HEALTHY MINDS POLICY INITIATIVE

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Access to medications for opioid use disorder in Oklahoma

Exploring the evidence for MOUD, barriers to care for Oklahomans, and possible policy solutions

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1 | Introduction

Decades of research and positive clinical outcomes have established medications for opioid use disorder (MOUD) as the gold standard for treating opioid use disorder, but many Oklahomans who need this treatment face significant hurdles in accessing it.

In Oklahoma, about 2% of adults, or more than 67,000 people, have opioid use disorder, higher than the national average of 1.4%, according to 2024–2025 data from the National Survey on Drug Use and Health. Nationally, only about one in five adults with opioid use disorder received medication-based treatment, the front-line approach.[1]

Approved medications for opioid use disorder — including formulations of methadone, buprenorphine, and naltrexone — have been proven effective, but systemic and structural barriers keep Oklahomans from accessing care. MOUD is associated with improved treatment and recovery outcomes, and it is credited with reductions in overdose and other opioid-related deaths, infectious disease transmission, and avoidable involvement with the criminal legal system.[2]

In this analysis, we offer the most complete look to date at the state of treatment for opioid use disorder (OUD) in Oklahoma. We explore the evidence for MOUD as the standard of care, examine the state's treatment network and regulatory landscape, and highlight barriers that limit access to MOUD and impact treatment outcomes.

Finally, we offer recommendations for Oklahoma policymakers and state agency leaders to strengthen the state's addiction treatment infrastructure and increase access to medication-based treatment statewide.

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Key takeaways

- Access to MOUD varies widely across the state — **only about 41% of the state is within a 30-minute drive to any MOUD facility**, and access to methadone facilities is even more limited. Federal changes to expand access to telehealth prescribing and mobile MOUD have increased access in some areas, and Oklahoma should work to extend these improvements statewide.
- High risk populations, like pregnant women and people involved with the criminal justice system, encounter even greater barriers to treatment access. **Less than half of Oklahoma counties** have at least one jail-based MOUD program, and **only two facilities in the state** are dedicated to offering comprehensive perinatal care along with access to outpatient medication-based treatment.
- **Insurers' prior authorization requirements can delay patients from starting and continuing substance use treatment**, which can increase health care costs, restrict providers from following best practices, and ultimately worsen treatment and mortality outcomes. Policymakers should move to limit insurers from requiring clinically unnecessary prior authorizations for MOUD.

- Oklahomans seeking treatment for opioid addiction are offered different treatment standards and can face more restrictive policies and participation requirements depending on where they live and seek care. Standardizing statutory and regulatory expectations and site-level participation policies for opioid treatment programs across the state to align with federal guidelines and national best practices could **improve patient retention rates and treatment outcomes** and streamline service provision and administrative compliance for treatment providers
- Unstable state and federal funding further complicate these challenges, especially for safety net providers, which makes long-term planning difficult for providers and can hurt treatment outcomes. For example, a state mental health agency budget shortfall in 2025 led to hundreds of contracts being cut, including ones that fund mental health and addiction services.

Recommendations

To solve the challenges we have outlined, we have five recommendations for Oklahoma agencies and policymakers that would strengthen access to MOUD statewide and eliminate unnecessary barriers to Oklahomans accessing treatment.

- **Reduce unnecessary prior authorization requirements** | Page 33
- **Align Oklahoma standards with national, patient-centric treatment guidance** | Page 34
- **Ensure dedicated, predictable funding for safety-net providers** | Page 34
- **Expand low-barrier, mobile treatment models** | Page 36
- **Strengthen opportunities for high-risk Oklahomans in need of MOUD** | Page 37

2 | Understanding opioid use disorder and its treatment

Opioid use disorder as a chronic disease of the brain

Although opioid dependence exists on a spectrum, opioid use disorder is a clinical diagnosis that refers to a treatable chronic disease shaped by the interaction of biological, psychological, and social and environmental factors, both for development and recovery.[3]

Like many other chronic diseases, addiction is largely influenced by a person's life experiences, biology, psychological state, social and community network, and environment — rather than self-control or individual choice. This concept is at the heart of the Disease Model of Addiction, which is supported by professional organizations and agencies including the National Institute of Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM).[4, 5, 6]

ASAM defines addiction as a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences."[7]

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Figure 1: Cycle of addiction

Different parts of the brain play different roles in the cycle of intoxication, withdrawal, and anticipation.

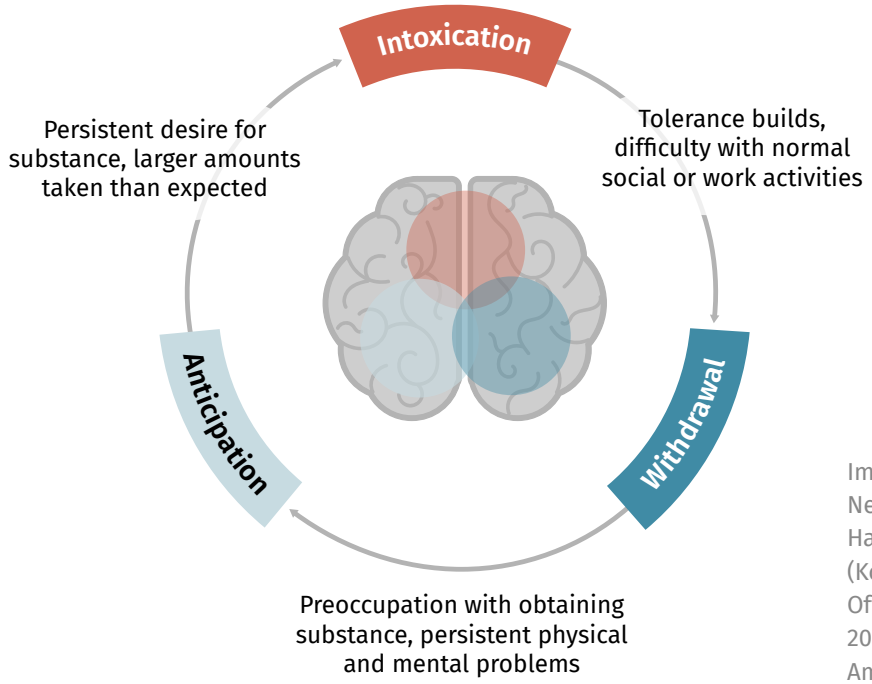


Image adapted from "The Neurobiology of Addiction: Where We Have Been and Where We Are Going" (Koob and Simon, 2009), and the Office of the U.S. Surgeon General's 2016 report "Facing Addiction in America

Many variables impact how susceptible a person is to start using or become dependent on addictive substances. For example, not everyone responds to opioids in the same way. Some people may be more vulnerable to developing an opioid use disorder because of inherited genetic factors, which research suggests account for about 40 to 60% of addiction risk.[8] Some people respond more intensely to opioids — genetic variability can influence how rewarding opioids feel and how the body processes them.

Certain health conditions can also increase risk, especially for people living with chronic pain alongside other chronic conditions.

Mental health status and substance use are closely connected, and each can affect the other. Substance use can trigger or worsen mental health conditions, while mental health conditions can increase the likelihood of substance misuse, sometimes to self-medicate or cope with difficult emotions.

Many with substance use disorders also experience depression, anxiety, or post-traumatic stress disorder. This connection is especially common among adolescents: one study found that about 60% of adolescents receiving community-based treatment for a substance use disorder also had a mental health condition.[9]

A person's childhood can also influence their risk of developing a substance use disorder later in life. People who have experienced more adverse childhood experiences (such as exposure to violence, physical abuse, or parental divorce) are at greater risk.[10] Left unaddressed, people with both mental health and substance use disorders are less likely to begin treatment and more likely to discontinue care, making recovery more difficult.

Addiction risk and recovery are often influenced by a person's family, friends, community, and living environment.[11] When community perceptions about substance use are positive and basic needs like stable housing, reliable transportation, employment, and economic security are unmet, a person is at higher risk for addiction and poor treatment outcomes. These challenges can also increase the risk of overdose: for example, a 2019 study published in the Journal of Drug and Alcohol Dependence found that overdose deaths were most common in economically disadvantaged ZIP codes marked by high unemployment.[12]

The recognition of opioid use disorder as a chronic disease is increasingly informing clinical practice and public policy. Still, access to evidence-based treatment remains limited compared to other chronic diseases. Like diabetes and high blood pressure, OUD treatment often requires long-term management, not just one-off interventions. The complex factors influencing addiction risk and recovery, together with the neurological changes associated with chronic opioid use, underscore the need for stronger statewide access to integrated physical, mental, and behavioral health care prioritizing patient needs.

Understanding the American Society of Addiction Medicine's treatment criteria

Clinicians determine a person's level of opioid dependence based on the severity of their symptoms. Different levels of dependence require different types and settings for treatment. The ASAM Criteria are the most commonly used set of standards in clinical decision making and for organizing the continuum of care. The criteria recommend that clinicians place patients in the least restrictive setting capable of safely meeting individual needs, progressing from outpatient therapy and MOUD to medically managed inpatient care.[13]

The criteria also recommend providers consider an individual's life circumstances and any potential barriers that may make it harder for patients to engage with treatment or negatively impact treatment outcomes: for example, patients experiencing housing instability and repeated relapse may benefit from a different clinical approach than patients with stable housing and reliable transportation. Treatment access and outcomes improve when clinicians deliver care that is both aligned with best practices and tailored to a person's individual needs.

3 | How opioid use disorder is treated through medication

MOUD works by stabilizing brain chemistry and alleviating cravings and, in the case of methadone and buprenorphine, withdrawal symptoms. This allows people in treatment to engage in recovery-oriented activities, instead of staying trapped in a cycle of intoxication and withdrawal.

Repeated opioid use fundamentally changes the brain's structure and functioning — it dysregulates regions of the brain involved in reward, motivation, memory, stress regulation, and executive functioning.

Chronic opioid use reinforces dependency by repeatedly flooding the brain with dopamine and other "feel good" neurotransmitters at levels that exceed what the body naturally produces as a reward for positive or beneficial behaviors. As a person becomes increasingly reliant on opioids to feel "normal," they start to need higher doses to stave off cravings and withdrawal. The measurable changes to the brain and recurring cycle of intoxication and withdrawal reinforce continued use despite the negative consequences associated with compulsive drug-seeking behaviors.

When people are dependent on opioids, they experience withdrawal when they reduce or stop using opioids. Withdrawal symptoms can include:

- intense cravings
- muscle aches
- nausea and vomiting
- insomnia
- difficulty regulating body temperature
- tremors
- and dehydration

While opioid withdrawal isn't typically life-threatening, it can cause severe physical and psychological stress. But complications such as dehydration, worsening co-occurring medical conditions, and an increased risk of overdose following relapse can cause serious harm or death. Without timely medical intervention, withdrawal symptoms ultimately reinforce continued opioid use.

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Although MOUD address opioid dependence through distinct pharmacological mechanisms, each is intended to reduce illicit opioid use, lower a person's risk of death, and support long-term recovery.

The medications are not considered substitutes for opioid addiction, but rather evidence-based interventions with a long history of effectively treating and managing OUD. No single medication is universally appropriate for every patient. Treatment and mortality outcomes improve when individuals have access to the full range of approved medications.

Behavioral health services like counseling and group therapy can complement medication-based treatment by helping patients address emotional triggers, develop coping skills, and manage co-occurring mental health conditions. However, MOUD alone decreases mortality risk and improves treatment outcomes even when patients cannot or do not want to participate in counseling. Because of this, both ASAM and SAMHSA have updated guidance to recommend patients not be denied MOUD solely because they are unwilling or unable to participate in supportive services like counseling.

