she got her master’s degree in counseling and she you know kept me alive on a day-to-day basis, you know, for a long time, but that wasn’t her responsibility. Eventually I felt like a burden to her and to other people,” said Dakota (Dakota, personal communication, March 8, 2021).

Institutional Interviews

To further answer some of my research questions, I interviewed two people that work for institutions that treat drug addiction. They are also referred to under a pseudonym for the purposes of anonymity.

The first was Andrew, someone who works for a national company that treats drug addiction. For people that want to go to an inpatient program that do not have insurance, “programs can range, with a detox, um low-end, $12,500, but on average, about $25,000-$30,000 for 30 days. Basically $1,000 a day,” said Andrew (Andrew, personal communication, March 11, 2021). It is also possible to finance your stay at rehabilitation, Andrew compared it to buying a $30,000 car. However, if you have bad credit, you will get denied, just like in the case of buying a car or a house. Andrew says that family members finance it if the patient cannot get approved.

Andrew is a treatment advisor, he points people in the right direction for treatment which depends on several factors. This company is a “for-profit” company, meaning they charge patients for treatment. Their treatment programs come in several different forms, including a Traditional 12 step, which usually involves a higher power, a self-management and recovery training regimen and cognitive behavior therapy. Andrew said people are assigned to different

programs based on their history with drug abuse and their current circumstances. Andrew also mentioned that there are 2 phases of rehabilitation, the first is a detox, and the second is the residential portion. All of the treatment programs that the company Andrew works for offers are inpatient. Andrew said that treatments can last anywhere from 30-90 days and the duration is set by the counselor that is assigned to each patient. The only outpatient care that is offered is after someone completes an inpatient stay, the outpatient comes with check-ins, which will cease after 90 days.

Andrew was asked to describe the differences between people that call for help who have insurance vs. Medicaid/Medicare vs. no insurance. “We’ve got to qualify them for insurance, see if they’re, you know, covered, and then match them up with a facility where they are covered,” said Andrew (Andrew, personal communication, March 11, 2021). He said people with insurance will be analyzed and given the treatment that best suits their needs. Andrew said insurance usually covers 100% of the cost to go to rehabilitation. If the insurance doesn’t cover everything, people can do payments on the remaining balance. With “Medicaid and Medicare, you have to use the state funded programs that accept those insurance. And they basically only have the one modality of 12-Step. There’s usually a waiting list, things like that. It’s more of a revolving door, get them in, get them out...tell them to go to a meeting.” The facility also has a free program for people that do not have insurance. They are usually ministry-based or the Salvation Army.

Andrew was asked if there are enough low cost or free resources available for people or if there is a demand for more. “No, definitely a demand for more. I can fill up 12 facilities a day just from phone calls I get,” he said (Andrew, personal communication, March 11, 2021).

After speaking with someone at a different institution, more information about how people are cared for based on their ability to pay was revealed. This institution is geared towards

people that do not have the income and insurance to pay for traditional rehabilitation treatment. Their care for drug rehabilitation is solely out-patient, but it is free for everyone. Paula helps people get into in-patient treatment at other facilities. She explained that people with insurance are always “first-pick” when it comes to getting a room in a facility. Further, she explained that even the types of insurance will determine whether someone gets admitted. This means that if there is no availability in Arkansas, and the individual has state insurance, they will be put on a waiting list, rather than sent to a facility that has the room. She further explained that people with insurance will be taken before others that are on Medicaid, even if the person with Medicaid was on the list first. Therefore, people that have been waiting to get into a facility with Medicaid can be skipped if someone gets on the list and has better insurance. Lastly, if you do not have any type of insurance, you will remain on the list until all other people with private insurance, state insurance & Medicaid have been assisted, regardless of the order you were placed on the list. Paula even went so far as to say that people on the list that do not have insurance will not get placed because they cannot pay. Paula’s facility sees a lot of this because some of the people they help have a criminal background. People with criminal backgrounds can have a hard time finding jobs and homes, which makes it nearly impossible to apply for Medicaid or insurance because they have no mailing address.

