THE CENTER
at Sierra Health Foundation

Exploring the Landscape of Medications for Addiction Treatment (MAT) in California

FINDINGS FROM A STATEWIDE ASSESSMENT

December 2, 2025

Acknowledgements

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How to Navigate this Report

This report explores the landscape of Medications for Addiction Treatment (MAT) in California.

- The content in this report is based on peer-reviewed and gray literature, collection and analysis of secondary data, and primary data collection from MAT providers, clients, and potential clients in the form of interviews, focus groups, site visits, and/or surveys.
- The intended audience of this report is organizations or individuals involved in shaping access to MAT at a high-level, such as policymakers, funders, and technical assistance providers.
- This report also summarizes promising practices for MAT providers; however, The Center at Sierra Health Foundation has produced a separate deliverable tailored to MAT providers, in the form of a website with MAT program case studies.

You can navigate this report from start to finish or by jumping to an area of interest. The table below describes each part of the report. A full table of contents begins on the subsequent page.

Part (hyperlinked)	**Description**
Executive Summary	• Summarizes the full landscape analysis report, including its purpose, methods, findings, and recommendations to further MAT expansion
Background	• Briefly reviews the overdose crisis in California, the options for MAT, and the purpose and scope of this landscape analysis report
The State of MAT in California	• Explores the history of MAT in California, providing at timeline of major policy and funding shifts that have expanded MAT access in diverse program settings, as well as MAT-related gaps and inequities • Subsections commonly include secondary data about MAT in California and quotations from MAT providers and clients throughout the state
MAT Barriers and Opportunities	• Addresses five areas of MAT barriers and opportunities through the lens MAT providers, statewide experts, and MAT clients throughout California • Subsections commonly include stakeholder quotations and/or data from a statewide MAT provider survey
Promising Programmatic Practices	• Shares five categories of promising MAT program practices, as described by MAT providers, statewide experts, and MAT clients inCalifornia • Subsections commonly include quotations from stakeholders about promising practices and/or tables with specific practice examples
Conclusions & Recommendations	• Summarizes key findings and lists recommendations for MAT expansion related to policy, funding, and technical assistance
Appendices	• Provides more details on report methods, including the full data tables from a statewide survey of MAT providers conducted for this assessment

Table of Contents

Glossary of Key Words and Acronyms

Key Word or Acronym	Definition in this Report
1115 waiver	A state-level waiver to explore innovative ways to use Medicaid funding; this report discusses how California has used its 1115 waiver to expand MAT access and cultural responsiveness
Affordable Care Act (ACA)	Enacted in 2010, a federal law that intends to lower healthcare costs and make health care insurance more affordable
Agonist (opioid agonist)	A drug that binds to opioid receptors and produces a similar effect as the opioid; as a "partial" agonist, doesn't bind fully and produces a less strong effect than a full agonist
Antagonist (opioid antagonist)	A drug that binds to opioid receptors and blocks opioids from reaching the receptors
Basic needs	Resources needed for survival, such as water, food, clothing, shelter, safety, and items that support hygiene
Buccal administration	A way to administer medication in which the medication is placed in the cheek, where it dissolves and is absorbed into the bloodstream
Buprenorphine	A prescription opioid medication and controlled substance; this report primarily focuses on buprenorphine as a partial opioid agonist used to treat for opioid use disorder
Carceral	Related to jail or prison settings
Contingency management	An evidence-based approach for changing substance use behavior through rewards that reinforce desired behaviors (such as adhering to treatment or abstinence); in this report, contingency management typically refers to treatment for stimulant use
Controlled substance	A drug regulated by the government, typically due to its potential for addiction and misuse
Culturally responsive	Acknowledging and providing care that reflects the culture of a patient or client with the intention of improving the quality of care
Disparity	A difference, typically rooted in injustice; this report focuses on disparities in opioid-related outcomes across different groups, such as disparities by race/ethnicity, gender identity, housing status, and geography, and others
Diversion	Distribution or use of prescription drugs that is not aligned with the intent of the prescription, such as selling one's prescribed medication or taking a medication not prescribed to you
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Launched in 2015 under a Medicaid 1155 waiver, allows counties to opt-in and oversee local, integrated delivery of substance use treatment services for Medi-Cal patients
Drug Enforcement Administration (DEA)	The United States federal agency that regulates and enforces laws related to illicit drugs and controlled substances
Fentanyl	An opioid drug; this report primarily focuses on illicitly produced fentanyl that has been a major driver of the current wave of the opioid-related overdose death crisis
Harm reduction	A set of practical strategies and ideas intended to reduce the negative consequences related to substance use

Induction (for buprenorphine)	Initiating the use of buprenorphine medication
LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning, and other identities)	An umbrella term used for communities with diverse sexual orientations, gender identities, and/or gender expression
Lived experience	Personal experience with a certain condition or identity, such as substance use or mental health disorders; this report primarily focuses on lived experience of substance use, especially opioid use
Low-barrier (low-threshold)	An approach that intends to minimize barriers to engagement; this report primarily focuses on low-barrier programs that offer medications for addiction treatment (MAT)
Macrodosing	Taking a larger than standard dose of a medication to achieve an intended clinical outcome; this report mentions macrodosing of buprenorphine
Medications for Addiction Treatment (MAT)	Medications for opioid use disorder (MOUD), such as methadone, buprenorphine, and naltrexone; this report occasionally references non-opioid forms of MAT (such as medications for stimulant use)
Medications for Addiction Treatment (MAT) provider	An organization that provides MAT or a person who works at such an organization, such as a clinician or other staff member
Medi-Cal	California's Medicaid program that provides health insurance for people and families with lower income, pregnant people, seniors, and people with disabilities, among others; Medi-Cal is funded through a combination of federal and state resources; MAT is typically covered by Medi-Cal
Methadone	A prescription opioid and controlled substance used to treat opioid use disorder by acting as an opioid agonist
Microdosing	Taking a smaller than standard dose of a medication to achieve a clinical outcome; this report mentions microdosing of buprenorphine
Naloxone (Narcan)	An opioid antagonist in the form of a nasal spray or injection that can be used to reduce opioid-related overdose
Naltrexone	A prescription opioid antagonist used to treat opioid use disorder and alcohol use disorder
Narcotic treatment program (NTP); also opioid treatment program (OTP)	A substance use treatment program that is federally certified to administer MAT and related services to clients *Mobile narcotic treatment programs* are NTPs with no set location, such as NTPs based in vans that park at different places in a community
Non-traditional treatment settings	Treatment settings for opioid use disorder outside of brick-and-mortar narcotic treatment programs, such as emergency departments, hospitals, primary care, street medicine, syringe services programs, and mobile narcotic treatment programs
Opioid settlement funds (OSF)	Funds resulting from settled lawsuits with pharmaceutical companies because of their contributions to the opioid epidemic; OSF are distributed to states, local jurisdictions, and tribal groups with the intention of supporting initiatives that address the ongoing opioid-related crisis
Overdose	The result of a drug dose that is greater than the body can handle, resulting in adverse symptoms and potentially death

Peer support specialist	A California certification (via the 1115 Medicaid waiver) that centers and trains adults with lived experience to provide culturally responsive services to people with mental health and/or substance use conditions
Polysubstance use	Pattern of using of more than one substance/drug, such as use of both opioids and stimulants over a period of time
Precipitated withdrawal	*See withdrawal*
Prior authorization	Process in which a person's health insurance must approve a health service or medication before it is provided in order for the service or medication to be covered by the insurance plan
Social determinants of health	The conditions in which people live that shape their health, such as their neighborhood, healthcare, education, social support, and economic wellness
State Opioid Response (SOR) grants	Federally funded grants given to states to address the opioid crisis
Stigma	Negative attitudes, beliefs, and stereotypes about a group of people that lead to marginalization of the group; this report primarily focuses on stigma related to MAT, drug use, and homelessness
Stimulant	A drug that speeds up nervous system activity; this report primarily discusses stimulants produced illicitly, such as methamphetamine or cocaine
Sublingual administration	A way to administer medication in which the medication is placed under the tongue, where it dissolves and is absorbed into the bloodstream
Substance use navigator (SUN)	A liaison between patients in emergency department/hospital settings and the substance use treatment system that helps build trust with and advocate for patients; this report typically references SUNs from the California Bridge model
Syringe services program (SSP)	A program that offers sterile syringes while collecting used syringes; typically, SSPs provide additional services such as health education, overdose prevention, basic need supplies, and referrals to social services
Take-homes	Doses of medication that can be taken home for use on future days rather than administered at a clinic; this report focuses on take-homes of methadone
Traditional Healer/ Natural Helper services	Culturally responsive substance use treatment services offered through "Indian Health Care Providers" (IHCP) for Medi-Cal members
Trauma	The result of one or many distressing experiences that create a long-lasting, negative impact on a person's life; may lead to physical or mental health challenges Can occur at many levels (e.g., individual, family, community) and both directly or indirectly (e.g., *vicarious trauma* through hearing or observing the traumatic experiences of others)
Trauma-informed approaches	Taking into account the experiences of trauma among clients and staff when designing how an organization and its staff design and deliver services
Withdrawal	The symptoms that can result when a person stops taking a drug; opioid-related withdrawal symptoms may include pain, cravings, vomiting, chills, and diarrhea, among others *Precipitated withdrawal* is a particularly strong and unpleasant form of opioid-related withdrawal that can result if buprenorphine is taken when opioids are still lingering in the body

Executive Summary

Purpose of this Landscape Analysis

Medications for Addiction Treatment (MAT)—including methadone, buprenorphine, and naltrexone—are an evidence-based intervention with high potential to curb California's opioid-related overdose crisis and improve the lives of people who use opioids. Ensuring MAT availability and acceptability is critical to its equitable uptake. In 2025, The Center at Sierra Health Foundation collaborated with an external consulting firm to conduct a statewide assessment of MAT to guide future implementation, policy, and funding related to MAT. This landscape analysis report summarizes the findings of the assessment, synthesized from a literature review, secondary data analysis, a statewide provider survey, and engagement of more than 122 MAT providers, subject matter experts, people who use opioids, and other key stakeholders throughout California in the form of interviews, focus groups, and site visits.

NOTE: The intended audience of this detailed landscape analysis report includes individuals and organizations that impact MAT provision at a high level, such as funders, policymakers, and technical assistance providers.

While this report also summarizes promising practices for direct provision of MAT, recommendations for MAT providers are shared separately on The Center at Sierra Health Foundation's website with MAT program case studies.