4 | Types of MOUD

Methadone, buprenorphine, and naltrexone are the three Food and Drug Administration-approved medications used to treat OUD.

Each medication works by attaching to opioid receptors in the brain found throughout the body, particularly in the brain and central nervous system.

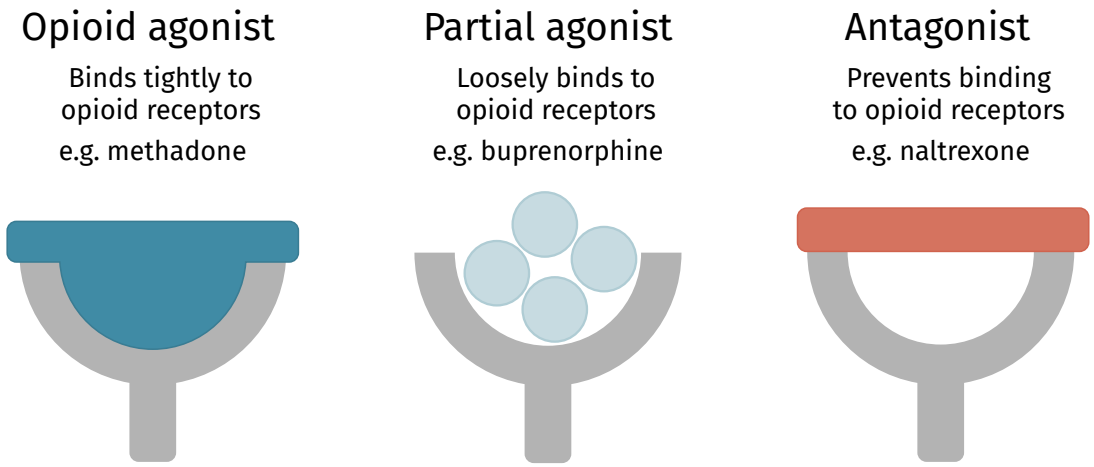
Table 1: Comparing types of medications for opioid use disorder

	Methadone	Buprenorphine	Naltrexone
Outpatient availability	Most restricted: Only available through an opioid treatment program (OTP)	Available in office-based outpatient setting or OTPs	Most accessible: Available in office-based outpatient settings or OTPs
Medication elligibility	• Typically for patients diagnosed with OUD who are physiologically dependent on opioids and who meet state and federal criteria for OTP admission • Growing evidence suggests methadone may improve treatment retention for patients using high-potency opioids like fentanyl	Typically for patients diagnosed with OUD who are physilogically dependent on opioids	Typically for patients diagnosed with OUD who are completely opioid-free
How it works	Opioid receptor agonist: Fully binds to and activates receptors, reduces opioid withdrawal and cravings	Opioid receptor partial agonist: Partially binds to and activates opioid receptors, reduces opioid withdrawal and cravings	Opioid receptor antagonist: Blocks opioids from binding to receptors; can reduce opioid cravings but doesn't relieve withdrawal symptoms
How it is taken or administered	Administered daily at an OTP or at home for stable patients. Available as daily tablets, liquid concentrate, and oral solution	Daily tablets, films that dissolve under the tongue, or extended-release injections. Some formlations, such as suboxone, also contain naloxone	Daily tablets or extended-release injections

	Methadone	Buprenorphine	Naltrexone
Other notes of interest	First medication approved to treat OUD, more than 60 years ago	In 2002 became first MOUD approved for use outside OTPs. Buprenorphine is available in multiple formulations, including buprenorphine-only products and buprenorphine and naloxone combination products such as Suboxone	Treats both opioid dependence and alcohol dependence
Who can prescribe in Oklahoma	Schedule II Physicians, physician assistants, and advanced practice registered nurses working in an OTP	Schedule III Physicians, physician assistants, and nurse practitioners who are DEA-registered, have completed training requirements, and are operating within their scope of practice	Schedule IV Any licensed health care providers authorized to prescribe and operating within their scope of practice

Sources: Food and Drug Administration, Drug Enforcement Administration

Figure 2: Visualizing how opioid agonists, partial agonists, and antagonists work with opioid receptors in the body



Graphic: Healthy Minds Policy Initiative | Illustration adapted from the Addiction Policy Forum

Methadone

Methadone was the first medication approved to treat OUD and remains one of the most effective forms of treatment for many patients.[14]

It works by stabilizing the brain for extended periods, rather than producing the rapid cycle of intoxication and withdrawal associated with illicit opioids. In doing so, patients are better able to maintain employment, participate in daily life, and pursue other recovery-oriented activities.

Although methadone shares its pharmacological classification with other synthetic opioids such as fentanyl and heroin, in clinical settings, it reduces mortality by more than 50% compared to those receiving no treatment.[15] It is also the most regulated type of MOUD and is only available through outpatient opioid treatment programs, or OTPS, and in inpatient settings. See Page 16 for additional details about OTPs.

Like other prescription medications, it can cause some level of physical dependence, but addiction medicine providers distinguish physical dependence from addiction itself.

Methadone is highly effective for treating OUD, particularly for those transitioning from high-potency opioids like fentanyl.[16] But it carries a greater risk of overdose and respiratory depression than other forms of MOUD, especially for people with low or no opioid tolerance.

Historically, methadone-involved overdose deaths were associated with methadone prescribed for pain management rather than through OTPs.

In 2023 and 2024, methadone was involved in a relatively small share of total opioid overdose deaths, accounting for about 5% of all opioid overdose fatalities nationwide.[17]

Overdose deaths that include methadone frequently involve other substances, such as alcohol and other central nervous system depressants like benzodiazepines. Methadone-involved overdose deaths continued to decline following federal policy changes that expanded access to take-home doses and telehealth services through OTPs.[18]

Buprenorphine

Buprenorphine emerged in 2002 as the first outpatient MOUD approved for use outside opioid treatment programs. It is also approved for treating chronic pain and managing withdrawal.

Buprenorphine reduces withdrawal symptoms and cravings without producing the euphoric effects associated with opioids like heroin and fentanyl.[19] Its effects level off at high doses, which contributes to a lower risk of respiratory depression and overdose than many other opioids. Buprenorphine also helps protect against relapse by blocking or reducing the effects of other opioids.

Although overdose is uncommon, it can occur, particularly among individuals with little or no opioid tolerance or when combined with alcohol, benzodiazepines, other central nervous system depressants. Nationwide, buprenorphine was involved in 2% of total opioid overdose deaths from 2019–2021, with more than 97% of those involving another substance.[20]

Addiction medicine providers increasingly identify extended-release injectable buprenorphine as a promising treatment for patients with limited access to care and inconsistent treatment engagement.

Injectable buprenorphine may improve treatment retention among high-need populations, including people who face transportation barriers, housing insecurity, or challenges adhering to their medication schedule. Injectable formulations have also demonstrated potential in prisons, jails and jail transition programs, homeless outreach, and mobile MOUD.[21, 22, 23]

Naltrexone

Naltrexone is an opioid antagonist approved to treat both alcohol and opioid dependence. For OUD, its extended-release formulation is generally recommended over daily oral tablets because it improves treatment adherence and continuity.

Naltrexone is the most accessible MOUD. Unlike methadone and buprenorphine, it is not a controlled substance, so it can be prescribed by any licensed provider.

But clinical guidelines recommend naltrexone is restricted to patients who have completed opioid withdrawal, which commonly takes seven to 14 days — posing a barrier to beginning treatment for people living in areas that lack medical withdrawal management services. Individuals who undergo withdrawal without medical supervision are more likely to discontinue treatment and return to use.[24] ASAM's national practice guidelines recommend that extended-release naltrexone be used for patients who are no longer opioid dependent for preventing relapse, rather than for those in active addiction.

Unlike methadone and buprenorphine, naltrexone does not activate opioid receptors; instead, it blocks them, to prevent opioids from binding. Because naltrexone does not activate opioid receptors, it is not typically associated with physical dependence and is consequently less effective at reducing cravings compared to methadone and buprenorphine.

Patients receiving naltrexone are generally less likely to remain in treatment than those receiving methadone or buprenorphine, in part due to the medications detoxification requirement. However, naltrexone may still be an appropriate treatment option for some patients depending on their clinical needs and life circumstances.

5 | Oklahoma's MOUD landscape

Opioid treatment programs and office-based opioid treatment are the two primary models for delivering medications for opioid use disorder. OTPs operate under extensive state and federal oversight and must navigate complex regulatory and statutory requirements governing how medications are prescribed and dispensed. Because outpatient methadone can only be dispensed through OTPs, it remains the least accessible MOUD in Oklahoma.

Office-based treatment offers a less restrictive pathway to care. Authorized providers may prescribe buprenorphine in traditional health care settings and are not subject to the same regulatory framework or participation requirements as OTPs, although some facilities may choose to require mental health treatment as a condition for receiving the medication. The expansion of OBOT has increased access to buprenorphine for many Oklahomans, particularly those living in rural communities; however, substantial geographic and provider gaps remain.

The recent federal policy changes have reduced certain restrictions on methadone and buprenorphine treatment, along with the expansion of mobile MOUD programs and other flexible delivery models have created new opportunities to reach underserved communities.

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Opioid treatment programs (OTP)

Oklahoma has 20 opioid treatment programs, which are facilities that provide MOUD and related treatment services. Eighteen of the state's OTPs are certified by SAMHSA and the Oklahoma Department of Mental Health and Substance Abuse Services and registered with the U.S. Drug Enforcement Administration and the Oklahoma Bureau of Narcotics and Dangerous Drugs. OTPs operated by Oklahoma's tribal nations and the U.S. Department of Veterans Affairs are not subject to ODMHSAS oversight.[25]

OTPs are the only outpatient settings allowed to dispense methadone for OUD. OTPs can also exist in intensive outpatient, residential, and hospital settings, and they may also provide buprenorphine and naltrexone.

OTPs provide the most comprehensive and highly regulated form of MOUD treatment, requiring substantial regulatory, clinical, and operational infrastructure. OTPs use a high engagement treatment model, and medication compliance is closely monitored by clinicians. Patients must

meet frequent — sometimes daily — attendance requirements and attend multiple counseling or group therapy sessions each month.

About half of providers in Shatterproof's Oklahoma treatment registry[i], a dataset of MOUD treatment providers, reported they neither dispense methadone nor provide formal referrals to an OTP. Among those that offer patients access to methadone, nearly half do so through referrals to an OTP operated by a separate organization. This fragmentation creates additional barriers to treatment initiation and continuity of care.

Oklahoma's OTPs are located primarily in Oklahoma City and Tulsa, as well as in regional population centers such as Tahlequah and Anadarko. They are required to accept SoonerCare and comply with the standards established by the Oklahoma Health Care Authority.[26]

Office-based opioid treatment

Office-based opioid treatment (OBOT) programs offer a more flexible approach to treating OUD that allows licensed health care providers, such as physicians, physician assistants, and nurse practitioners, to prescribe buprenorphine in health care settings including primary care, hospitals, Certified Community Behavioral Health Clinics (CCBHCs), and federally qualified health centers (FQHCs).

Patients can access buprenorphine and sometimes naltrexone through these settings, but not methadone.

Initially, OBOT programs were limited to physicians who obtained a waiver from the DEA, but this requirement was removed in 2023, so any provider who can prescribe Schedule III medications can prescribe buprenorphine after they meet certain training requirements.[27]

Removing the waiver requirement expanded the pool of buprenorphine prescribers and increased buprenorphine prescriptions obtained from retail pharmacies.[28, 29] Still, no meaningful gains were observed in the number of new patients initiating treatment. Some data show the removal of the waiver requirement was not enough to overcome existing barriers, such as provider and community stigma, transportation, and other challenges, particularly for those living in rural areas.[30, 31]

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i Shatterproof is a national nonprofit working to transform systems, support families, and end the stigma of addiction. Through its Treatment Atlas, Shatterproof works to improve transparency in addiction treatment by providing information about treatment facilities and the quality of care they offer, helping individuals and families make more informed decisions.

