Oklahoma's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the State of Oklahoma present an **unprecedented opportunity for generational investment** in treatment capacity for chronic substance abuse (CSA) and severe mental illness (SMI).

Oklahoma is set to receive **more than $650 million** (*$670,456,488.11*) in opioid settlement funds—equal to more than one-third of the state's share of the monumental Tobacco Master Settlement Agreement.[1] With nineteen separate settlements and payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The state must ensure that this opportunity for treatment investment does not go underutilized. **Oklahoma can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

Oklahoma places all opioid settlement funds into the Oklahoma Opioid Abatement Revolving Fund, and provides that the Attorney General shall not expend more than 10 percent of funds for "statewide opioid abatement projects," and requires all statewide projects be approved by the nine-person Oklahoma Opioid Abatement Board.[2] [3] The remaining funds are to be disbursed to political subdivisions in amounts calculated from a complex formula determining the relevant share of the impact of the opioid epidemic on each subdivision.[4] **The state should amend the statute to allow the Attorney General to allocate a larger percentage of funds for statewide projects and require approval by the legislature instead of the Board.** Current allocations are not available, and therefore it is not possible to see if opioid funds are being allocated responsibly.

The state must rein in the potential misallocation of these funds and prioritize investments in comprehensive treatment networks. **Three priorities** (Certified Behavioral Health Clinics, secure psychiatric beds, and community SMI/CSA response) **will ensure these funds have the largest impact** on Oklahoma.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care, have table funding and are supported by all recent presidential administrations. CCBHCs are a key response to the crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Solution: Fund the development and expansion of CCBHCs.**
    - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
    - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
    - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

State Psychiatric Hospitals

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. Oklahoma currently has only **4.4 state psychiatric beds** per 100,000 people available for civil patients.[5-6] Treatment Advocacy Center recommends a rate of 30-60 beds per 100,000. Even counting non-public secure psychiatric beds, Oklahoma still falls short of the minimum.[7] Secure beds are costly, but a necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Solution: Fund the expansion of civil psychiatric beds.**
    - Invest in expanding state hospital capacity.
    - Move forensic (criminal) commitments to a jail-based restoration facility.
    - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for institutions for mental diseases (IMDs).

Inpatient Stabilization Centers and Mobile Crisis Teams

Emergency departments (EDs) are supposed to be a last-resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care. This is especially true for low- to medium-acuity mental health crises. In order for CCBHCs and state psychiatric bed expansions to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else these investments will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Solution: Fund community-based mental health response resources.**
    - Expand community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
    - Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).
    - Support integration with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

[1] KFF. "Actual Tobacco Settlement Payments Received by the States (in millions)." Accessed 8 September 2025. https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments.
[2] 74 O.S. § 30.6 (OSCN 2025), Political Subdivisions Opioid Abatement Grants Act. https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=487121.
[3] 74 O.S. § 30.7 (OSCN 2025), Political Subdivisions Opioid Abatement Grants Act. https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=487122.
[4] 74 O.S. § 30.8 (OSCN 2025), Political Subdivisions Opioid Abatement Grants Act. https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=487123.
[5] Treatment Advocacy Center, "Oklahoma Psychiatric Beds Report." 2023. https://www.tac.org/wp-content/uploads/2023/10/Oklahomabedsinformation.pdf.
[6] United States Census Bureau, "2023 American Community Survey – Total Population." https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000.
[7] Silver, Shanti, "Estimating Psychiatric Bed Need in the United States," p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.