Key Findings: The State of MAT in California

1. MAT prescribing, especially for buprenorphine, has increased dramatically from 2014–2025, and providers credit this improvement as key to reducing overdose-related mortality and morbidity.
2. Notable disparities exist in MAT availability by geography, especially in rural areas.
3. Racial disparities in MAT availability and acceptability persist, particularly for people who are American Indian/Alaska Native, Black/African American, and Latine. Racial disparities intersect with other disparities—such as when comparing Latina women to non-Latino white men.
4. While emerging less frequently in this assessment, other key MAT-related disparities may occur by age, gender identity, sexual orientation, immigration status, primary language spoken, and incarceration history, among other factors.
5. Although California appears to perform better than the U.S. average when considering the likelihood of being prescribed MAT for opioid use and treatment success once MAT is prescribed, there is room to improve both of these measures.

Key Findings: Major Policy and Funding Milestones for MAT in California

1. Shifts in Medi-Cal, including expanded Medi-Cal eligibility, initiation of Medi-Cal billing for MAT through the Drug Medi-Cal Organized Delivery System, and the addition of billable peer support specialist roles have supported the reach, financial sustainability, and quality of MAT programs.
2. Loosened MAT regulations, such as expanding take-home methadone doses, permitting new mobile narcotic treatment programs, eliminating the X-waiver, and allowing telehealth prescribing have made MAT more available and accessible. While driven initially by COVID-19 emergency exemptions, the success of these loosened regulations—without adverse outcomes reported—led to their permanence, which benefited Californians.
3. Unprecedented investment in MAT—through State Opioid Response grants, California state general funds, and opioid settlement funds—has facilitated projects in diverse settings beyond specialized opioid treatment programs, including hospitals, carceral settings, harm reduction programs, residential treatment, primary care, emergency medical services, and mobile models.

Key Findings: Barriers to MAT in California

1. Pervasive stigma poses steep barriers to MAT, especially for methadone, which is perceived as "drug-switching" in some communities and is regulated by stringent requirements that reinforce stigma. MAT-related stigma is compounded by the even greater stigma related to drug use; people who use opioids commonly experience poor treatment in healthcare settings and this fuels trauma, distrust, and the spread of misinformation.
2. Providers underestimate patient fear and trauma related to buprenorphine induction in the era of fentanyl. While providers generally perceive buprenorphine induction as challenging but manageable, many people with a history of opioid use cite withdrawal "horror stories"—both their own experiences and the experiences of their peers.
3. High-threshold MAT logistics—including insurance hurdles, transportation, scheduling appointments, and the disconnected structure of healthcare—continue to pose barriers to accessibility and engagement. Overlapping health and social conditions—particularly homelessness, stimulant use, and co-occurring mental health disorders—exacerbate the challenges in navigating MAT logistics.
4. Fear of MAT diversion (i.e., a MAT client selling their medication or giving it to others) has resulted in strict state methadone laws and enormous administrative burden for existing and new MAT programs. Regulations on emerging MAT options—such as injectable buprenorphine—pose barriers to accessing one's medication of choice.
5. Inadequate funding of MAT programs—resulting from low Medi-Cal billing reimbursement rates, stagnant annual grant amounts, and inflexible allowable use of available funds—poses a sustainability risk and contributes to staff turnovers. MAT programs that depend fully on grants are at heightened sustainability risk due to their inability to bill for services.

Key Findings: Promising Practices for MAT Implementation

1. Tailoring MAT to the changing drug supply, such as through adapted buprenorphine induction techniques and higher doses of methadone, is supporting patient engagement in MAT. Shared decision-making with clients around their medication choice and induction process options supports agency, trust, and improvements in the patient experience.
2. Continuous, whole-person care supports MAT engagement by addressing clients' holistic needs. MAT programs are providing a wide range of in-house MAT and whole-person services while using partnerships to fill capacity gaps, expand their scope, and improve their impact.
3. Low-threshold models recognize the social inequities that underly opioid use and clients' ability to engage with MAT's logistical hurdles. Applying a harm reduction lens supports low-threshold care by destigmatizing drug use, centering client-defined goals, and allowing people with lived experience to shape and strengthen MAT programs.
4. MAT programs are destigmatizing MAT and providing accurate MAT information among providers, patients, and patients' families, with peer-to-peer approaches noted as promising among providers and patients. Truly reaching patients with destigmatizing, accurate information requires going *to* people who use opioids, as well as promoting the spread of positive MAT experiences through "word of mouth" in communities of people who use drugs.
5. MAT programs are building resilience to anticipated funding changes through non-financial staff retention techniques, improving program efficiency, and soliciting buy-in from internal sources of power. Many programs are engaging the broader community around the topics of MAT, overdose prevention, and harm reduction, with mixed success

Conclusions, Recommendations, and Questions for the Future

This assessment of California's MAT landscape notes the great strides that California has made in expanding MAT access. In particular, policy change and financial investment in MAT at the federal and state levels have lowered barriers to access, engaged a wider range of MAT providers, and reduced MAT-related stigma. Beyond the many findings listed above, this assessment yields several recommendations for policymakers, funders, and technical assistance providers to further MAT expansion across the state, while raising several key questions for the future (see next page).

	Recommendations	Future Questions to Explore
POLICY	1. Explore options to further loosen MAT restrictions, such as ensuring state regulations on methadone align with federal law, considering minimums or mandates related to take-home doses of methadone to ensure that individual programs do not impose unnecessary barriers, and reducing insurance and logistical hurdles to injectable buprenorphine access. 2. Explore options to increase buprenorphine stock at pharmacies to ensure that buprenorphine is readily accessible regardless of where a MAT client lives. 3. Explore options to reduce the administrative burden for methadone programs, such as paperwork requirements and licensing processes, so that more time goes to patient care and MAT delivery is more efficient with fewer resources.	• To what extent will recent California legislation (AB 2115) bring state methadone practices in alignment with federal law? • What models have been used in and beyond California to improve buprenorphine stock in pharmacies? • What policy levers are involved in the pricing of different formulations of buprenorphine (e.g., sublingual vs. injectable)?
FUNDING & SUSTAINABILITY	1. Ensure Medi-Cal reimbursements are sufficient for existing MAT programs, including reimbursement rates for provider roles and Incidental Medical Services. 2. Carve out funding for innovation, as has been done in successful past MAT pilots, to expand MAT into settings with high potential but limited infrastructure (e.g., primary care). 3. Fund capacity-building to help MAT programs that rely on grant funding become self-sustaining through Medi-Cal billing. 4. Explore options to expand mobile narcotic treatment program (MNTP) implementation.	• What are the true costs of operating different MAT program models? • What would a detailed map of California's MAT funding ecosystem look like? • What models exist for MAT program sustainability within community organizations? • How can funders offset changes to the funding landscape that may make MAT resources more scarce?
TECHNICAL ASSISTANCE	1. Develop standard, iterative and ongoing guidance around buprenorphine induction options so that MAT providers have better awareness of the options available to mitigate precipitated withdrawal and reduce negative patient induction experiences. 2. Consider how MAT program design and evaluation can center patient-defined success criteria in addition to traditional, clinically meaningful metrics (e.g., avoiding overdose). 3. Provide support for scenario planning so that MAT programs can sustain and adapt their work within a range of possible future funding environments.	• What types of trainings do MAT programs need most, and to what extent do these trainings exist? • What are the specific protocols by which MAT programs can make services low-barrier? • What role does the technical assistance marketplace play in addressing this report's recommendations?

BACKGROUND

Ending the opioid-related overdose crisis: the role of MAT

"There are people walking in this world today because they were able to access MAT... Without MAT, they wouldn't be here...it gives people their lives back." *- MAT provider*

1. California is experiencing a fatal opioid-related overdose epidemic

In parallel to the broader U.S., California is experiencing a crisis of drug-related fatal overdose, driven in part by the presence of synthetic opioids like fentanyl in the drug supply. In 2022, approximately 1.8% of Californians had opioid use disorder.[2] In 2023, nearly 8,000 Californians died of opioid-related overdoses, representing a fatal opioid-related overdose death rate of 21 per 100,000.[3] While California's opioid-related death rate is lower than that of the U.S. (24 per 100,000), the state hosts the highest count of overdose deaths nationally due to its large population size.[4,5]

> **"When fentanyl first came out, I literally got PTSD because of how many overdoses that I had to deal with on a daily basis."**
>
> *-MAT client*

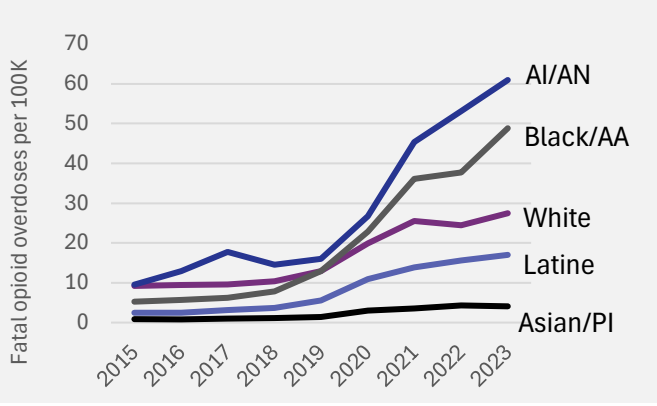
2. California's fatal overdose epidemic is characterized by inequity

Opioid-related overdose death disparities occur with respect to:[i]

- **Sex.** Men experience fatal opioid overdose at a rate more than three times that of women.[3]
- **Race/ethnicity.** While most opioid-related overdose deaths occur among white Californians, (i) American Indian/Alaska Native people and Black/African American people experience fatal opioid-related overdose at rates nearly triple and double that of the general population, respectively (Exhibit 1).[3]