For this project, Healthy Minds Policy Initiative obtained Oklahoma-specific treatment provider data from Shatterproof through a data request. The dataset includes office-based opioid treatment (OBOT) providers, Certified Community Behavioral Health Clinics (CCBHCs), opioid treatment programs (OTPs), and other addiction treatment providers. Additional details about the methodology and data limitations are available on Page 39.

The DEA and Health and Human Services (HHS) recently expanded several COVID-era buprenorphine telehealth flexibilities through Dec. 31, 2026.[32] Data showed the changes were not associated with increases in overdose deaths and consequently, clinicians may now prescribe buprenorphine before conducting an in-person examination, using audio-visual and audio-only telehealth services.[33]

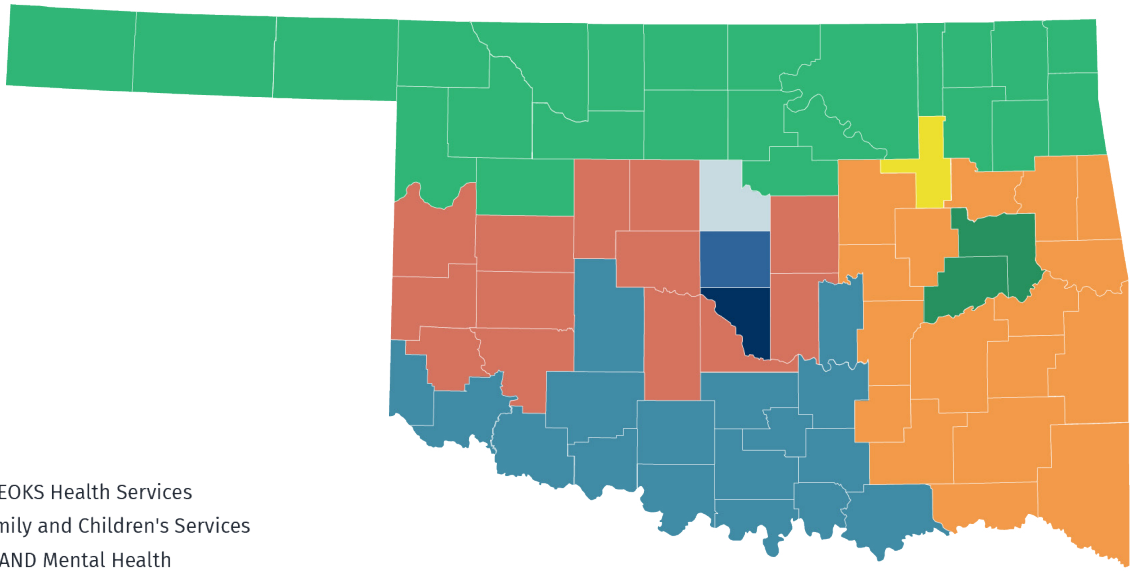
While OBOT has expanded access to care, significant geographic gaps remain. About 30% of counties in the nation do not have a buprenorphine prescriber.[34] In Oklahoma, roughly 35% do not have a single buprenorphine prescriber, with shortages particularly pronounced in certain rural areas.

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHCs) are the foundation of Oklahoma's statewide behavioral health infrastructure, providing integrated treatment across all 77 counties to anyone who asks for it, regardless of their ability to pay. CCBHCs must provide access to MOUD directly or through formal partnerships with other facilities.[35]

Most of Oklahoma's CCBHCs provide access to outpatient naltrexone and buprenorphine, along with counseling, case management, crisis care, peer support, and recovery services. For methadone, Oklahoma's CCBHCs commonly refer patients to OTPs to coordinate access. They may dispense methadone directly to patients if they are certified as an OTP or formally integrated with one.

Figure 3: Certified Community Behavioral Health Clinics serving Oklahoma counties



CREOKS Health Services
Family and Children's Services
GRAND Mental Health
Green Country
Lighthouse Behavioral Wellness Centers
NorthCare
Red Rock
Tulsa County: Family and Children's Services, Counseling and Recovery Services, GRAND Mental Health, and CREOKS Health Services
Oklahoma County: NorthCare, Red Rock, Family and Children's Services/Hope Community Services

Medication availability varies across Oklahoma's CCBHCs, and some may not provide direct access to all MOUD formulations at all their satellite locations, leaving some Oklahomans without access to the most appropriate medication for their circumstances. Of 12 Oklahoma CCBHCs in Shatterproof's treatment dataset, only three reported offering injectable buprenorphine on-site through other providers. One site offers off-site access through an affiliate, and two have written agreements with external providers. Eleven out of 12 offered some level of on-site access to buprenorphine-naloxone combination products, and nine offered buprenorphine without naloxone.

Mobile MOUD

Recent federal reforms expanding mobile MOUD models are intended to improve treatment access in underserved and hard-to-reach communities.[36] Mobile methadone units operate as extensions of certified OTPs and may dispense all forms of MOUD, provide take-home doses, conduct intakes and initial exams, and provide telehealth treatment and counseling.

Mobile methadone units can also collect mandatory drug testing samples, a common barrier for OTP patients in rural Oklahoma. Mobile units that dispense or facilitate access to buprenorphine can operate without OTP certification.

To improve access in rural communities in the southwest part of the state, the Southwest Oklahoma Development Authority (SWODA) funds and operates a mobile MOUD unit that connects patients to virtual appointments with partnering treatment providers. The medications aren't dispensed on-site. Instead, the provider submits the buprenorphine prescription to the patient's preferred pharmacy. The unit also provides telehealth access to counseling and other behavioral health interventions, reducing the need for some patients in southwest Oklahoma to travel long distances for care. Despite the improvements, some patients still travel up to an hour for care, one stakeholder reported.

The Tulsa Fire Department's Overdose Response Team and Oklahoma City's Alternative Response Team also provide low-barrier MOUD access in high-need areas of the state.[37, 38] These programs respond directly to overdose calls, provide peer support, dispense MOUD, and connect individuals with treatment and social services.

Tulsa Fire Department's Overdose Response Team plays a critical role in delivering overdose prevention services and real-time overdose response, particularly for Tulsans experiencing mental illness, substance use disorders, homelessness, chronic illness, and mobility challenges.

The team deploys a mobile integrated health care model alongside peer recovery support specialists to provide overdose response, follow-up outreach, and care coordination for individuals at high-risk of overdose.

The mobile unit screens patients for OUD, provides overdose education and personalized safety planning, and connects individuals with case management and community resources to address any underlying health and social needs.

The team also provides short-term buprenorphine treatment and medications for withdrawal management while linking their clients with addiction medicine providers and treatment facilities for long-term treatment. The Tulsa Overdose Response Team conducts follow-up visits for patients beginning buprenorphine treatment to monitor medication safety and withdrawal symptoms, and support treatment engagement and continuity of care.

Between February 2025 and May 2026, the Tulsa Fire Department's Overdose Response Team completed 608 in-person overdose follow-up visits and conducted an additional 391 outreach contacts through phone calls, text messages, and emails. The team also initiated 350 self-directed outreach efforts, resulting in 1,550 contacts with individuals throughout Tulsa. They also provided 90 transports to treatment facilities and 117 doses of suboxone.

6 | Barriers to MOUD treatment in Oklahoma

Oklahoma's treatment infrastructure is fragmented, and patients often face a complex path to accessing the care they need. Sometimes patients may have to travel long distances to reach a provider, and the type of medications, participation requirements, and treatment standards offered often varies significantly across the state. Even when patients do find a provider, overly burdensome insurance requirements can delay them from starting and staying engaged with care.

People at especially high risk — for example, people with OUD in jails or prisons, or pregnant women with OUD — face even steeper challenges in accessing care.

Finally, unstable funding underpins and amplifies many of these challenges, especially in the safety-net behavioral health system. In this section, we outline how these barriers prevent more Oklahomans from accessing MOUD.

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Geographic and transportation barriers

Access to MOUD treatment is uneven across the state: only about 41% of the state's area is within a 30-minute drive to an MOUD facility. People who need access to methadone may face even longer travel times, as only about 10% of the state's area is within a 30-minute drive to an OTP, the only facilities that can distribute methadone.

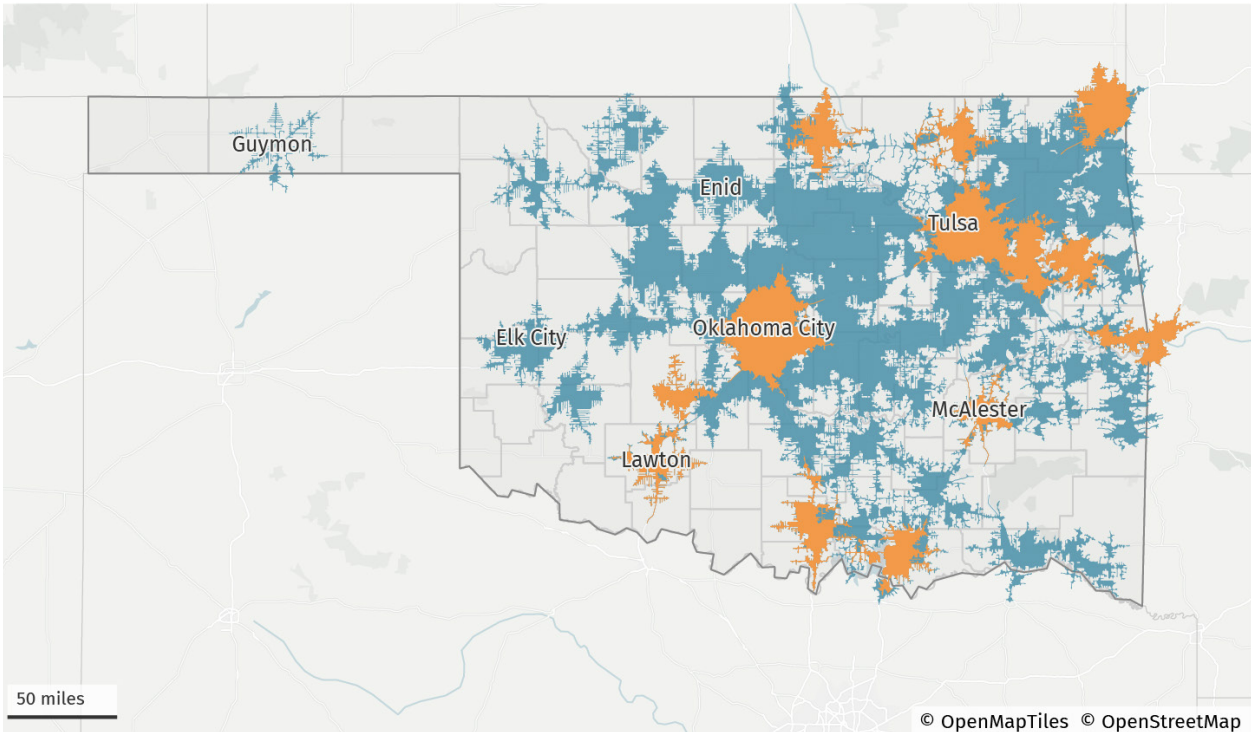
Most of the state's OTPs are located in more populous areas — about 75% of Oklahoma and Tulsa counties, for example, is within a 30-minute drive to an OTP. But even those who live near a treatment program can face transportation barriers, as zoning requirements often push OTPs into industrial areas, away from population centers and reliable public transportation.