Conclusion

The purpose of this study was to examine the relationship between a person's socioeconomic status and their ability to gain access and afford drug recovery programs in the state of Arkansas. Through my research, I have found that having insurance is the key to gaining access to rehabilitation facilities in Arkansas. Paula, an intake specialist from a drug rehabilitation center, explained that people with insurance are always "first-pick" when it comes to getting a room in a facility. Even then, the quality of the insurance can determine what type of care you receive. Andrew, an advisor from a national rehabilitation institution that operates in Arkansas, said private insurance gives you the ability to choose from different treatment programs, whereas state insurance provides limited options and does not cover lengthy treatments. He said Medicaid or Medicare insurance holders were considered a "revolving door, get them in and get them out" (Andrew, personal communication, March 11, 2021). In Arkansas, there are over 240,000 people without insurance (Kaiser Family Foundation, 2020). Only 41.9% of people in the state of Arkansas have employer-sponsored (private) insurance, the other 58.1% have Medicare, Medicaid, CHIP, Nongroup, Military or no insurance at all (Kaiser Family Foundation, 2020. This puts the number of people without private insurance in Arkansas at 1,173,344 people by using the U.S. Census Bureau (2019) numbers. In Arkansas, there is a 17.4% poverty rate, translating into over 525,000 residents living below the poverty line.

The survey and interviews showed the availability of private insurance played a critical role in access to rehabilitation treatment. This links availability of rehabilitation care to employment, since private insurance typically is supplied through the private employer. All insurance plans are different. Some private insurance covers drug rehabilitation treatment but it is not guaranteed that there will be no cost to the patient. Some insurance companies will pay for

a certain amount of time, while others may only pay for certain types of services. A key finding from the survey and limited interviews is the unemployed, unless they are covered by Medicare or Medicaid, are excluded from obtaining drug rehabilitation services.

Andrew, an intake specialist at a national treatment center, also said that the cost of treatment is about $1,000 a day for those without insurance, (Andrew, personal communication, March 11, 2021). Rehabilitation can also be financed, but only if you have an adequate credit history. This means that people without insurance and good standing credit must pay everything out of pocket.

Andrew and Paula both talked about "wait lists." Which refers to lists that people are placed on if they wish to attend treatment, but there is no space at the time. Paula mentioned it took up to three months to get a spot in a facility, and if someone has insurance gets on the waiting list after someone who doesn't, they are automatically accepted before the person that has no insurance.

Through my individual interviews, four out of the seven mentioned that cost was a factor in their decision. One participant also said if programs were less expensive, people would be more willing to go. Another participant mentioned that she had believed that all rehabilitation centers were costly. Through this study, I have found that some people do not inquire about rehabilitation because they believe it is out of their financial means. I interviewed one person that would be considered medium- to high-income, and he did not mention cost at all. About 16% of the survey participants said they left or did not attend drug rehabilitation treatment because of cost issues. Again, the survey showed 21% said they were uninsured and 60% of respondents said they might have stopped using drugs sooner if rehabilitation facilities were less expensive.

Lastly, 37% of survey participants said they were unaware of low cost or free resources available for people struggling with addiction.

There are several social costs associated with people who don’t attend drug rehabilitation centers. The majority of the survey participants were unemployed, homeless and incarcerated at some point during their addiction and recovery. Several respondents believed they were burdens to friends and family and therefore isolated themselves. Some respondents thought going to drug treatment was “weird” and the social stigma around treatment deterred them from getting help. From the survey participants, 72% or 21 of 29 respondents reported being unemployed for a length of time during their addiction or recovery, percent? Over 53% of the respondents reported being homeless at some point during their addiction or recovery and over 63% of respondents reported being incarcerated at some point during their addiction or recovery. This survey suggests there are significant social costs associated with failure to obtain drug rehabilitation services. On the contrary, there are social benefits for people that attend a drug treatment program. They are with people that understand their circumstances, they are treated physically, emotionally & spiritually to heal from their addictions, and they are in stable environments.

There were limitations to this survey. This sample size is small compared to the number of people that fit into the research criteria in the state, therefore we cannot make general claims based on the size of this survey pool. This study is one of few of its kind, and it was able to provide a starting point for other studies on this subject. This type of study is important to understand the access to drug treatment services in the state of Arkansas and more studies like this one are important for future understanding. Every person’s story is different, and the only way to understand the system and improve it, is by researching individuals that have experienced the system.

There are several things that contribute to people not being able to attend rehabilitation. Whether it's the cost of the programs, the lack of resources, the lack of knowledge or the social stigmas associated with drug use, this study has identified common ideas believed by people who have wanted or received drug rehabilitation treatment. Mental health played a large role in the participants of this survey and general unaffordability of treatment was also a huge contributing factor. What we can hope for in the future is a breaking down of the stigmas associated with drug use and better programming for people who need help and do not have private insurance.