Exhibit 1: Fatal opioid-related overdose rates by race/ethnicity

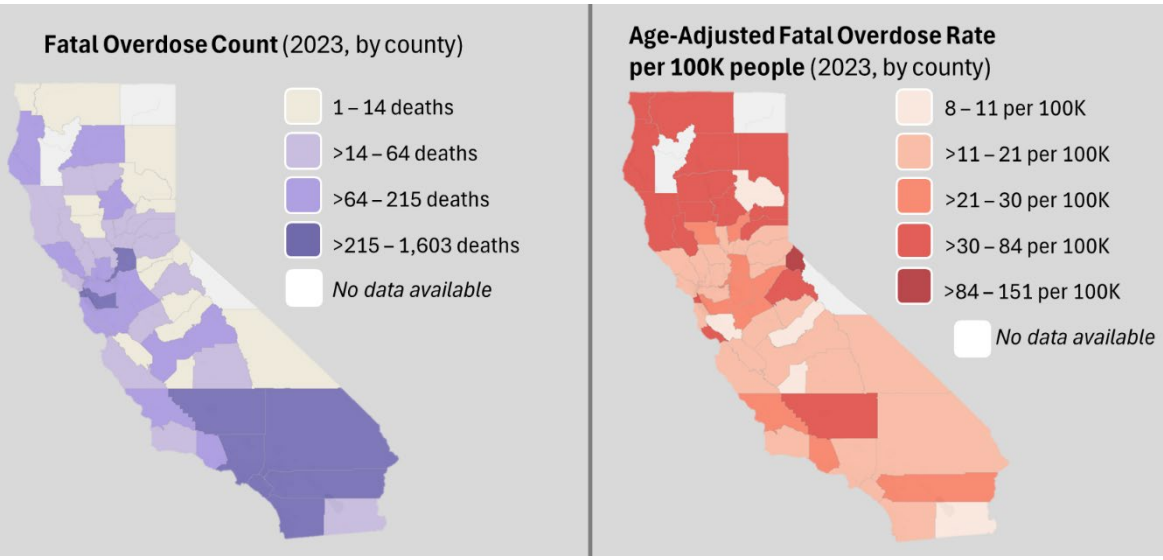
AI/AN = American Indian/Alaska Native, AA = African American, PI = Pacific Islander. Data source: California Overdose Surveillance Dashboard



[i] Overdose death disparities likely reflect disparities in who uses opioids; however, data on who uses opioids in California are not readily available. Note: Sex categories on the California Overdose Surveillance Dashboard include "male" and "female." No data are provided for nonbinary people. In addition, given that overdose death data are drawn from sources like death certificates, these data may not accurately reflect gender identity if the sex listed on a person's death certificate does not match their gender identity.

- **Age.** Fatal opioid-related overdose impacts all ages; in 2023, people 30-44 years experienced the highest rate.[3]
- **Housing status.** 2023 data from Los Angeles—the California city with the largest homeless population—noted overdose as the leading cause of death for people experiencing homelessness. Overdose made up 45% of deaths, with fentanyl involved in 70% of overdose deaths.[6]
- **Geography.** The rate and magnitude of overdose deaths vary across California counties (Exhibit 2).[3,ii] Notably, while more populated counties have the highest counts of opioid-related overdose deaths (purple map below), less populated rural counties—particularly those in the North State and North Coast regions of California—are among the counties with the highest overdose rates, when adjusting for age distribution and population in each county (orange map below).

Exhibit 2: Fatal opioid-related overdose counts (left, purple) and rates (right, orange) in California in 2023. Darker shading represents higher fatal overdose counts or rates.[ii] See Appendix 4 for a full data table of county-level fatal overdose counts and rates in 2023. (*Data source: California Overdose Surveillance Dashboard*)



3. Medications for Addiction Treatment play a role in reducing opioid-related harm and curbing the fatal overdose crisis

Medications for addiction treatment (MAT) are a set of evidence-based drug therapies used to treat opioid use disorder and include methadone, buprenorphine, and naltrexone.[7] Methadone and buprenorphine—the most commonly used and well-studied types of MAT—have consistently demonstrated substantial reductions in opioid-related mortality, all-cause mortality, serious

> **"MAT has impacted the community in a huge way because people that are lost in their addiction are becoming part of the community [again]."**
>
> *-MAT client*

[ii] Note: The rate for Alpine is unstable. Rates for Sierra, Colusa, Amador, Mariposa, Inyo, and Plumas may be unstable.

opioid-related acute care, and opioid-related morbidity while supporting retention in opioid use disorder treatment better than alternative interventions.[8-12] While research is mixed on functional outcomes for MAT,[13,14] providers and clients interviewed for this assessment spoke at length about the ways in which MAT can give people with opioid disorder their lives back through improved functioning, relationships, and quality of life. Exhibit 3 summarizes MAT options.

Exhibit 3: Three categories of MAT approved by the U.S. Food and Drug Administration as of mid-2025[15,16]

	Methadone	Buprenorphine	Naltrexone
Medication options	• Oral concentrate • Tablets for oral suspension • Controlled substance	• Pill with or without naloxone • Film for sublingual or buccal use, with or without naloxone • Long-acting injection • Controlled substance	• Pill • Long-acting injection • Not a controlled substance
Pharmacology	• Opioid agonist	• Partial opioid agonist	• Opioid antagonist
Availability in California	• Federally licensed narcotic treatment program (NTP)	• Federally licensed narcotic treatment program (NTP) • Clinicians (MD, DO, NP, PA) with Schedule III prescribing authority • Pharmacists	• Any prescribing clinician

Terminology note: *In this report, we use "MAT" primarily to refer to medications for opioid use disorder, including buprenorphine, methadone, and—less frequently—naltrexone. However, other medications for addiction treatment, such as those for stimulant use, are also occasionally discussed in this report*

4. Exploring the state of MAT in California can inform overdose response efforts

From August 2024 – September 2025, The Center at Sierra Health Foundation—a statewide nonprofit organization that has managed three rounds of MAT Access Points grantmaking—led a statewide assessment of MAT. The purpose of the assessment was to understand (i) the state of MAT access in California, (ii) barriers to and facilitators of MAT access, (iii) promising practices for MAT program implementation, and (iv) opportunities to further MAT access and equity through policy and funding.

The assessment included a literature review, analysis of secondary MAT-related quantitative data, a statewide survey for MAT providers, and engagement of more than 122 MAT providers, people who use opioids, subject matter experts, and other key stakeholders throughout California in the form of interviews, focus groups, and site visits.[iii]

[iii] Detailed methods are in Appendix 1. Interview and focus group participants representing a given stakeholder type (e.g., provider) answered similar questions about MAT. For simplicity, participants in both interviews and focus groups are referred to as "interviewed" providers, experts, and clients in the body of this report.

THE STATE OF MAT IN CALIFORNIA

THE STATE OF MAT

Policy and funding shifts have driven MAT expansion in the past decade

Since 2014, shifts in federal and state policies and funding priorities have transformed the landscape of MAT availability and regulations across California, creating unprecedented access.

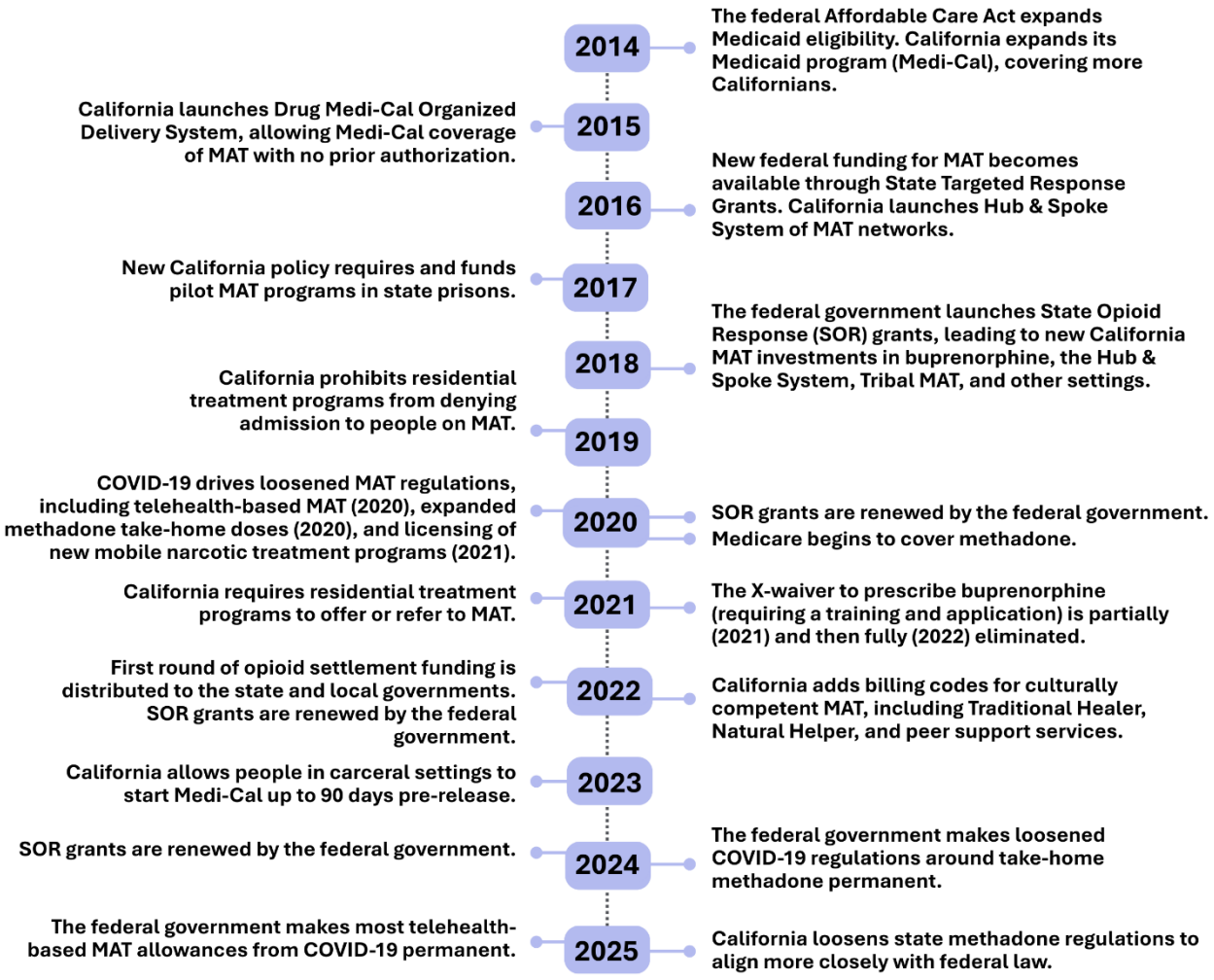
"Access [to MAT]—it's incredible the changes that have happened over the last decade."

-MAT client

1. Major policy and funding changes have expanded MAT access in California

Exhibit 4 summarizes key policy and funding shifts, which are subsequently detailed after the exhibit.