Inadequate treatment availability is more pronounced in rural areas of the state. For six Oklahoma counties — Beaver, Cimarron, Harmon, Jackson, Jefferson, and Tillman — no part of the county is within a 30-minute drive of any provider offering MOUD.

Although Oklahoma's urban centers account for the largest number of overdose deaths in the state, rural counties commonly experience higher overdose death rates along with inadequate provider access.

Figure 4: Parts of Oklahoma within a 30-minute drive to an MOUD treatment facility or opioid treatment program (OTP)

About 41% of the state's area is within a 30-minute drive to an MOUD facility, but only about 10% is within a 30-minute drive to an OTP.



Areas within a 30-minute drive to an MOUD facility

Areas within a 30-minute drive to an OTP

Source: Healthy Minds analysis of Shatterproof data

For our analysis, we chose to examine parts of Oklahoma within a 30-minute drive to an MOUD location. This is a commonly used benchmark in studies examining geographic access to substance use disorder treatment and primary care. Note that our analysis only examined geographic areas within a certain driving distance; it does not account for population density in those areas.

Additional maps, including regional findings, are in appendices beginning on Page 40.

Figure 5: Oklahoma County access to OTP facilities via 30-minute drive
84% of Oklahoma County's area is within a 30-minute drive to an OTP.

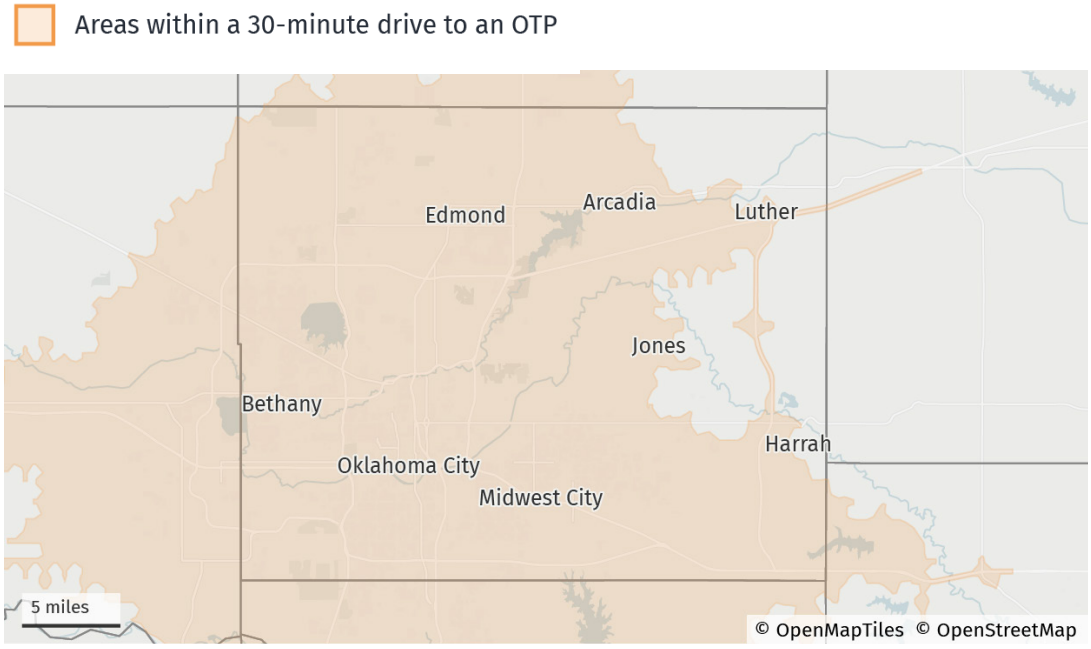
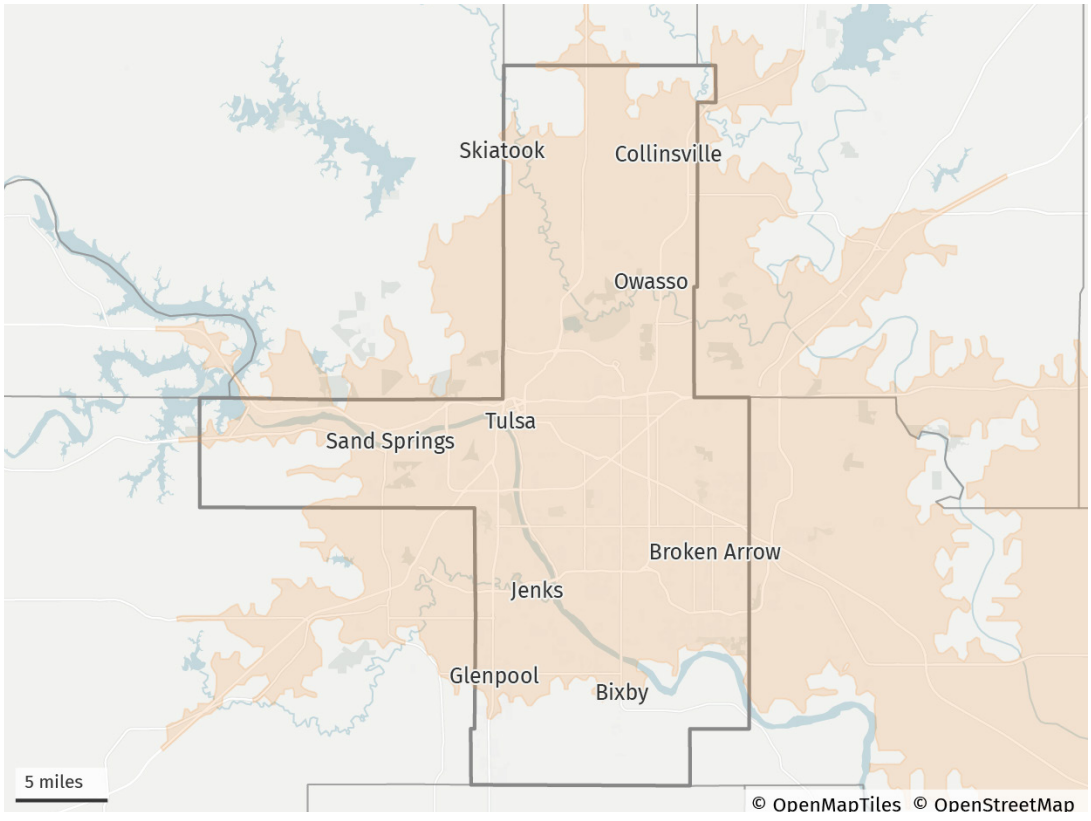


Figure 6: Tulsa County access to OTP facilities via 30-minute drive
77% of Tulsa County's area is within a 30-minute drive to an OTP.



Source for both maps: Healthy Minds analysis of Shatterproof data

MOUD providers are also not distributed proportionately to the state's population. For example, though Oklahoma and Tulsa counties are the state's most populous, they have relatively lower rates of providers compared to other regions.

Table 2: MOUD provider supply rates per 100,000, by region

Region	Population	Providers	MOUD provider supply per 100,000
Northwest	104,860	11	10.49
Northeast	190,470	34	17.85
Southwest	151,594	15	9.89
Southeast	997,251	29	2.90
Oklahoma County	816,490	24	2.93
Tulsa County	693,514	20	2.88

Source: Healthy Minds analysis of Shatterproof treatment provider registry

Even when people live within a reasonable distance to an MOUD provider, they may face hurdles in accessing the type of MOUD that best suits their needs.

The types and formulations of available MOUD vary drastically across providers, meaning patients may have access to different medication options depending on where they seek treatment. These disparities are often pronounced in rural areas, where providers may have limited training on addiction medicine or may be unwilling to prescribe MOUD.

For example, of 195 buprenorphine providers in Oklahoma, only 16 reported providing access to all MOUD and none do so exclusively on-site. (Providers may offer MOUD on-site, through another location operated by the same organization, or through referral to an external provider.)

Before the elimination of the federal X waiver requirement in 2023, which required providers to obtain a waiver in order to prescribe buprenorphine, SAMHSA maintained a public directory of buprenorphine providers.

Currently, there is no comprehensive database to identify Oklahoma clinicians who actively prescribe buprenorphine. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) partnered with Shatterproof to maintain a treatment locator but ended the contract in 2025. As a result, the state's provider registry may not reflect the current treatment infrastructure. Shatterproof gathers data annually by sending a voluntary survey to providers.

Since responses are voluntary and self-reported, the locator might not accurately show the availability of buprenorphine treatment or provide a clear picture of clinicians who prescribe MOUD and accept new patients.

Even when patients can get a prescription for MOUD, they may have trouble filling it: only around half of retail pharmacies across the U.S. carry buprenorphine for OUD treatment, and one in five will not order it.[39] Oklahoma does not publicly track which pharmacies routinely stock and dispense buprenorphine for OUD, making it difficult to identify pharmacy access gaps across the state.

Burdensome insurance requirements

Even when patients can access a treatment provider, insurance restrictions may limit their access to care. Patients must often navigate referrals, limited provider networks, and insurance restrictions on which medications are covered — all of which complicate treatment access and retention. Even when patients can access a treatment provider, insurance restrictions may still limit care. Drug formularies, dosage limits, and utilization management tools can restrict access to MOUD.

Patients should be able to access MOUD as soon as they are ready to seek care and continue treatment without delays due to clinically unnecessary administrative requirements. Even brief delays can discourage people from starting treatment and can put people at risk for continuing to use substances, overdose, and disengaging from treatment altogether.

But insurance restrictions can create unnecessary hurdles that force patients to wait before they can start treatment and can hinder treatment continuation for those taking medications that require frequent reauthorizations. For example, insurance companies require prior authorizations as a means of "utilization management," which refers to tools that insurers' leverage to evaluate whether a particular medical treatment or service is necessary, appropriate, and cost-effective. Prior authorizations are one of the primary tools used to contain costs but have been shown to delay or deny necessary care and increase administrative burden on both patients and providers, particularly in addiction medicine. In fact, nearly 70% of insured adults indicate prior authorization requirements are a burden in seeking health care.[40]

Prior authorizations require providers to obtain insurers' approval before prescribing certain medications or delivering specific services, unless patients are willing to pay out of pocket.[41] They are often cited by clinicians as a major barrier to timely and patient-centered addiction treatment, particularly for patients who would benefit from buprenorphine.[42]

As of July 2026, Oklahoma's Medicaid program, Soonercare, covers extended-release naltrexone, generic buprenorphine-naloxone tablets, and most recently, Brixadi, an injectable form of buprenorphine, without requiring a prior authorization.

But providers who determine that prescribing buprenorphine as a dissolvable under-the-tongue film would be most clinically appropriate for their patient must obtain prior authorization before initiating treatment and every three months thereafter — regardless of the patient's needs, clinical stability, or time in treatment. Also, patients with commercial insurance who might benefit from injectable buprenorphine may still have to meet strict prior authorization rules, since the July decision does not apply to all health plans.

Oklahoma lacks any public data to show the rate of prior authorization requirements imposed by SoonerCare or Oklahoma's commercial insurers. However, several addiction medicine providers from across the state said in interviews that prior authorization requirements can hinder treatment initiation and continuity of care for patients with OUD. Providers also noted that most buprenorphine prior authorization requests, excluding injectables, are ultimately approved.

Further, some Oklahoma addiction medicine providers are concerned about upcoming managed care regulatory changes as they may relate to addiction treatment access. Starting in 2027, Medicaid managed care organizations (MCOs) will have greater discretion in certain utilization management and prior authorization practices. As a result, access to services and treatment options could vary across plans, even when benefits covered under SoonerCare remain unchanged.