The people that are suffering from a broken public health system are those that are poor, uninsured and in need of help. These findings show the dire need of affordable resources that are needed in the state of Arkansas. Many people end up homeless, incarcerated & without help due to the immense cost associated with drug treatment rehabilitation and mental health treatment. Many turn to self-medicating to deal with mental disorders or other life stressors that could be remedied by treatment that they cannot afford. Historically, the poor have been looked over by healthcare and mental health facilities. The way people get help is by paying, and if one cannot pay, they are not helped. The system is based on greed and it is broken. The heartbreaking truth is that people with higher incomes have more accessibility to healthcare and those with lower incomes are refused treatment because they cannot pay. Tragically, the people in low-income brackets recognize that they have little options for treatment and do nothing about their addictions or mental health issues because they know they cannot afford the costs.

This research is not solely about how different people recover, it is to show that for many, there are not opportunities to do so. People that have private insurance and good credit have access to more treatment options and literally "jump the line" in terms of getting placed in facilities, while people with no insurance and bad credit get skipped.

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Appendix

Appendix 1

Screening Questions:

1. Have you had or do you currently have an illegal drug abuse problem?
    a. Yes*/No
2. Have you tried to stop using, wanted to stop using, or have you stopped using illegal substances?
    a. Yes*/No
3. When you were or if are seeking out recovery programs, was or is it in the state of Arkansas?
    a. Yes*/No
4. Is your illegal drug abuse current? - Question for stats on sampling pool.
    a. Yes/No
5. Were you or are you in a recovery program? - Question for stats on sampling pool
    a. Yes/No
6. What is or was your income during your addiction and recovery? - Question for stats on sampling pool

The sampling questions determine eligibility for the survey. The answer choices marked with an "*" had to be chosen for the participant to be eligible to participate.

Survey Body Questions for Participants:

1. What is your sex?
    a. Female
    b. Male
    c. Other: _______

2. What is your current age?
    a. Under 18
    b. 18-24
    c. 25-34
    d. 35-44
    e. 45-54
    f. 55-64
    g. 65-74
    h. 75+

*If “A” is selected, thank, exit to close

3. What is your race or ethnicity?
    a. White/Caucasian
    b. Black/African American
    c. Hispanic/Latino
    d. Native American
    e. Asian
4. What types of substances have you or do you abuse?
   *multiple selections allowed
    a. Crack
    b. Cocaine
    c. Methamphetamines
    d. Hallucinogens (LSD or alike)
    e. Heroin
    f. Inhalants
    g. Ketamine
    h. MDMA (ecstasy or molly)
    i. PCP
    j. Prescription Opioids (your own only)
    k. Non-Prescription Opioids (not your own/bought/secondhand)
    l. Prescription Stimulants
    m. Salvia
    n. Synthetic Cathinone (Bath Salts)
    o. Other _____________

5. When was the most recent date of drug use?
    a. fill in the blank

6. Do you believe you have a drug addiction?
    a. Yes
    b. No
    c. I don’t know

7. How long have you been using drugs? (Total time if more than one period).
    a. Less than 1 year
    b. 1-3 years
    c. 3-5 years
    d. 5-10 years
    e. 10-20 years
    f. 20+ years

8. Why did you start using drugs?
    a. Open-ended question 250-character limit

9. Have you wanted to stop, but felt like you couldn't? Why?
    a. Open-ended question 250-character limit

10. Have you ever attended a rehabilitation program of some kind? If so, describe the type of care?
    *Multiple selections allowed
    a. Yes- Inpatient
    b. Yes- Outpatient
    c. Yes- Day treatment or partial hospitalization
    d. Yes- N.A. (Narcotics Anonymous or alike)
    e. Yes- Sober Living Community
    f. No
    g. Other-

11. How many times have you been to a rehabilitation program?
    a. 0
    b. 1
    c. 2
    d. 3-5
    e. 5-7
    f. 7+

12. Was a rehabilitation program successful for you? (Did you stop using drugs for more than 3 months after release?)
    a. Yes
    b. No
    c. Multiple attempts- Some were, some were not

13. How long did you participate in each rehabilitation program? If there were multiple rehabilitation stays, select each answer that is applicable to at least one stay.