Exhibit 4: Major policy and funding changes to the MAT landscape in California



Expanded Medi-Cal coverage allowed access to MAT for more Californians

In 2014, the federal Affordable Care Act (ACA) allowed California to expand eligibility for Medicaid, known as Medi-Cal in California, to people who were previously uninsured or underinsured.[17] In 2015, California launched the *Drug Medi-Cal Organized Delivery System (DMC-ODS)*, the country's first demonstration project to provide substance use treatment services for Medi-Cal patients under Medicaid Section 1115 authority, and eliminated the prior authorization requirement for buprenorphine.[18,19]

> **"2015 is when you saw the first large boost of admissions for MAT… you have to acknowledge the role that the ACA played…**
>
> **Then DMC-ODS started shifting how MAT services were being offered in of California and how MAT was beginning to be viewed…**
>
> **Then the State started heavily investing, and every year since 2017, it's shifted to the positive."**
>
> *-Statewide expert*

MAT providers interviewed for this assessment described the ability to bill Medi-Cal for MAT services as "game-changing," and national studies suggest that buprenorphine prescribing increased more steeply among Medicaid beneficiaries than beneficiaries of other payer sources following these changes.[20-22]

Unprecedented investment in opioid response launched California MAT expansion projects

In 2016, the federal 21st Century Cures Act allocated funding for expansion of MAT services through State Targeted Response (STR) grants.[23] In 2017, California leveraged STR funds to launch the Hub & Spoke System, focused on expanding MAT coverage in primary care settings statewide, including for people who are uninsured or underinsured.[24]

In 2018, the federal government launched State Opioid Response (SOR) grants to address the opioid crisis. California used its initial SOR funds, plus STR funds, to expand MAT statewide through the Hub & Spoke System, buprenorphine availability, and the Tribal MAT Project,[25] and has been awarded SOR grants in every subsequent round of funding (2020, 2022, 2024).[26] Key partners—such as The Center at the Sierra Health Foundation—have facilitated state investments as grantmaking intermediaries.

California's opioid response is funded via three main sources:

- California State General Funds
- State Opioid Response (SOR) grants (federal government)
- Opioid Settlement Funds

MAT requirements in carceral settings expanded life-saving access and post-release care continuity

Fatal overdose upon release from custody is high;[27] therefore, initiating and supporting continuation of MAT during incarceration can save lives,[28] in addition to not forcing people to go through withdrawal. In 2017, California passed two laws (SB 843, SB 826) requiring and funding pilot MAT programs for people in state prisons, which resulted in nearly 20,000 people who were incarcerated in prisons receiving MAT as of July 2025.[29] With respect to county jails, counties participating in a SOR-funded learning

collaborative about MAT in criminal justice settings from 2018-2022 reported more than 30,000 people receiving jail-based MAT in that period.[30] In January 2023, California amended its Medicaid 1115 waiver to start people in jails, prisons, and youth correctional facilities on Medi-Cal up to 90 days pre-release to support care continuity.

> **"For the first time ever, the prison system was responsible for doing some sort of care continuity for people post release."**
>
> *-MAT provider*

Residential treatment requirements ensured that all patients can receive or be referred to MAT

In 2019, California adopted a law (SB 992) that prohibited residential treatment facilities from denying admission to clients with a MAT prescription. In 2021, California adopted legislation (SB 184) that required state-licensed drug or alcohol use residential treatment facilities to either (i) offer MAT on site or (ii) provide a referral for MAT.[31]

Telehealth-based MAT increased access for patients who face barriers to in-person appointments

Prior to 2020, clinicians prescribing MAT typically had to see a client in person due to the Ryan Haight Online Pharmacy Consumer Protection Act.[32] In 2020, federal lawmakers approved an emergency exemption to allow telehealth for buprenorphine treatment during the COVID-19 pandemic.[33-36] That year, surveyed California addiction treatment providers reported treating more than half of patients via telehealth.[36]

In 2025, the Drug Enforcement Administration (DEA) made video telehealth regulations—as well as audio telehealth regulations for up to a six-month supply of buprenorphine—permanent (42 CFR Part 12). Providers and experts interviewed in this assessment noted telehealth as key for expanding MAT access in rural areas and for clients for whom mobility, transportation, or scheduling may be barriers.

> **"COVID-19 allowed expansion of telehealth... Telehealth has a lot of room to grow in terms of being able to provide low barrier access to folks, particularly in rural areas or underserved urban areas."**
>
> *-Statewide expert*

Take-home methadone removed the barrier of visiting a methadone clinic daily

In 2020, following the emergence of the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued an emergency regulation expanding eligibility for take-home dosing of methadone. This included giving people take-home doses from the beginning of treatment and extended many people's take-homes to 14–28 days, pending patient stability.[37-39]

> **"The focus for the first 50 years of methadone was making sure it does not get in the hands of people who don't need it...Recently, regulatory changes have put the focus on how we get the medicine to the people who need it."**
>
> *-MAT provider*

Medicare coverage for methadone reduced insurance barriers to MAT for Medicare beneficiaries

In 2020, Medicare began covering methadone for the first time, in response to the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.[40] Research among Medicare beneficiaries nationwide suggests that methadone dispensing increased following the policy change, particularly among beneficiaries under age 65 and beneficiaries dually eligible for Medicare and Medi-Cal.[41]

X-waiver elimination allowed more clinicians to prescribe buprenorphine

From 2000–2021, buprenorphine provider capacity was constrained by the "X-waiver"—a process that required providers to take a training course, submit an application, and receive an identification number.[32,42] While initially limited to licensed physicians, the 2016 federal Comprehensive Addiction and Recovery Act expanded X-waiver access to nurse practitioners and physician assistants.[43] In 2021, the U.S. Department of Health and Human Services began to allow providers without an X-waiver to prescribe buprenorphine for up to 30 patients;[32] in 2022, they eliminated the X-waiver requirement entirely (Mainstream Addiction Treatment Act).[42,44]

> **"I went into an emergency department [years ago] and was told not one single doctor had an X waiver to give me medication, which is basically saying, 'Sorry, go out and use heroin.' Now we have access in emergency rooms across California."**
>
> *-MAT client*

Mobile methadone brought MAT where people already are

From 2007–2021, the DEA prohibited new mobile narcotic treatment programs (NTPs).[45] In 2021, in response to the COVID-19 pandemic, the DEA announced new regulations allowing all licensed NTPs to deploy mobile methadone units, coined "methadone vans" (21 CFR).[46] A 2021 study of a San Francisco-based methadone van found that participants found the van less chaotic and stressful than brick-and-mortar methadone clinics,[46] showing promise for this model, and the state has invested in mobile methadone-specific programs since this policy change.[47]

> **"When the DEA lifted that moratorium [on mobile methadone], there was this opportunity to launch something new that hasn't been [allowed] in a decade or more."**
>
> *-MAT provider*

Opioid settlement funds stabilized existing state and local overdose prevention efforts

In 2022, based on the outcomes of lawsuits filed against the opioid industry for their role in the opioid crisis, California received its first round of opioid settlement funding (OSF).[48] The 15% of funds allotted to the state added stability to existing overdose prevention projects, while the 85% of funds allotted to cities and counties allowed local governments more resources to tailor their overdose response.

> **"Every time you say 'fentanyl', someone [in pharma] gives out a big cheer because you didn't say Oxycontin...They created this enormous group of people that were dependent on an opioid, and then that supply just crashed [as opioid prescriptions for pain management were restricted]... Every illicit manufacturer...all of a sudden had the world's largest opioid market."**
>
> *-MAT provider*

Medi-Cal adaptations allowed culturally responsive MAT roles to be reimbursed

In 2022, California amended its Medicaid 1115 waiver to allow DMC-ODS beneficiaries to receive Traditional Healer and Natural Helper services provided by "Indian Health Care Providers" (IHCP).[34] That same year, California launched a Medi-Cal Peer Support Services benefit to allow peers with lived experience to be certified as a unique provider type for reimbursable behavioral health services.[49]

> **"Centering people with lived experience... in clinical spaces, elevating their voices...is key in transforming culture. It is critical to have people with lived experience integrated into care."**
>
> *-MAT provider*

Sustaining and expanding loosened methadone regulations reduced barriers to methadone

In 2024, HHS updated its rule governing MAT (42 CFR Part 8), which included making permanent the expanded methadone take-home doses granted during COVID-19. The update also eliminated the one-year requirement of opioid use prior to treatment eligibility, promoted provider autonomy in dispensing MAT to opiate treatment programs, and focused on patient-centered, destigmatizing language.[50]

In 2025, California AB 2115 loosened state methadone regulations to align more closely with updated federal laws by (i) allowing non-methadone clinic physicians to prescribe 72-hour "bridge" doses of methadone and conduct federally required physical exams, (ii) extending take-home methadone doses, (iii) no longer requiring non-drug related lab work, counseling sessions, or a length of prior opioid usage, (iv) allowing patients to miss up to 30 days of treatment prior to program removal, and (v) giving physicians greater discretion over methadone dosing.[51]

A press release for CA law AB 2115 claimed:

"The bill will radically change California's strategy on the treatment of opioid addiction by transforming California from a state with the most restrictive methadone laws in the country, into one of the most accessible."[52]

THE STATE OF MAT

MAT has expanded substantially and is implemented in diverse settings

Since 2014, MAT, especially buprenorphine, has expanded across diverse treatment settings outside of traditional opioid treatment programs. Providers and experts interviewed for this assessment identify MAT as a key contributor in reducing overdose mortality and morbidity.

"I feel really excited about what's happened the last five to ten years. People are dying at massive rates from overdose, and we're responding, and the numbers are shifting and it's because of [our] response and easier access to MAT."