A 2022 study found that Medicaid prior authorization requirements for MOUD are highly variable across states, with more than 50% of Medicaid beneficiaries with OUD coverage being subject to prior authorization requirements.[43] The study also found Medicaid managed care organizations were more likely than fee-for-service payors to require prior authorizations for buprenorphine products.

Nationally, physicians report spending substantial amounts of unbillable time navigating prior authorization requirements. A 2025 survey conducted by the American Medical Association found that physicians spend approximately 13 hours per week managing prior authorizations alone. Most respondents also reported that unnecessary prior authorizations led to increased health care utilization due to delayed treatment, emergency department visits, and medically unnecessary step-therapy protocols.[44]

Inconsistent treatment standards

Oklahomans receiving methadone, and in some cases buprenorphine, across the state may be subject to program-specific policies that that exceed what are required or recommended. In some cases, OTPs implement excessive participation requirements that can discourage treatment engagement while providing limited clinical value.

Updates to methadone and buprenorphine regulations have increasingly shifted toward lower-barrier, more patient-centered approaches to care instead of overly restrictive policies that are known to hinder patients' uptake and engagement in treatment.

OTPs must follow a patchwork of state and federal laws and regulations, but states and individual OTP sites can also establish their own policies. This means patients may encounter more restrictive participation requirements depending on where they receive care.

For example, a 2022 Oklahoma law required all patients to be observed by clinic staff during urine collection for drug testing despite federal guidance recommending otherwise.[45, 46] SAMHSA notes that observed urine collections can be distressing or re-traumatizing and instead recommends that treatment be provided in a therapeutic context that prioritizes building trust and respect with patients. A 2024 study in the journal Drug and Alcohol Dependence found that OTPs with high levels of random and observed urine drug screening had lower long-term retention rates.[47]

There have been some positive changes in OTP policies in recent years. Historically, OTPs required patients to frequently, if not daily, travel to the clinic for observed dosing and attend multiple counseling or group therapy sessions each week. But recently, SAMHSA made permanent the COVID-era methadone flexibilities that increased methadone's take-home quantity limit after finding the policy improved treatment access and outcomes without increasing diversion.

The updated regulations also allow patients to become eligible for take-home doses earlier in treatment, authorize nurse practitioners and physician assistants working within OTPs to order methadone where permitted under state law, and permit OTPs to provide extended take-home doses under certain circumstances, including individuals who are incarcerated or living in a nursing home.[48]

The DEA and SAMHSA require OTP sites to maintain "diversion monitoring" plans to ensure patients are taking methadone doses as prescribed, but they leave room for states and OTPs to determine method and frequency. One way OTPs do this is by performing "medication call-backs," in which patients eligible for take home doses are required without advance notice to return to the clinic, often within 24 hours, so providers can ensure they are taking their medication appropriately. Each OTP has discretion on which patients are eligible to receive take-home doses, how many doses are allotted, and how often the call-backs occur.

Diversion monitoring and other clinical tools can play an important role in clinical decision-making and medication management, but these tools are most effective when they have a clear, clinical purpose and are used to inform individualized treatment planning and monitor treatment progress — not as punitive measures.

Overly restrictive participation requirements and other punitive policies may discourage people from continuing treatment, especially for Oklahomans who must travel long distances for care or balancing family and work responsibilities. Implementing state-level, standardized treatment protocols aligned with national guidance and best practices would simplify regulatory compliance for providers and ensure that all Oklahomans have access to evidence-based care.

Unstable funding for addiction treatment

Federal and state funding for addiction treatment has become increasingly unstable, particularly for the safety-net system, which complicates long-term planning and sustainability for Oklahoma's behavioral health infrastructure.

Medicaid remains the largest payer of substance use disorder treatment in the United States and provides critical funding to Oklahoma's safety-net providers. Nearly one-fifth of all adults with substance use disorders, and just under 70% of current Medicaid enrollees with a substance use disorder gained coverage through Medicaid expansion.[49]

Federal changes resulting from H.R. 1 are likely to pose new challenges in sustainably funding addiction treatment. H.R. 1, the major budget reconciliation bill passed in 2025, is projected to reduce federal Medicaid spending by $1 trillion over the next decade.[50] The law did not set lower income limits for Medicaid eligibility, but its provisions are likely to increase costs for Medicaid enrollees and will pose burdens for states and enrollees through its new work requirements and more frequent eligibility checks.

Beginning in 2027 under H.R. 1, many SoonerCare enrollees will be required to complete and provide documentation of 80 hours of work, volunteering, studying, or a combination of these activities, each month to stay eligible for Medicaid. The law includes an exemption to these requirements for people with substance use disorders, but the exemption only applies if their condition significantly impairs their ability to meet the requirements or they are participating in a treatment program.[51]

People who have been in recovery for more than five years are not eligible for the exemption, despite evidence that substance use disorder is a chronic condition — and that people may relapse even after long periods of abstaining from drugs.

Related:
How federal changes to Medicaid will affect mental health services in Oklahoma

These changes are expected to result in 7 million Americans losing coverage. Insurance instability is particularly dangerous for patients with opioid use disorder, as even brief interruptions in treatment are associated with increased risk of relapse, overdose, and disengagement from care.

Federal grant funding also remains uncertain. In January 2026, the federal government briefly announced approximately $2 billion in cuts to SAMHSA grants supporting substance use prevention, recovery, and opioid treatment services only to rescind the decision the following day.[52] Although temporary, the disruption had immediate consequences for both patients and providers, as some clinics may have paused services, reduced programming, or prepared workforce reductions.[53] Even brief disruptions to funding streams can destabilize treatment facilities and negatively impact patient health outcomes.

Additional concerns have emerged surrounding the proposed federal restructuring of behavioral health grant programs. The Trump administration's budget proposal for fiscal year 2027 would reduce federal funding for mental health and substance use disorder treatment by approximately $600 million and consolidate several existing substance use grants into a single $4.6 billion Behavioral Health Innovation Block Grant — less than the existing grants it would replace (compared to fiscal year 2025 funding levels).[54, 55]

The proposal intends to offer states more flexibility to address unmet behavioral health needs, but its impact on services is unclear. Consolidating multiple substance use grants into the broader proposed grant could dilute targeted opioid funding priorities.

If the proposed budget receives Congressional approval, states may eventually be required to restructure their existing opioid response strategies and redistribute limited mental and behavioral health dollars across competing priorities ranging from crisis care to recovery services.

Oklahoma providers also face state-level funding instability. In 2025, the state mental health agency faced a major budget shortfall that led to the abrupt cancellation of 312 contracts and a reduction in funding for 122 grant recipients, including organizations that provide mental health and addiction services. Continued funding realignments and sudden changes to provider contracts create uncertainty for providers and may undermine the state's efforts to build a consistent, financially sustainable system of care.

Behavioral health providers in Oklahoma are particularly vulnerable to administrative burden and fluctuations in federal funding, as many are safety-net providers obligated to care for patients regardless of their ability to pay.

ODMHSAS is currently awaiting approval from the governor for a proposed emergency rule that would reduce the income threshold used to determine eligibility for state-funded behavioral health services from 200% to 138% of the federal poverty level, further exacerbating funding challenges for safety net providers. While CCBHCs would still be obligated to serve all individuals regardless of their insurance status or ability to pay, they would no longer receive reimbursement for services provided to uninsured Oklahomans with incomes between 138% and 200% of the federal poverty level.

Limited access to MOUD for Oklahomans at highest risk

MOUD during pregnancy

Opioid use in pregnancy has increased substantially in recent decades. In Oklahoma, the number of pregnant women diagnosed with a substance use disorder has more than quadrupled since 1999.[56]

Illicit opioid use during pregnancy is associated with negative health outcomes, including maternal and fetal mortality, preterm labor, and neonatal opioid withdrawal syndrome. Symptoms of opioid withdrawal are observed in approximately one birth every 25 minutes in Oklahoma.[57]

The American College of Obstetricians and Gynecologists, the American Society of Addiction Medicine, and SAMHSA support MOUD as the first-line treatment for pregnant women with opioid use disorder, but only 50 to 60 percent of pregnant women receive treatment.[58] [59] [60]

The Oklahoma Maternal Health Task Force identified substance use, lack of access and resources, delays in treatment, and poor continuity of care as contributing factors to pregnancy-related deaths from 2017 to 2021.[61] Roughly 48.1% Oklahoma counties are designated maternity care deserts, and about 15% of all women receive inadequate prenatal care.[62]

For those with OUD, access to integrated perinatal medication-based treatment is especially challenging.

Oklahoma has just two facilities offering comprehensive prenatal and postpartum care for women with substance use disorders. These are the STAR (Substance Use Treatment and Recovery) clinic in Oklahoma City and, starting in October 2026, the OSU School of Medicine's Maternal and Addiction Recovery Care Program in Tulsa. Both programs combine specialized perinatal care with access to substance use treatment, counseling, mental health supports, and case management services.

MOUD in jails and prisons

Oklahomans with substance use disorder in jails also face inadequate MOUD access.

People with substance use disorder are disproportionately represented in jails and prisons. Across the U.S., nearly two-thirds of people in jails have a history of substance use disorder, and an additional 20% who do not meet substance use disorder diagnostic criteria were arrested for drug-related offenses.[63]

Since 2024, ODMHSAS has partnered with TK Health (formerly TurnKey Health) to implement jail-based MOUD programs across 39 counties, although medication availability and treatment eligibility vary by facility.

No publicly available information indicates the consistency or scope of the treatment programs or the medications made available. But stakeholders indicate that the majority of Oklahoma's jail-based programs commonly rely on buprenorphine products due to methadone's operational and regulatory constraints.

However, two Oklahoma jails have recently implemented pilot programs to expand access to methadone. ODMHSAS and the Oklahoma Department of Corrections have partnered with an OTP, Maric Health, to provide methadone treatment to limited cohorts at Mabel Bassett and Lexington facilities — the total number of participants totaled 43 as of 2025.

7 | Recommendations

To solve the challenges we have outlined, Oklahoma agencies and policymakers can make changes that would strengthen access to MOUD statewide and eliminate unnecessary barriers to Oklahomans accessing treatment.

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Page 6

How opioid use disorder is treated through medication
Page 9

Types of MOUD
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Oklahoma's MOUD landscape
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Barriers to MOUD treatment in Oklahoma
Page 21

Reduce unnecessary prior authorization requirements

Burdensome prior authorization requirements for MOUD can delay or even altogether discourage a patient from beginning treatment from opioid use disorder.

And unnecessary prior authorization requirements can put insurers at risk for parity violations: the Legal Action Center argues that excessive prior authorization requirements for substance use disorder treatment may violate the Mental Health Parity and Addiction Equity Act if those requirements are not comparable to those applied to medical and surgical benefits or are administered more restrictively.[64]

Lawmakers can address this barrier and ensure timely access to lifesaving treatment by limiting prior authorization requirements across public and private payors.

The state should prohibit insurance companies from requiring clinically unnecessary prior authorization for any generic buprenorphine formulations and limit how often payors can require reauthorization. For example, the state could restrict prior authorization during the first 30 days of treatment or allow initial approval while prohibiting repeated reauthorizations every few months.

Alternatively, the state could establish fair standards for behavioral health coverage in statute. Healthy Minds Policy Initiative supported SB 1646 during the 2026 legislative session, which would have required commercial insurers to use "generally accepted standards of care" when making coverage decisions for mental health and substance use disorder treatment.

If enacted, the policy would have more closely aligned insurers' coverage decisions with nationally recognized, evidence-based clinical guidelines, such as the ASAM criteria. Similar legislation is expected to be reintroduced in 2027.