* Multiple selections allowed
    a. 30 days
    b. 60 days
    c. 90 days
    d. over 90 days

14. Do you consider yourself still addicted, recovering or recovered?
    a. Still addicted
    b. Recovering
    c. Recovered

15. How much money did you have to pay for your rehabilitation program?
    a. Fill in the blank

16. Did you leave or not attend a rehabilitation program because of cost issues?
    a. Yes
    b. No

17. How would you describe the level of care you received at your rehabilitation facility? 1= terrible, 10= great
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5
    f. 6
    g. 7
    h. 8
    i. 9
    j. 10

18. Do or did you have medical insurance during your addiction and recovery?
    a. Yes- private insurance
    b. Yes-Medicare or Medicaid
    c. No- couldn't afford
    d. No- didn't want it

19. Do you believe you would have been clean sooner if rehabilitation facilities were less expensive?
    a. Yes
    b. No
    c. I'm not sure
    d. Still not clean

20. Were you employed during your addiction?
    a. Yes
    b. No
    c. Sometimes

21. Did you have any other source of income?
    a. Yes
    b. No
    c. Other _______________

22. Are or were you aware of low-cost or free resources available for people struggling with addiction?
    a. Yes
    b. No

23. Were you homeless at any point during your addiction or recovery?
    a. Yes- 30 days or less
    b. Yes- 1-3 months
    c. Yes- 3-6 months
    d. Yes- 6-12 months
    e. Yes- 12 months +
    f. No

24. Were you in jail or prison at any time during your addiction or recovery?
    a. Yes- 30 days or less
    b. Yes- 1-3 months
    c. Yes- 3-6 months
    d. Yes- 6-12 months
    e. Yes- 12 months +
    f. No

25. Were you on public assistance at any time during your addiction or recovery?
    a. Yes- 30 days or less
    b. Yes- 1-3 months
    c. Yes- 3-6 months
    d. Yes- 6-12 months
    e. Yes- 12 months +
    f. No

26. Were you unemployed at any time during your addiction or recovery?
    a. Yes- 30 days or less
    b. Yes- 1-3 months
    c. Yes- 3-6 months
    d. Yes- 6-12 months
    e. Yes- 12 months +
    f. No

27. Do or did you have a support system during your addiction or recovery? (For example, a family member, a friend, or a mentor?)
    a. Yes
    b. No
    c. Part of the time
28. What is or was YOUR annual income at the time of your addiction and recovery?
    a. $0
    b. Under $12,000
    c. $12,000-$25,000
    d. $25,000-$42,000
    e. $42,000-$75,000
    f. $75,000-$100,000
    g. $100,000+

29. Are you willing to participate in a follow up interview?
    a. Yes
    b. No
    c. Maybe

*If no, thank you, exit to close.

30. What is your first name, last name, and phone number for a follow-up interview?
    a. Fill in the blanks

Appendix 2

Institutional Review Board Approval Letter:

To:	Whitney A King BELL 4188
From:	Douglas J Adams, Chair IRB Full Board
Date:	02/16/2021
Action:	**Approval**
Action Date:	02/16/2021
Protocol #:	2010294734
Study Title:	Recovering from Substance Abuse in Arkansas The Accessibility and Affordability of Drug Treatment Programs
Expiration Date:	02/15/2022
Last Approval Date:	
Risk Level:	

The above-referenced protocol has been approved following Full Board Review by the IRB Committee that oversees research with human subjects.

If the research involves collaboration with another institution then the research cannot commence until the Committee receives written notification of approval from the collaborating institution's IRB.

It is the Principal Investigator's responsibility to obtain review and continued approval before the expiration date.

Protocols are approved for a maximum period of one year. You may not continue any research activity beyond the expiration date without Committee approval. Please submit continuation requests early enough to allow sufficient time for review. Failure to receive approval for continuation before the expiration date will result in the automatic suspension of the approval of this protocol. Information collected following suspension is unapproved research and cannot be reported or published as research data. If you do not wish continued approval, please notify the Committee of the study closure.

Adverse Events: Any serious or unexpected adverse event must be reported to the IRB Committee within 48 hours. All other adverse events should be reported within 10 working days.

Amendments: If you wish to change any aspect of this study, such as the procedures, the consent forms, study personnel, or number of participants, please submit an amendment to the IRB. All changes must be approved by the IRB Committee before they can be initiated.

You must maintain a research file for at least 3 years after completion of the study. This file should include all correspondence with the IRB Committee, original signed consent forms, and study data.

cc: Rob Wells, Investigator

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