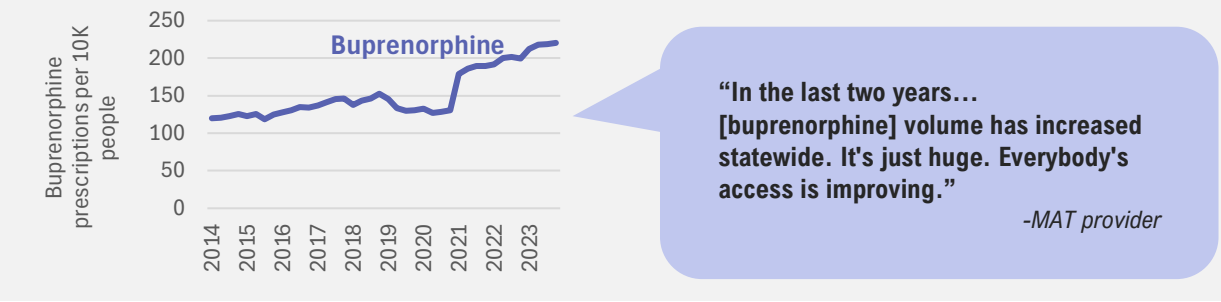
-MAT provider

1. MAT prescribing, especially buprenorphine, has increased overall

Facilitated by major changes to the policy and funding landscape, MAT prescribing has increased in the past decade. In particular, buprenorphine prescriptions more than doubled from 2014–2023 (Exhibit 5).[3]

Exhibit 5: Buprenorphine prescriptions per 10K Californians, 2014-2023

Data source: California Overdose Surveillance Dashboard

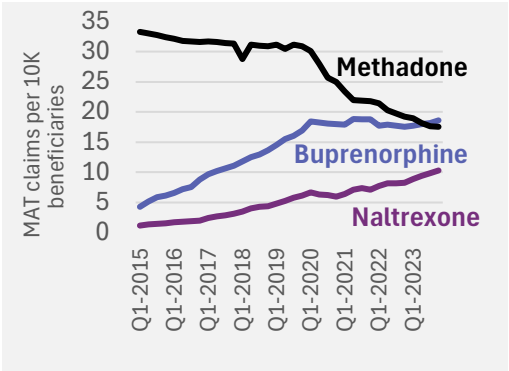


When considering all MAT options, buprenorphine and naltrexone claim rates for people with Medi-Cal (Exhibit 6) have increased sharply over the past decade, while methadone claim rates have been relatively stable and have recently decreased, possibly due to greater availability of buprenorphine, which has more flexible prescribing practices.

As of 2023, California hosted 359 outpatient programs providing methadone, buprenorphine or naltrexone, including 172 federally certified opioid treatment programs.[53] In 2025, there were 5,044 MAT practitioners in California, including 4,872 buprenorphine practitioners.[54]

Exhibit 6: Quarterly Medi-Cal claims for methadone, buprenorphine, and naltrexone
per 10,000 enrolled beneficiaries (2015–2023)

Data source: State of California Open Data portal



2. MAT is being implemented in diverse settings

As of 2025, California currently leverages State Opioid Response funds, state funds, and opioid settlement funds for "Opioid Response Project" grants,[55] facilitating MAT in diverse settings beyond narcotic treatment programs, including emergency departments, emergency medical services, carceral settings, primary care, residential treatment, mobile settings, telehealth, syringe services programs, youth-specific treatment programs, and Tribal and urban Indian communities. Exhibit 7 shares examples of some California models.

In addition to the examples below, The Center at Sierra Health Foundation has developed a series of MAT program case study videos that discuss MAT through the voices of diverse California MAT providers.

Exhibit 7: Examples of MAT implementation in diverse California settings

Setting	Example project(s)
Hospital-based	The California Bridge program funded hospitals to begin treatment with buprenorphine for patients who were in withdrawal in the emergency department, creating 24/7 access to buprenorphine treatment, along with a "bridge" to continue MAT services in the community with the support of a Substance Use Navigator (SUN).[56] Growing from 30 pilot hospitals in 2018, the California Bridge model is in 291 of California's 330 hospitals as of 2025, reaching approximately 1 in 4 Californians. Research indicates that the California Bridge program has been highly successful in (i) consulting patient navigators, identifying opioid use disorder, and providing buprenorphine in emergency departments; (ii) increasing opioid use disorder treatment engagement 30 days after the emergency department visit; and (iii) reaching populations that typically do not receive buprenorphine, including those with housing instability, those on Medi-Cal, and those who use stimulants.[56-58] *"California Bridge just changed the landscape of low-barrier access to buprenorphine in the emergency department. That meant that people could get access to clinics…refills, and all of those things that come along with that…[it has] really paved the way for a sea change."* *- CA Bridge Program staff*
Emergency Medical Transport	In 2021, Contra Costa County piloted the first EMS buprenorphine project in the U.S., in which paramedics provided buprenorphine to patients in opioid-related withdrawal.[59] Data from year 1 of the pilot indicate that the 36 patients experienced no adverse outcomes, with 50% retained in treatment at 7 days follow-up and 36% at 30 days.[60] Data from a similar EMS buprenorphine program in San Francisco (131 patients) concluded that buprenorphine-naloxone administration during EMS improved symptoms and affirmed the safety of the protocol without direct physician oversight.[61] *"Seeing that patient change into a totally different patient has really been remarkable for some paramedics to say, 'oh, wow, this does make a difference.'…That paramedic who becomes a champion of EMS buprenorphine has been a remarkable shift."* *- EMS buprenorphine provider*
Primary Care	In 2017, California introduced the Hub & Spoke System to increase MAT access in primary care clinics. "Hubs," representing opioid treatment experts, were matched with several "spokes," representing office-based settings, to create collaborative regional service networks covering approximately 70% of California's geography and population.[62] After 15 months of implementation, there was a documented 335.7% increase in the mean monthly number of buprenorphine inductions in all hubs.[63]

Carceral Settings	California SB 843, passed in 2016, funded and required MAT integration into state prison substance use treatment systems. California Correctional Health Care Services reports that more than 32,000 people who were incarcerated have been evaluated for MAT across 35 state prisons, and nearly 20,000 provided MAT as of mid-2025, with 2023 evaluation data suggesting 22% of people receiving MAT and an overall 84% MAT acceptance rate.[29,64]	
Syringe Services Programs	The Humboldt Area Center for Harm Reduction (HACHR) partners with telehealth vendor Bright Heart Health to bring MAT to people in rural Humboldt County. Services are offered via a low-barrier, outdoor pop-up tent set up adjacent to a partnering clinic. HACHR focuses on relationship building with clients, offering what they need—including food, clothing, and harm reduction supplies. This approach creates comfort for clients who know they will not be judged for non-abstinence or a return to use.	*"Because we're a harm reduction organization, people are accustomed to … letting us know the whole 'naked truth' about what it is that they're doing. So, when people decide to do recovery through us, they already have that level of comfort."* *- HACHR staff*
Residential Treatment	The Los Angeles Centers for Alcohol and Drug Abuse (L.A. CADA) hosts 141 state-licensed treatment beds.[65] Two of its residential treatment settings are licensed for Incidental Medical Services (IMS), which allows MAT billing via Medi-Cal. Other residential programs have MAT coverage through a SAMHSA-certified community behavioral health clinic (CCBHC), which funds clinicians to rotate across L.A. CADA's non-IMS residential treatment sites and outpatient facilities to provide MAT. L.A. CADA partners with community agencies for referrals and partners with the county's largest behavioral health pharmacy to keep medications in stock.	*"What we like to do is by the time they are done with their residential stay, there's already some stabilization that happens…we've learned that [MAT] is a clinical way to give holistic, whole-person care that actually allows for success when they leave residential treatment."* *- L.A. CADA staff*
Mobile Narcotic Treatment Programs	Tarzana Treatment Centers (TTC) launched a van-based mobile narcotic treatment program (NTP) in the San Fernando Valley in 2025, focused on bringing methadone services to people least likely to access them. The mobile NTP will visit tiny home sites serving people who are unhoused and who are involved in case management services, as well as small community clinics that do not offer MAT. Van design is tailored to different services, with spaces for (i) counseling, intake, and telehealth; (ii) physical exams; (iii) dosing; and (iv) a bathroom for specimen collection.	*"The goal is to bring services for opioid use disorder, which are very regulated…as close to them as possible, especially those community members who are unhoused, who have transportation challenges and would otherwise not be able to stay in stable treatment settings."* *- TTC staff*
Mobile Buprenorphine	In 2024, the San Francisco Department of Public Health launched a Night Navigation street care team—a collaboration with the Department of Homelessness and Supportive Housing and several community-based agencies—in a neighborhood highly impacted by overdose and homelessness. The program offers immediate, telehealth-based connection to MAT and a safe place to sleep so that clients can start MAT, followed by case management and additional stabilization support if needed. In just its first four weeks, the program facilitated telehealth visits with 173 people and resulted in 134 buprenorphine prescriptions, 33% of which were filled.	

THE STATE OF MAT

Despite notable expansion, MAT-related gaps and inequities remain

As with many public health interventions, MAT expansion has reinforced underlying health care disparities across geography, race/ethnicity, sex, income, and other characteristics. Providers and experts interviewed in this assessment highlighted equity in MAT as a persistent challenge, despite targeted funding focusing on many communities most impacted by opioid use disorder.

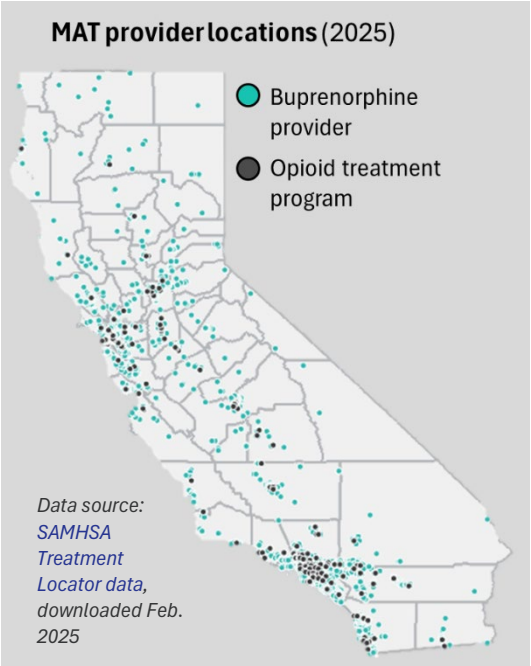
"It's increased statewide, which is great...the numbers are looking good. But then when you really dissect and peel, it's still not reaching those that it needs to reach."

-Statewide expert

1. MAT is not reaching all Californians who might benefit from it

In 2022, discharge data for Californians admitted into treatment publicly funded substance use treatment facilities indicated that just 56% of people who used opioids had MAT as part of their treatment plan. While this percentage is higher than that of the U.S. overall (40%), this may highlight gaps in MAT availability or provider or patient acceptability. In addition, analysis of the same dataset suggests that while California is ahead of the U.S. overall in the odds of treatment success on MAT relative to other treatment modalities, gaps remain. In particular, Californians with MAT in their treatment plan had a 12-22% lower odds of "treatment success" from their treatment episode—indicated by treatment completion or transfer to another facility (rather than leaving mid-treatment)—compared to people whose treatment plans did not involve MAT.[iv] Although prior research suggests that MAT is generally supportive of treatment retention relative to non-MAT treatment modalities,[11,12] these findings point to potential barriers that may be limiting MAT's impact. Moreover, as will be described in the rest of this section, these barriers emerge inequitably, resulting in disparities in

Exhibit 8: Location of California MAT providers.
See Appendix 4 for a full data table of provider locations.