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The Oklahoma Health Care Authority can also use its authority to limit excessive prior authorizations. For example, in April 2018, the Centers for Medicare and Medicaid Services (CMS) issued guidance stating that it would not approve Medicare Part D formularies that require more than one prior authorization for buprenorphine annually. Within two years, the number of prior authorizations for brand-name buprenorphine and naloxone products decreased by 96%, and those for generics decreased by 99%.[65] Medicare's restriction on excessive prior authorizations was associated with a substantial increase in buprenorphine prescribing, as well as reductions in substance use disorder-related inpatient and emergency department admissions.

OHCA should leverage Medicare's approach, as well as review contractual agreements with managed care plans to ensure managed care organizations' prior authorization implementation is consistent with the standard of care established by national guidelines and clinical best practices.

Align Oklahoma standards with national, patient-centric treatment guidance

Inconsistent treatment standards and a patchwork of state and federal policies mean that Oklahomans participating at OTPs across the state receive different standards of care based on where they go to access medication.

As federal updates to MOUD regulations have increasingly moved toward low barrier, trauma-informed approaches and non-punitive policies, Oklahoma should update and align its policies for opioid treatment programs with federal guidance and best practices.

Further, ODMHSAS and OHCA should develop and maintain a comprehensive, publicly available dashboard to help policymakers identify gaps in treatment availability and capacity and make it easier for Oklahomans to find an active prescriber at the moment they decide to seek treatment. Plans to address these challenges are included in the newly adopted Rural Health Transformation plan, including: funding, education, and resources to help reduce risks, prevent overdoses, and support individuals and families affected by substance use.

Ensure dedicated, predictable funding for safety-net providers

The Oklahoma Legislature and executive agencies should allocate dedicated, predictable funding to Oklahoma's behavioral health safety-net providers.

With a pending proposed rule that would lower the income threshold for eligibility for state-funded behavioral health services, providers are concerned about further increases to their uncompensated care costs, especially as the number of uninsured Oklahomans is expected to rise due to recent federal policy changes regarding Medicaid eligibility.

CCBHCs provide treatment to anyone who asks for it, regardless of their ability to pay. The state reimburses CCBHCs for treating people without insurance; the state allocates available funding at the end of the year to offset providers' uncompensated care costs. CCBHCs, however, report that these payments are inadequate.

See more about the proposed rule and Medicaid changes on Page 29.

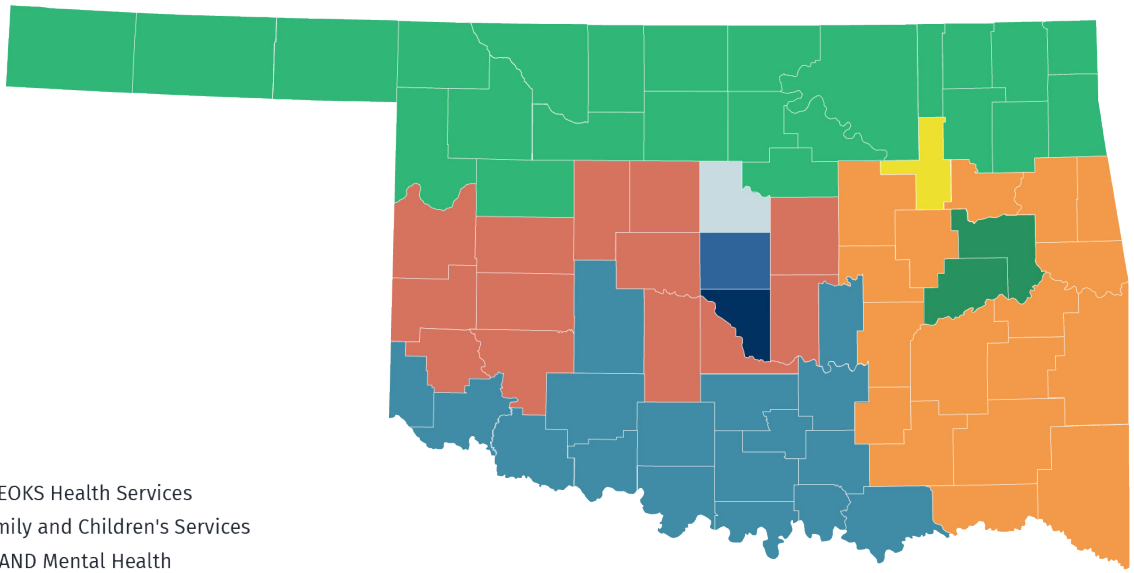
Even as demand for services remains high, financial instability may compel providers to stretch limited resources, reduce staffing, and scale back programming.

Opioid abatement funds may be used to support treatment services, including MOUD, other evidence-based interventions related to OUD. Cities, counties, and school districts can apply for grants through the Oklahoma Opioid Abatement Board.[66]

As providers face increasing uncompensated care and uncertainty around future funding streams, opioid abatement funds provide an opportunity for the state to preserve or expand treatment capacity and prevent service disruptions while sustainable funding solutions are developed.

Abatement funds should be strategically invested in Oklahoma's treatment infrastructure to help strengthen access and address service gaps while reducing pressure on providers serving large numbers of uninsured patients.

Figure 7: Certified Community Behavioral Health Clinics serving Oklahoma counties



- CREOKS Health Services
- Family and Children's Services
- GRAND Mental Health
- Green Country
- Lighthouse Behavioral Wellness Centers
- NorthCare
- Red Rock
- Tulsa County: Family and Children's Services, Counseling and Recovery Services, GRAND Mental Health, and CREOKS Health Services
- Oklahoma County: NorthCare, Red Rock, Family and Children's Services/Hope Community Services

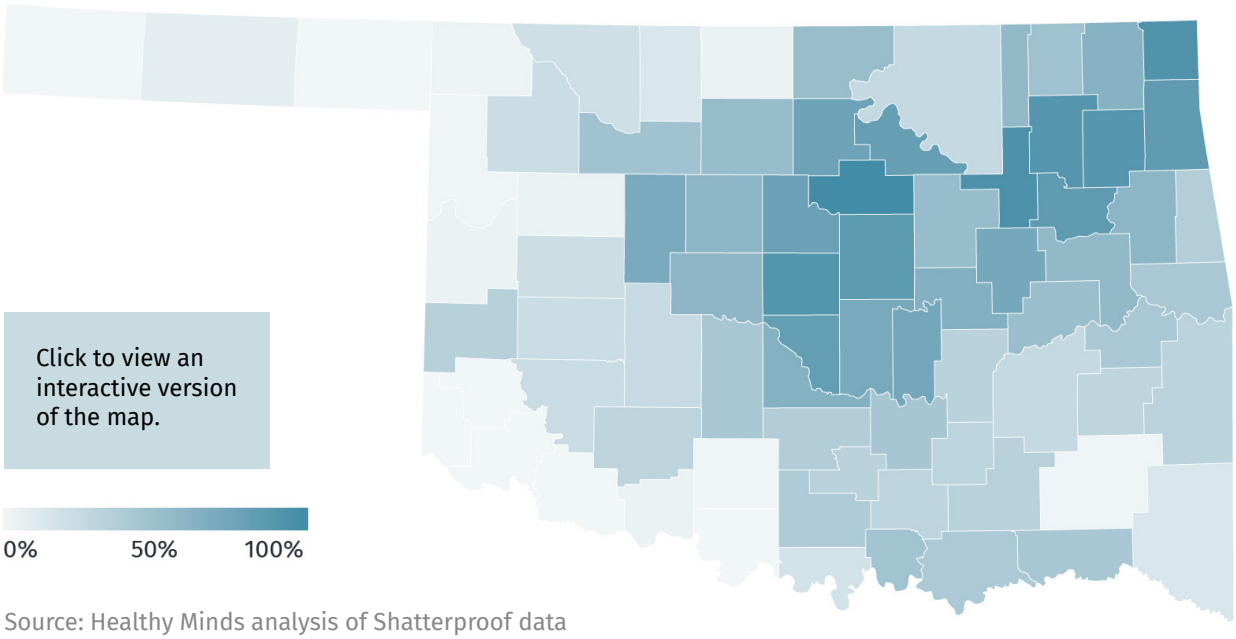
Expand low-barrier, mobile treatment models

Together with telehealth options, mobile MOUD should be part of Oklahoma's solution to offering better statewide access to treatment.

Our analysis of Oklahoma's geographic distribution found that parts of the state require long drives to access MOUD — even more so for people who need to access methadone. Even in parts of the state with better MOUD coverage by driving distance, people without regular access to a car can struggle, as public transportation in Oklahoma is limited.

Figure 8: Percentage of county area within 30-minute driving distance to an MOUD facility

Statewide, about 41% of the state's total area is within a 30-minute drive to an MOUD facility. Six counties — Beaver, Cimarron, Harmon, Jackson, Jefferson, and Tillman — do not have any part of its area within a 30-minute drive to an MOUD facility.



Source: Healthy Minds analysis of Shatterproof data

Especially in geographically isolated areas and regions with insufficient physician coverage to meet demand for MOUD, mobile MOUD can offer an important access point to people who may otherwise struggle to access care.

Oklahoma communities should consider innovative funding solutions — including leveraging opioid abatement and federal grant dollars — to expand mobile MOUD programs. Communities can look to examples of successful Oklahoma programs, such as SWODA's mobile outreach and treatment for OUD, as well as dedicated overdose response teams in Tulsa and Oklahoma City.

Community pharmacies could also play a role in offering greater MOUD access, especially in rural and underserved areas. Several states have authorized pharmacists to do so under collaborative practice agreements with physicians or other authorized prescribers. Community pharmacies can also increase access to methadone in partnership with established OTPs.

In June 2026, SAMHSA issued an advisory highlighting the role pharmacists can play in expanding access to MOUD, particularly buprenorphine.[67] Congress has also established a pathway for DEA-registered pharmacists to become authorized to both prescribe and dispense buprenorphine, provided they are operating within their authorized scope of practice under state law.

Pharmacists can support those with OUD and those receiving MOUD by providing screening and early intervention, medication management, naloxone distribution, and facilitating transitions between MOUD formulations.

With more than 96% of the U.S. population living within 10 miles of a community pharmacy, pharmacists are one of the most accessible health care professionals and can serve as an important entry point into the continuum of addiction treatment.

Strengthen opportunities for high-risk Oklahomans in need of MOUD

Policymakers should devote special attention and funding for high-risk populations in need of MOUD, including pregnant women and people in jails and prisons.

Despite substance use disorders being disproportionately prevalent among people in jails and prisons, jail-based MOUD is underutilized in Oklahoma and across the nation. In the U.S., fewer than 50% of jails offer any form of MOUD, and only 13% provide the medications to all incarcerated individuals who have OUD.[68]

ASAM recommends that jails implement universal screening for substance use disorder, provide all FDA-approved MOUD upon entry, and coordinate continued treatment post-release.[69] Care coordination alone can improve treatment engagement and is associated with reductions in both overdose deaths and overall mortality.

More than 20 states, including Montana and Louisiana, have received federal approval to use a Medicaid waiver — a Section 1115 reentry demonstration — to cover certain transitional health services through Medicaid for eligible people nearing release from incarceration. As Healthy Minds wrote in a 2024 analysis, services offered through these waivers can include case management, comprehensive MOUD, and a 30-day supply of prescribed medications upon release. These services are intended to support continuity of care during the vulnerable transition from incarceration back into the community.

Oklahoma jails offer some access to MOUD, but treatment, patient capacity, and medications vary significantly by facility. The state should expand jail-based MOUD programs and strengthen care continuity following release to improve treatment outcomes.

State spotlight: Rhode Island

Oklahoma could borrow from Rhode Island's statewide jail-based treatment program that provides universal screening, access to all FDA-approved MOUD based on clinical and individual needs, and linkage to care following release.

Within one year of implementation, the state experienced a 12% reduction in statewide overdose mortality and a 61% reduction in overdose deaths among individuals in the first year of release. Approximately 75% of participants also reported continued MOUD treatment.

Rhode Island's program was initially funded through a legislative budget appropriation, but other states have tapped alternative funding streams to facilitate jail-based treatment. For example, Kentucky recently allocated Opioid Abatement funding to expand MOUD services across 14 facilities across the state.

Although formal outcome data are still emerging, broader evidence for jail-based MOUD across other states suggests these programs improve treatment retention and reduce mortality while incarcerated and after release.

Further, Oklahoma lawmakers should earmark funding to expand wraparound perinatal OUD care in geographically isolated areas of the state.

Many pregnant women with opioid use disorder do not receive MOUD, even though professional organizations identify it as the frontline approach for OUD during pregnancy.

Substance use disorder among pregnant women has increased dramatically in Oklahoma over the last two decades, and the state only has one dedicated clinic that integrates substance use treatment in perinatal obstetrics care. Inadequate treatment access puts women and babies at risk for negative health outcomes and has even been identified as a contributing factor in some Oklahoma pregnancy-related deaths.

8 | Conclusion

Opioid use disorder is a treatable chronic disease, but Oklahomans who need medication for treatment encounter unnecessary barriers in acquiring it. Lawmakers and state agencies can make policy changes that allow people to start treatment sooner — and increase the likelihood that they stay in treatment, ultimately creating a healthier future for the state and its residents.

9 | Data limitations

The findings presented in this analysis should be interpreted in light of several data limitations. First, much of the information obtained from Shatterproof is based on self-reported data rather than claims data. As a result, responses may be subject to reporting inconsistencies, misinterpretation of survey questions, or variation in how services and access are defined across providers. Additionally, provider-level data do not capture client-level needs, utilization patterns, or whether individuals who would benefit from specific medications or services are successfully able to access them.

Telehealth reporting also lacks specificity regarding which services are offered. For example, sites may provide one or more of the following services: intake, induction, or follow-ups. Consequently, the data reflect reported service availability rather than the extent to which clients are receiving or able to obtain low-barrier telehealth services.

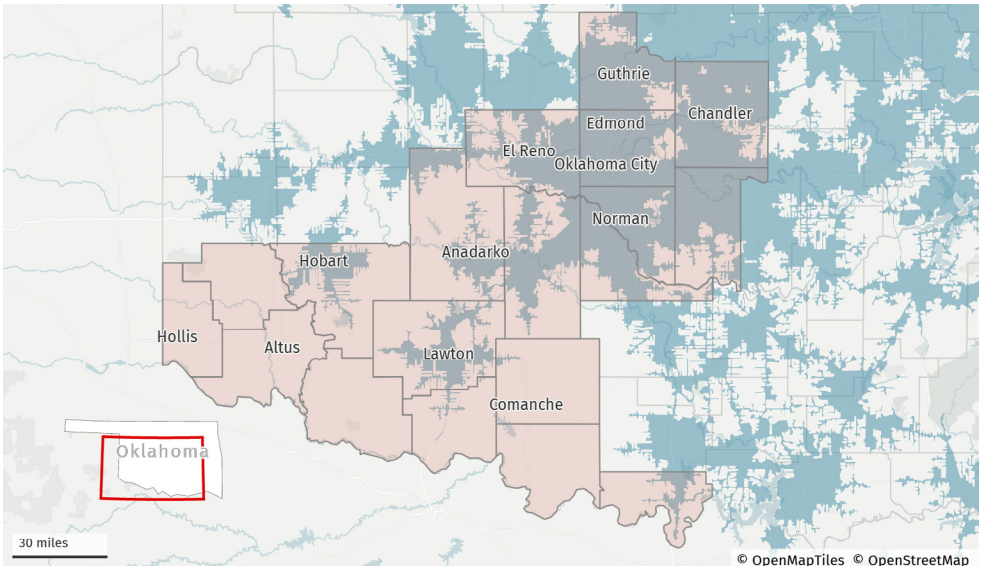
Much of the collected data was reported by CCBHCs, meaning the analysis likely overrepresents larger organizations rather than individual OBOT providers. ODMHSAS does not maintain a comprehensive clearinghouse of office-based treatment providers. Prior to the removal of the federal X waiver in 2023, SAMHSA published a list of waivered providers in each state. It is now unclear whether the number of buprenorphine prescribers has changed since that time. Additionally, OBOT providers were not asked to indicate their patient load, making it difficult to assess whether existing capacity is sufficient to meet community need.

10 | Appendices

Appendix A: Drive time maps by region: Southwest

Figure 9: Parts of southwest Oklahoma within a 30-minute drive to an MOUD treatment facility

36% of southwest Oklahoma is within a 30-minute drive to an MOUD facility.

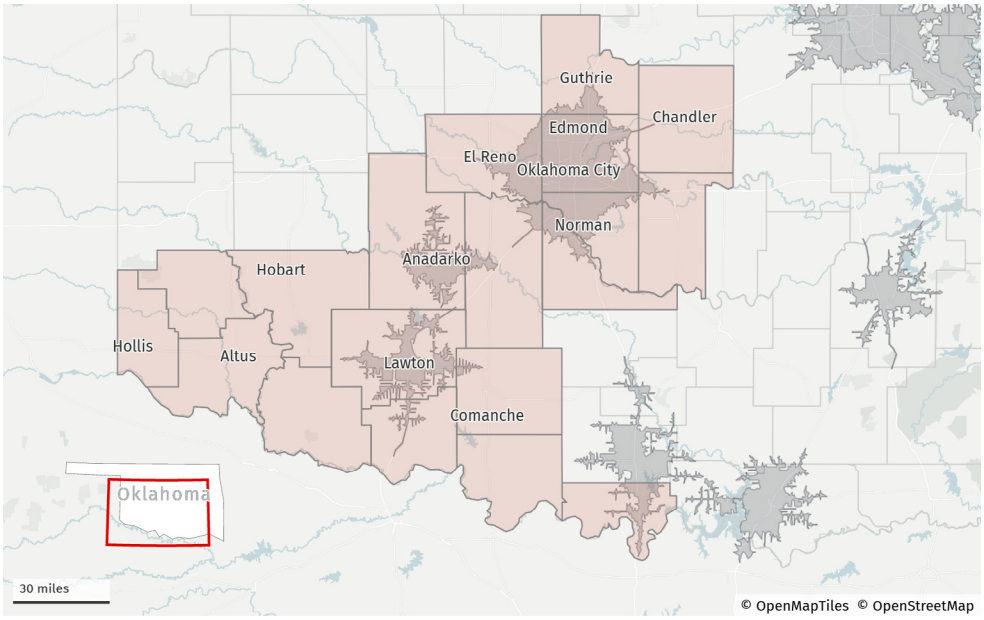


Click each map to view larger versions.

Areas within a 30-minute drive to an MOUD facility

Figure 10: Parts of southwest Oklahoma within a 30-minute drive to an OTP

13% of southwest Oklahoma is within a 30-minute drive to an OTP.



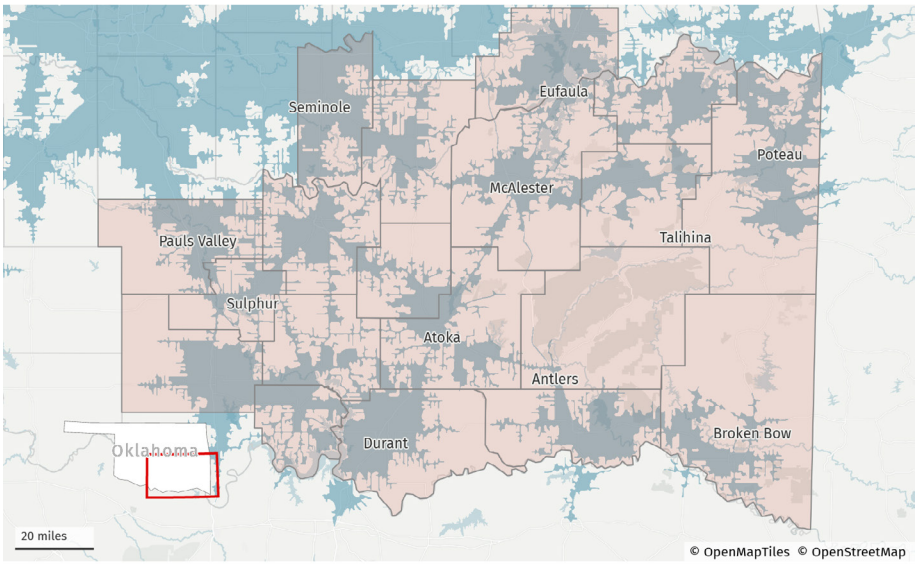
Areas within a 30-minute drive to an OTP

Source for both maps: Healthy Minds analysis of Shatterproof data

Appendix B: Drive time maps by region: Southeast

Figure 11: Parts of southeast Oklahoma within a 30-minute drive to an MOUD treatment facility

36% of southeast Oklahoma is within a 30-minute drive to an MOUD facility.

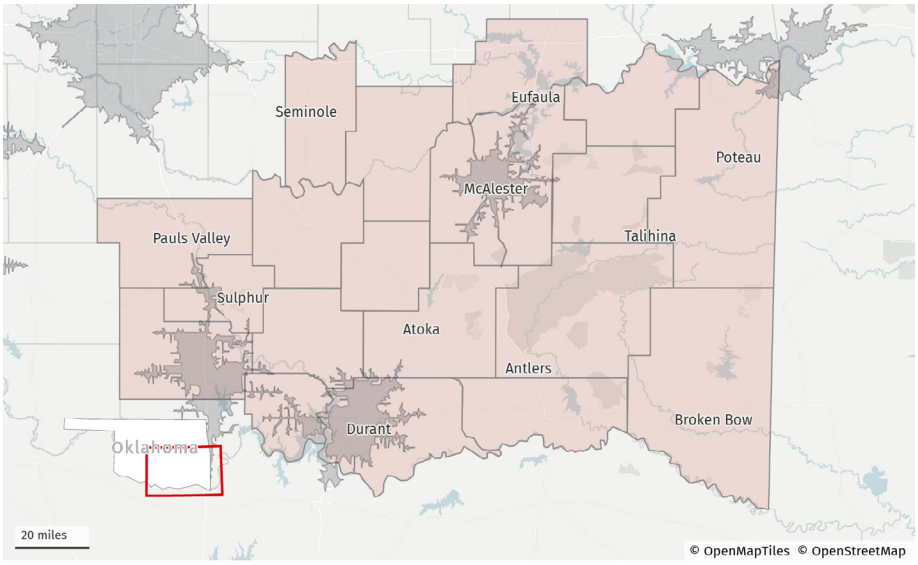


Click each map to view larger versions.

Areas within a 30-minute drive to an MOUD facility

Figure 12: Parts of southeast Oklahoma within a 30-minute drive to an OTP

6% of southeast Oklahoma is within a 30-minute drive to an OTP.