[iv] OR: 0.83; 95% CI 0.78 – 0.88. The following factors were controlled for: sex, age, race/ethnicity, housing and employment status at time of admission, education level, veteran status, service setting (outpatient, detox, or residential), and whether opioids were their primary or secondary substance of concern at admission. This analysis is limited to cross-sectional data and number of discharges from publicly funded substance use treatment programs (which may mean individual people are duplicated, if discharged more than once in 2022). Data on MAT type or potentially confounding variables such as geography or severity of opioid use disorder were not available. Length of MAT treatment is typically longer than non-MAT treatment, which may present limitations to comparing these services among people discharged within a single one-year period. Treatment completion or transfer may not properly represent "treatment success." See Appendix 2 for more details on this analysis and its limitations.

MAT access and uptake related to geography, race/ethnicity, age, sex, and language, among other characteristics.[v]

2. MAT availability varies by geography

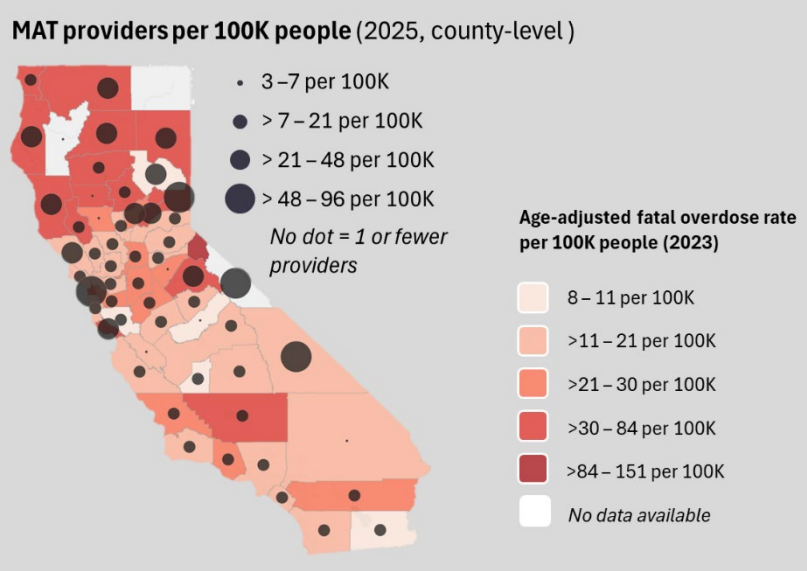
As shown in Exhibit 8, the availability of buprenorphine providers (blue) and opioid treatment programs (black)—which provide methadone and can also provide buprenorphine—varies across California. Due to the more regulated nature of methadone, more than a dozen counties lack opioid treatment programs. In contrast, all but one county (Alpine) has a buprenorphine provider.

Exhibit 9 shows how MAT availability corresponds to fatal overdose burden, with the number of MAT providers per 100,000 residents (indicated by the size of black dots) overlaid on county overdose rates (indicated by the color of the county). Ideally, bigger dots would correspond to darker-shaded counties, implying provider availability was closely matched to need.[vi]

Exhibit 9: MAT provider density and fatal opioid-related overdose rates at the county level. See appendix 4 for a full data table of provider density and a full data table of fatal overdose rate.

Black dots signal the rate of MAT providers per 100,000 population, with larger dots signaling higher rates of MAT providers. Dots do not distinguish between the size or capacity of MAT programs, such as how many clients they are able to serve. *(Data sources: SAMHSA Treatment Locator Data, Feb. 2025, California Department of Finance Population Estimates, 2025.)*

Red shading indicates the rate of fatal opioid-related overdose per 100,000, with darker red indicating higher fatal opioid-related overdose rates. *(Data source: California Overdose Surveillance Dashboard, 2023)*



Rural areas experience unique MAT challenges

In California, a qualitative study of 26 MAT providers from the Hub and Spoke system in 2018–2019 found that staffing shortages, insufficient mental and behavioral health professionals, and long travel times in rural areas

> **"It's still difficult to find clinics that have...providers that prescribe MAT. I work with...a lot of rural counties, and they're like, 'we literally have zero clinics to send these patients to."**
>
> *-MAT provider*

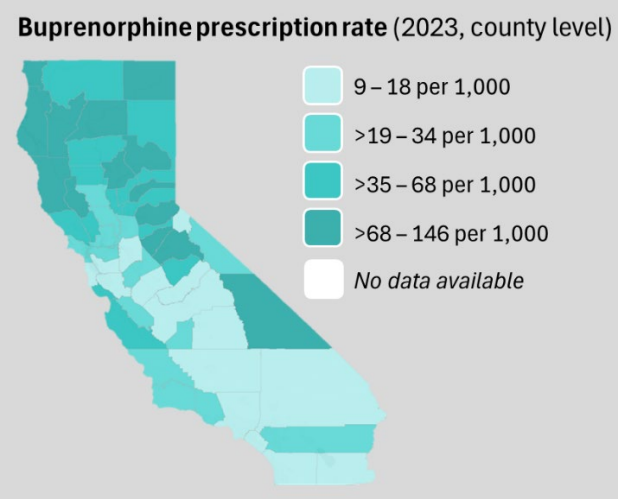
[v] Other social determinants of health that influence in MAT-related disparities and intersect with geography, race/ethnicity, age, sex, sexual orientation and gender identity, and language—such as homelessness and health insurance coverage—are detailed in other sections of this report.

[vi] San Francisco County is fully occluded by the dot representing fatal opioid-related overdose rate; its shading is the second-darkest red, indicating a rate of >30–84 per 100,000.

limit MAT capacity and availability[66]—limitations that have been documented in research from the broader U.S.[32,67,68] In interviews conducted for this assessment, California MAT providers noted that rural areas, especially small Northern California counties, lack access to methadone clinics—a gap that has also been noted in nationwide research.[68-70] However, interviewed providers praised these rural counties for their "creativity" in expanding buprenorphine access—as indicated by relatively high rates of buprenorphine prescription (Exhibit 10).

Exhibit 10: Buprenorphine prescription rates per 1,000 people at the county level (by patient location)

Darker blue shading indicates higher rates of buprenorphine prescribing. See Appendix 4 for a *full data table of buprenorphine prescription rates*. *(Data source: California Overdose Surveillance Dashboard, 2023)*



Some urban areas are underserved by MAT

Research utilizing a geospatial framework found that among "opioid dependence priority areas" in California, South Central Los Angeles had unmet treatment need, and South Central Los Angeles, Santa Barbara County, Ventura County, and the city of Sacramento had low MAT capacity overall.[71] A smaller study of downtown Los Angeles identified gaps in pharmacy capacity to provide MAT in zip codes with high overdose rates, including zero pharmacies located in a zip code with one of the highest rates of opioid-related overdose death and no buprenorphine at any non-chain pharmacies downtown.[72] In addition, a Los Angeles-based study of driving times to access methadone found that longer estimated drive times corresponded to lower completion of methadone treatment episodes.[73]

3. Racial disparities in MAT access persist

Racial disparities in MAT access and treatment outcomes in the U.S. have been well established, as well as their links to geographic, environmental, and structural barriers among people who are not white, particularly for Black/African American and Latine people.[74-87] National research comparing Medicaid expansion states (like California) to non-expansion states, as well as comparing state-level buprenorphine receipt among racial groups, suggests that California's MAT landscape may foster more racial equity relative to some other U.S. states.[87,88] However, racial disparities persist, with California-specific research indicating shorter duration of long-term buprenorphine treatment episodes for non-white individuals,[76] less MAT receipt and treatment completion among Black/African American and Latine people,[80,89] lower MAT uptake among Black/African American people who are incarcerated,[64] fewer MAT-related visits

> **"Data shows that white patients are offered MAT at much higher rates than Black patients…known [California] safety net hospitals that serve high proportions of black patients…have not opted in to expanding MAT access."**
>
> *-Statewide expert*

among non-white individuals (especially American Indian and Alaska Native people),[78] and lower buprenorphine prescription rates in zip codes made up of mostly people of color that are not explained by income, urbanicity/rurality, or opioid mortality.[90]

> **"People should have options... access to methadone is predominantly in lower income communities of color, versus higher income communities having more access to buprenorphine."**
>
> *-Statewide expert*

An analysis of 2022 California substance use treatment episode discharge data from publicly funded facilities, conducted as part of this assessment, suggests that when controlling for housing status, recent arrest history, sex, age, and whether opioid use was a primary or secondary concern at admission, Latine patients who used opioids had 21% lower odds of MAT in their treatment plan than white patients (95% confidence interval [CI] 16-26% lower odds), a finding consistent with national research.[75,77,82,84,87,91] In contrast, Black patients had 31% higher odds of MAT in their treatment plan than white patients (95% CI 16-47% higher odds), a finding that contradicts established literature[74,75,77,82,84,87,91] and may be due to geographic, income, or other confounding factors not accounted for in the model (see Appendix 2).

MAT providers and statewide experts participating in this assessment emphasized racial gaps in MAT prescribing or receipt, most frequently with respect to Black/African American and American Indian/Alaska Native patients. Those interviewed highlighted the ways in which healthcare systems reinforce racism in terms of where MAT is available and who is offered MAT, whereas those surveyed most commonly identified these groups when asked who their programs could better serve (Exhibit 11).

Exhibit 11: Racial/ethnic groups that California MAT programs felt they could better serve when prompted on a statewide survey *(n=42 unique MAT programs)*

4. MAT for adolescents and young adults represents an access gap

The aforementioned analysis of 2022 California substance use treatment episode discharge data from publicly funded facilities suggested that patients in older age groups (40-64 years) had 4.5 times greater odds of having MAT in their treatment plan compared to those 21-39 years old (95% CI 3.6 – 5.8 times greater odds), whereas adolescents and young adults ages 12-20 had 62% lower odds (95% CI 55-67%

lower odds.)[vii] An interviewed statewide expert noted that adolescents are an underserved yet key population for MAT because of the potential to shift their life trajectory with early opioid use disorder detection and treatment.

Despite examples of successful MAT induction among youth in California,[92] and a range of California Youth Opioid Response (YOR) projects that incorporate MAT expansion for youth,[93] interviewed MAT providers shared that existing MAT services remain relatively inaccessible to youth due to stigma, inconvenient operating hours (e.g., during school), and lack of youth-specific expertise close to where they live. They noted that providers are hesitant to prescribe MAT to youth, especially without parental consent, which can be challenging if youth have been kicked out of their homes.

> **"There are almost no adolescent specific programs for MAT... adding a 16-year-old girl to a methadone clinic of middle-aged adults is just not the right milieu."**
>
> *-Statewide expert*

5. Immigrants and people with low English proficiency face barriers to MAT

A scoping review of the opioid epidemic among U.S. immigrants noted that immigrant enrollment in MAT programs is low, which stems from complex sources including stigma, cultural barriers, language barriers, affordability, geographic barriers, and immigration status-related fear.[94] In California, a study on substance use treatment barriers among Latine immigrants in northern California identified language, cultural, legal, and gender-based barriers as key themes,[95] while other California studies have noted that people with limited English proficiency are less likely to obtain health care services like pain medication and mental health care.[96,97] While some interviewed MAT providers cited language-related capacity barriers to MAT within their program, approximately 90% of those surveyed reported serving patients who speak a language other than English (Exhibit 12). The most common non-English language is Spanish, and most programs report capacity to serve clients in their primary language (Exhibit 13).

Exhibit 12: Non-English language among MAT program clients *(n=43 unique MAT programs)*

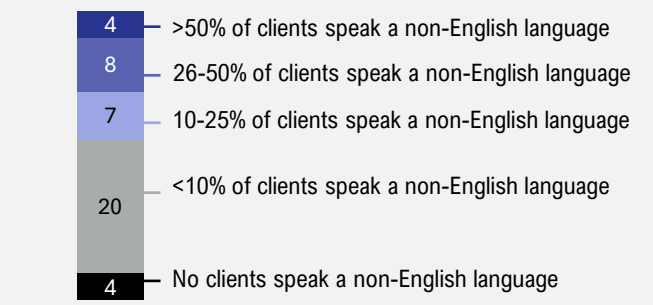
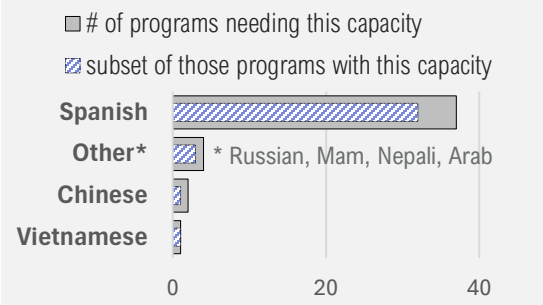


Exhibit 13: MAT program language needs and capacity *(n=43 unique MAT programs)*



Notably, evolving immigration policies can reduce or heighten immigration-related barriers to care. A mid-2025 federal "information exchange agreement" that allows Immigrations and Customs

[vii] Details of this analysis are in Appendix 2.

Enforcement (ICE) personnel to view personal Medi-Cal beneficiary data[98] is anticipated to prevent undocumented immigrants in California from seeking health care, as has been the case with previous federal regulations that linked immigration-related procedures to Medi-Cal use.[99] The information sharing agreement has resulted in lawsuits from California and several other states.[100]

6. Sex, sexual orientation, and gender identity relate to potential MAT disparities

Prior U.S. research suggests that sex plays a role in MAT outcomes, with mixed findings as to the types of sex-based disparities that may exist.[101] In California, prior research on methadone treatment in Los Angeles found that although female clients were more likely to be retained in methadone treatment, they had lower odds of progressing in and completing their treatment plan than male clients.[102,103] Moreover, interactions between sex and race were observed, with Black/African American and Latine female clients less likely to be retained in treatment than non-Latine white male clients.[103]

A 2023 scoping review on MAT among LGBTQ+ people called for further research,[104] which requires better data collection related to sexual orientation and gender identity.[105] In California, some interviewed providers noted opportunities to improve MAT for LGBTQ+ people, and a 2022 report from California Correctional Health Care Services noted the importance of their program in providing MAT to transgender people who are incarcerated, citing higher likelihood of substance use disorder in this group.[64]

> **"There's work to be done in the LGBTQ community...we need groups where people can feel safe and able to talk about the things that are specific to their community."** *-MAT provider*

MAT BARRIERS AND OPPORTUNITIES

BARRIERS & OPPORTUNITIES

Stigma is an underestimated, pervasive, and persistent barrier to MAT

Stigma is a well-established barrier to MAT.[106] Providers and clients interviewed in this assessment emphasized that California has made great strides in reducing stigma against MAT, resulting in treatment approaches that are more collaborative, compassionate, and human-centered than ever. However, stigma remains a top barrier to MAT and manifests in policies, the medical system, individual providers, social norms, and within families. Ultimately, stigma can drive people with opioid use disorder to instead medicate on the streets, where there is less judgment, yet higher risk of overdose.

> **"Stigma and discrimination is a huge issue... Folks have had such horrible experiences trying to access care related to substance use."**
>
> *-Statewide expert*

1. Pharmacy-specific stigma creates "roadblocks" to buprenorphine

Providers and clients interviewed for this assessment shared widely that MAT has been "villainized" at the pharmacy level. They shared that pharmacists often hold stigma against people who use drugs, such as assuming they pose a diversion risk when they access MAT and more generally feeling discomfort in serving them. As a result, pharmacies may be reluctant to fill prescriptions, choose not to stock MAT (or cap their stock), and create an environment where it is "habitual" for MAT clients to feel judged when filling prescriptions. A 2022 study found that only 46.8% of California retail pharmacies had buprenorphine in stock.[107]

> **"Pharmacies treat buprenorphine users like full blown addicts. It's very, very hard to find a [good] pharmacy."**
>
> *-MAT client*

2. MAT is still stigmatized as "replacing one drug with another"

Despite increasing awareness of MAT over the past decade, communities still commonly misconceive of MAT as a "free drug" or "switching one drug for another," rather than as a useful medicine. Interviewed providers and clients repeatedly described stigma from friends, family members, and even employers, with concrete risks to employment if an employer requests drug screenings or is not flexible in allowing an employee to visit a methadone clinic daily. Providers felt that opioid treatment programs were viewed as "the last resort," which was a misconception reflected in national data suggesting that people with severe opioid use disorder—rather than more mild or moderate disorders—are more likely to receive MAT.[86] Settings intended to support people with opioid use disorder—such as 12-step programs or faith-based recovery settings—may consider MAT "cheating" and refuse to sponsor MAT clients. The stigma around "the right way" to do treatment is internalized by clients, posing barriers to MAT initiation and/or retention.

> **"I've been in AA for a lot of years and [MAT] is really frowned upon...people think you're not clean."**
>
> *-MAT client*

3. Methadone holds additional stigma relative to buprenorphine

Interviewed providers and clients described stigma as especially prominent for methadone, and this stigma at times generates misinformation and/or distrust for this medication option. Many clients suggested that methadone, as a full opioid agonist, was more of a "substitute" for drugs than buprenorphine, and some claimed that methadone is harder to quit because it gets into your bones—a misconception documented in prior U.S. research.[108] Both providers and clients made references to buprenorphine making people feel "normal" versus methadone making them "zoned out." In addition, the tight regulation of methadone—often requiring daily clinic visits—reinforces methadone-specific stigma by making patients feel overly monitored, and breeds suspicion that some doctors are keeping people on methadone only for the money.

One interviewed provider suggested that methadone-related stigma also manifests in doctors, who sometimes continue patients on buprenorphine despite many failed episodes, even if other viable options exist. This creates trauma and distrust in MAT, with San Francisco research demonstrating repeated induction corresponding to lower treatment retention.[109]

> **"If someone receives treatment for an illness six times and it doesn't work, why are we continuing with that treatment? If we all get on board, we all put down the stigma, and we say, 'this is another option.'"**
>
> *-MAT provider*

4. MAT-related stigma reflects the intersectional identities of potential clients

While stigma is pervasive, one interviewed provider noted that "every demographic has its stigma" that relates to patients' intersecting identities, such as their age, gender identity, race/ethnicity, cultural practices, politics, socioeconomic status, and geography (Exhibit 14).

Notably, people who use drugs, especially those who are unhoused, experience extensive stigma related to those characteristics[110-112] that compounds MAT stigma. Interviewed providers emphasized that policies expanding resources for this group (e.g., community-based naloxone distribution) counter this stigma. In contrast, policies criminalizing this group (e.g., frequent sweeps of homeless encampments and increased penalties for carrying small amounts of fentanyl) reinforce it.

Exhibit 14: Examples of how stigma manifests across different areas of patient identities and characteristics

Area	Example
Politics	Clients living in politically conservative areas may observe more anti-drug use messaging that exacerbates shame.
Racial or Cultural Identity	Clients may experience stigma related to racial or cultural identity, such as what it means to engage with MAT as a Black or Indigenous person.
Age	Those older may feel that "it's too late to change" or have internalized decades of highly stigmatizing messages about drug use, whereas those younger may feel shame about having a health issue at a young age.
Socio-economic Status	Patients from higher socioeconomic classes may be hesitant to engage in methadone for fear of being "in the same bracket as someone that's homeless."
Geography	Clients living in small rural towns where everyone knows everyone may feel heightened stigma.

5. Destigmatization of people who use MAT lags behind destigmatization of MAT

Although MAT has been increasingly destigmatized within the medical community, there has not been a comparable destigmatization of people who can benefit from MAT—i.e., people who use opioids—especially when they are also part of other stigmatized groups, such as people experiencing homelessness. Interviewed clients spoke at length about feeling judged by doctors.

> **"I judge myself enough, you know? And then I try to get help [from a doctor], and I'm like, 'wait, don't judge me'…makes it worse."**
>
> *-Client not on MAT*

of MAT programs surveyed as part of this assessment have experienced **opposition from local community members** *(13/43 programs)*.

At the community level, interviewed providers suggested that stigmatization of drug use, rather than stigmatization of MAT itself, underlies local opposition to MAT programs, such as advocacy to keep MAT programs—and therefore people with opioid use disorder—far from neighborhoods and businesses. These insights suggest that even if MAT is completely destigmatized as a medication, MAT access will be limited until drug use is comparably destigmatized.

6. Stigmatizing healthcare experiences—including with MAT—drive distrust

Surveyed MAT providers listed previous negative experiences with MAT or in a MAT program as a top barrier to patient engagement, second only to being unhoused, while interviewed patients detailed these negative experiences (Exhibit 15).