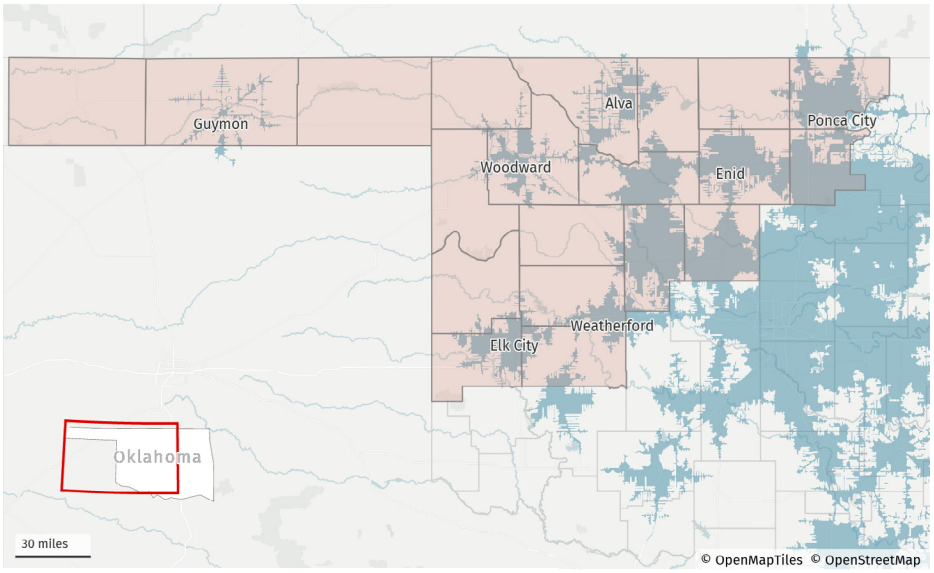
Areas within a 30-minute drive to an OTP

Source for both maps: Healthy Minds analysis of Shatterproof data

Appendix C: Drive time maps by region: Northwest

Figure 13: Parts of northwest Oklahoma within a 30-minute drive to an MOUD treatment facility

26% of northwest Oklahoma is within a 30-minute drive to an MOUD facility.

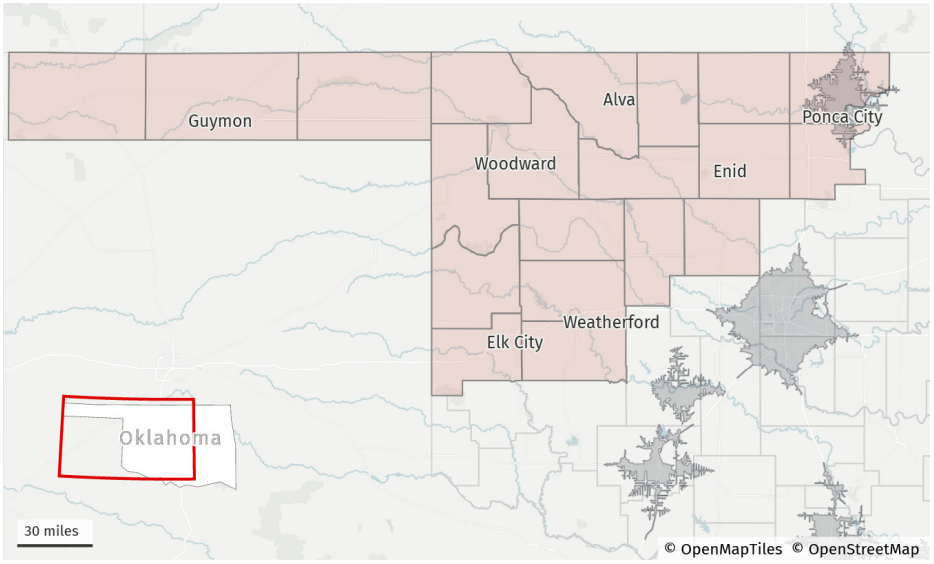


Click each map to view larger versions.

Areas within a 30-minute drive to an MOUD facility

Figure 14: Parts of northwest Oklahoma within a 30-minute drive to an OTP

2% of northwest Oklahoma is within a 30-minute drive to an OTP.



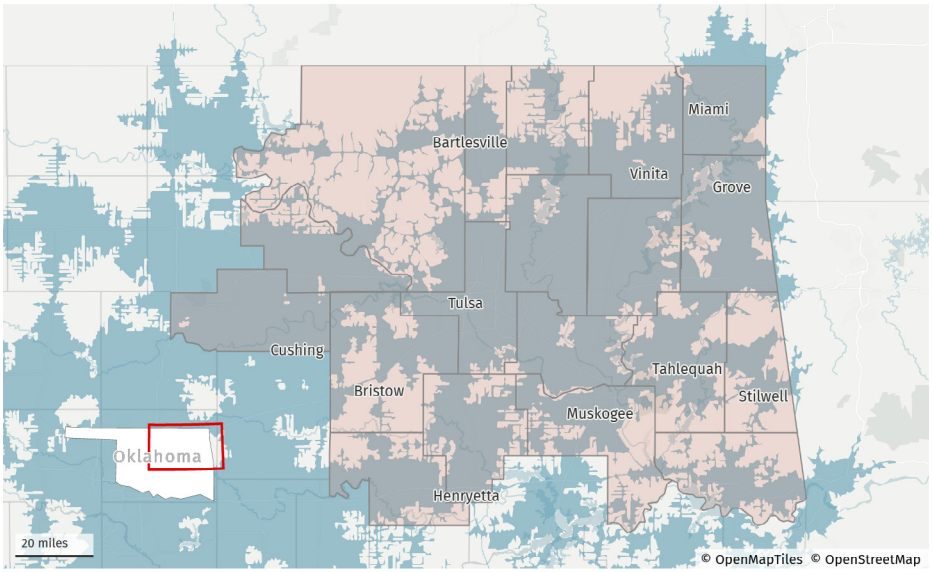
Areas within a 30-minute drive to an OTP

Source for both maps: Healthy Minds analysis of Shatterproof data

Appendix D: Drive time maps by region: Northeast

Figure 15: Parts of northeast Oklahoma within a 30-minute drive to an MOUD treatment facility

68% of northeast Oklahoma is within a 30-minute drive to an MOUD facility.

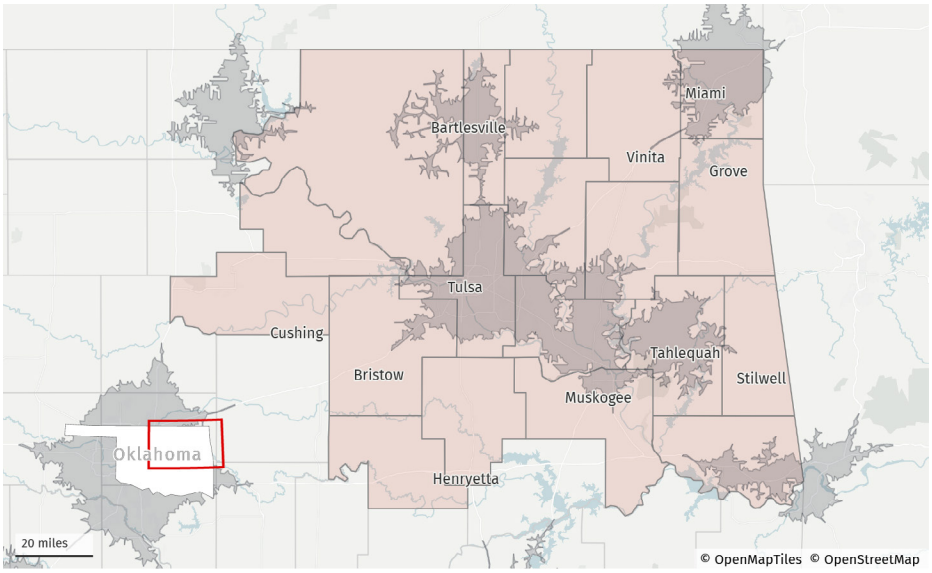


Areas within a 30-minute drive to an MOUD facility

Click each map to view larger versions.

Figure 16: Parts of northeast Oklahoma within a 30-minute drive to an OTP

21% of southwest Oklahoma is within a 30-minute drive to an OTP.



Areas within a 30-minute drive to an OTP

Source for both maps: Healthy Minds analysis of Shatterproof data

Appendix E: County drive-time area percentages as tables

Region	County name	Percentage of county area within 30-minute drive to MOUD facility	Percentage of county area within 30-min drive to an OTP
Northeast	Adair	36.7	0.6
Northeast	Cherokee	59.6	42
Northeast	Craig	62.8	1.8
Northeast	Creek	53.3	9
Northeast	Delaware	84.1	0.2
Northeast	Mayes	89.2	12.2
Northeast	Muskogee	56.1	9.3
Northeast	Nowata	48.2	3
Northeast	Okfuskee	64.6	0
Northeast	Okmulgee	72	0
Northeast	Osage	26.4	8.2
Northeast	Ottawa	92.1	68.5
Northeast	Pawnee	81	0.7
Northeast	Payne	98.9	0
Northeast	Rogers	90	22.9
Northeast	Sequoyah	42	23.7
Northeast	Tulsa	94.1	77.2
Northeast	Wagoner	84.9	70.7
Northeast	Washington	56.2	44.4
Northwest	Alfalfa	13.9	0
Northwest	Beaver	0	0
Northwest	Beckham	34.8	0
Northwest	Blaine	70.5	0
Northwest	Cimarron	0	0
Northwest	Custer	22.1	0
Northwest	Dewey	4	0
Northwest	Ellis	1.7	0
Northwest	Garfield	53.1	0
Northwest	Grant	3.5	0

Click to view a sortable, downloadable version of this table.

Region	County name	Percentage of county area within 30-minute drive to MOUD facility	Percentage of county area within 30-min drive to an OTP
Northwest	Harper	2.6	0
Northwest	Kay	52.6	31.4
Northwest	Kingfisher	58.7	0
Northwest	Major	47.4	0
Northwest	Noble	77.1	4.7
Northwest	Roger Mills	3.5	0
Northwest	Texas	7.4	0
Northwest	Washita	23.1	0
Northwest	Woods	20.6	0
Northwest	Woodward	23	0
Southeast	Atoka	33.4	0.6
Southeast	Bryan	40.8	32.3
Southeast	Carter	39.5	33.4
Southeast	Choctaw	42.8	0
Southeast	Coal	31.3	0
Southeast	Garvin	37.4	1.4
Southeast	Haskell	42.2	0
Southeast	Hughes	32.5	0
Southeast	Johnston	31	2.4
Southeast	Latimer	30	0.1
Southeast	Le Flore	32.2	1.5
Southeast	Marshall	46.7	13
Southeast	McCurtain	14.1	0
Southeast	McIntosh	51.1	0.1
Southeast	Murray	33.1	6.1
Southeast	Pittsburg	26.1	16.9
Southeast	Pontotoc	43.8	0
Southeast	Pushmataha	1.7	0
Southeast	Seminole	73.2	0
Southwest	Caddo	25.6	15.4
Southwest	Canadian	58.6	24.4
Southwest	Cleveland	81.9	39.3
Southwest	Comanche	30.8	26.7
Southwest	Cotton	3.7	3.6

Region	County name	Percentage of county area within 30-minute drive to MOUD facility	Percentage of county area within 30-min drive to an OTP
Southwest	Grady	42.8	6.3
Southwest	Greer	0.1	0
Southwest	Harmon	0	0
Southwest	Jackson	0	0
Southwest	Jefferson	0	0
Southwest	Kiowa	23.4	0
Southwest	Lincoln	85.8	0.1
Southwest	Logan	78.3	8.7
Southwest	Love	18.3	17.3
Southwest	McClain	63.9	15.6
Southwest	Oklahoma	90.7	83.5
Southwest	Pottawatomie	71.1	2.7
Southwest	Stephens	1.3	1.3
Southwest	Tillman	0	0

Click to view a sortable, downloadable version of this table.

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