In the statewide survey for this assessment, MAT providers ranked **negative experiences with MAT or MAT programs** as the second-highest barrier to patient engagement in MAT.

Exhibit 15: Examples of stigma experienced within MAT settings by clients who use drugs

Feeling dehumanized, perceived as "drug-seeking," "dirty," an "addict," or an "animal"—not an individual worthy of tailored medical care	*"I've watched many people [who use drugs] walk into medical facilities and get asked to leave."* -Statewide expert
Feeling infantilized, such as not being listened to, not being trusted to get MAT in batches or a day early, and being required to undergo frequent urine drug screening	*"I told the [pain clinic] I needed to get off methadone because I was losing coverage…They would not withdraw me. I ended up quitting cold turkey and going through those withdrawals by myself. It was horrendous."* -MAT client
Feeling coerced, such as being given anxiety medication without one's knowledge during withdrawal or feeling overmedicated in jail	*"When I went to jail, they overdosed me and gave me 16mg three times a day. I thought I was gonna die."* -Client not on MAT
Feeling underserved by providers, such as having to educate providers about opioid use and not being educated on MAT side effects	*"…how buprenorphine can mess with your teeth, how you're supposed to brush your teeth after you take it…I wouldn't have known if it wasn't from somebody else that's on it telling me."* -Client not on MAT

Stigmatizing healthcare experiences drive distrust of providers, while exacerbating other forms of medical distrust—rooted in racism, classism, colonialism, and other systems of oppression.[113-116]

> **"A really big barrier is the way that our patients are treated and expect to be treated based on past experiences."**
>
> *-MAT provider*

BARRIERS & OPPORTUNITIES

Providers underestimate patient fear and trauma related to MAT induction

The era of fentanyl poses unique challenges for MAT induction. While providers are generally optimistic about induction practices, patients—especially those not currently on MAT—express fear and distrust due to real and perceived negative induction experiences.

"Matching how we approach treatment with what's going on with the current drug supply is something that still needs to happen."

-MAT client

1. Withdrawal is a key barrier to MAT that is heightened in the era of fentanyl

Withdrawal from opioids can produce excruciating, incapacitating symptoms, motivating continued drug use as a mechanism to prevent it. A study of Los Angeles County residents, most of whom were current or former users of MAT, noted that withdrawal avoidance is the top driver of opioid use and that people who use opioids go "to great lengths" to avoid withdrawal, including engaging in high-risk injecting behaviors and using substances like alcohol, Xanax, and antihistamines to the point of sedation.[117] Notably, withdrawal-related concerns may be heightened among people most at risk for overdose. Studies of people who use opioids in San Francisco and Los Angeles found that homelessness makes withdrawal challenging due to the lack of resources needed to undergo withdrawal safely, such as privacy, a safe place to rest, security for personal belongings, and a bathroom.[118,119]

"If you've gone through opiate withdrawal, you're gonna be really motivated to not go through that again. So, if we can't make it comfortable for people, that's a huge barrier."

-MAT client

Withdrawal-related trauma and fear are well-established barriers to buprenorphine engagement.[117,118,120,121] If opioids are still lingering in a patient's body upon induction, the intake of buprenorphine (a partial agonist for opioid receptors) can cause "precipitated withdrawal"—a sudden onset of potentially severe withdrawal symptoms. Relative to heroin, fentanyl use carries a greater risk of precipitated withdrawal because fentanyl remains in adipose tissues longer. Ironically, to avoid precipitated withdrawal, standard buprenorphine induction requires patients to be in withdrawal. While pre-induction withdrawal has always been a barrier to buprenorphine use, this barrier is heightened in the era of fentanyl because patients often wait longer—and are in withdrawal longer—prior to starting buprenorphine.

"In the age of fentanyl, it's just gotten so much trickier to do these inductions... storage in adipose tissue means it sticks around for way longer than you'd expect it to, and people metabolize it at massively different rates...So you have some folks that can take their buprenorphine 12 hours after fentanyl and be fine. Other people, they do it seven days later and still experience precipitated withdrawal, and it's just really difficult."

-MAT provider

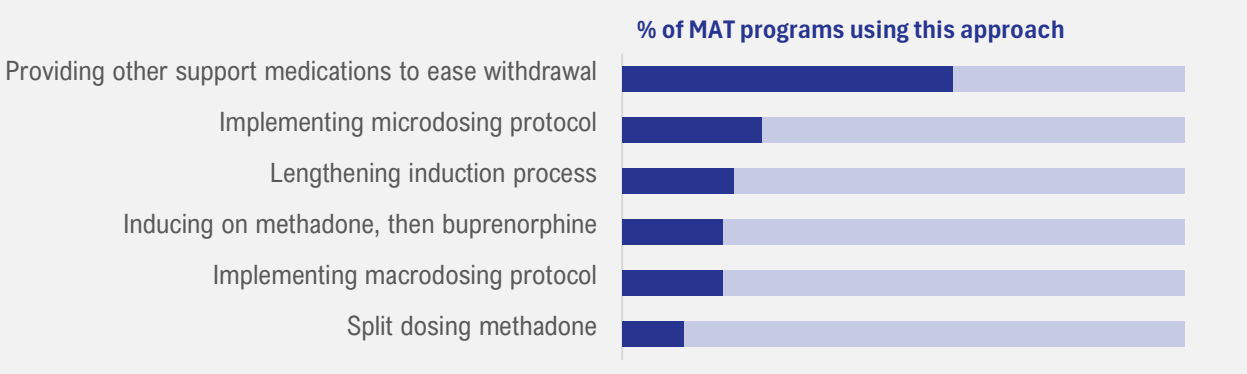
Withdrawal-related trauma and fear can also be a barrier to methadone induction. While methadone does not cause precipitated withdrawal since it is a full opioid agonist, current standards for methadone dosing were set prior to fentanyl's omnipresence in the street drug supply. Because fentanyl is a more potent opioid than heroin, standard induction doses of methadone are often insufficient to avoid symptoms of opioid withdrawal. Only 12% of providers in the statewide survey for this assessment (5/43) reported using increased methadone dosages in response to the changing drug supply, and clients interviewed for this assessment reported continuing to use street opioids to augment inadequate methadone doses.

2. Insufficient induction guidance in the era of fentanyl fuels patient distrust

While various studies have been published about potentially promising buprenorphine induction techniques in the era of fentanyl, there is no standard guidance on induction options. Providers participating in surveys for this assessment are using a range of approaches for buprenorphine induction (Exhibit 16).

> **"Providers don't know how to do this, and don't know whether it's safe, and don't know what to tell patients about how successful it might be, or how to select patients or to advise them."**
>
> *-MAT provider*

Exhibit 16: How MAT programs are approaching buprenorphine dosing in response to fentanyl (n=43 unique MAT programs) *Note: all but one program reported using at least one of these strategies.*



Providers interviewed for this assessment acknowledged that they are "still figuring out" how to handle buprenorphine induction. While some described detailed procedures, referenced specific published methods, or noted protocols for communicating tradeoffs to patients, others had little knowledge on the topic. Notably, getting induction correct the first time a patient transitions to MAT is key to patient retention. The largest study of outpatient-based low-dose buprenorphine ("microdosing") to date indicated that San Francisco patients who attempted low-dose induction multiple times (because the first time did not work) were less likely to be retained.[109]

A San Francisco study found that patients who attempted low-dose induction on buprenorphine multiple times **were less likely to stay on buprenorphine**.[109]

Client perspectives from this assessment reflected inconsistent provider approaches to buprenorphine induction. Among those dissatisfied with their experience, some felt they got buprenorphine too soon while others waited too long. For these patients, miscalibration with what patients needed to avoid withdrawal symptoms created real experiences of suffering and trauma, fear of future MAT use, and distrust in providers.

> **"They don't know what the f*ck to do with fenty."**
>
> *-MAT client*

3. Providers underestimate buprenorphine-related withdrawal as a barrier

In interviews for this assessment, there was palpable disconnect between provider and client attitudes toward buprenorphine induction. While some providers acknowledged buprenorphine induction challenges, most described buprenorphine induction as a manageable challenge. In contrast, clients—particularly those who had started but discontinued buprenorphine—spoke at length about pre-induction withdrawal, described as "going through hell for three days." Those familiar with precipitated withdrawal described it as "the worst withdrawal imaginable." Even those without buprenorphine experience knew withdrawal "horror stories." Overall, clients perceived buprenorphine induction as unnecessarily punitive, questioning why there are not more ways to boost comfort during the process.

> **"What I didn't like about buprenorphine was you had to wait. You had to be sick first to take it."**
>
> *-Client not on MAT*

Mirroring the disconnect between providers and patients, one statewide expert interviewed for this assessment described buprenorphine as "just not that hard" compared to other pharmacological treatments, while another described the fear of precipitated withdrawal as "a little bit overblown" relative to its occurrence. It is possible that the fear of precipitated withdrawal is disproportionate to the risk, and recent research suggests that U.S. providers are implementing many protocols to reduce pre-induction withdrawal (in addition to precipitated withdrawal) symptoms.[122] While these insights may highlight opportunities for better patient education, focusing too much on documented withdrawal rates poses real barriers to treatment initiation by (i) overlooking lived and perceived experiences of people who use opioids, and (ii) failing to capture the extent of withdrawal-related trauma that has been experienced, documented, and disseminated through community knowledge networks, rather than official databases. The disconnect from the patient experience may stem from providers and experts having limited interactions with patients not using MAT and is important to interrogate.

> **"They looked at the incidence of precipitated withdrawal in the era of fentanyl, and found it was like 1%. So, there's a lot of fear of precipitated withdrawal that is a little bit overblown."**
>
> *-Statewide expert*

BARRIERS & OPPORTUNITIES

Assuming all patients can navigate MAT logistics is a "doctor-centered fantasy"

In theory, MAT offers an unprecedented reduction in fatal overdose risk. In practice, high logistical barriers to care are exacerbated by overlapping health and social conditions that make MAT inaccessible to many.

"It's kind of an emergency when someone decides that they're going to get sober. You can't be like, 'Let's wait 'til next month when your insurance kicks in.'"

-MAT provider

1. The logistics of initiating and continuing MAT can make engagement infeasible

Providers and clients interviewed for this assessment noted the many procedural "hoops" that patients must navigate during MAT. While low-barrier services (such as no wait list, drop-in services, etc.) were cited as the second biggest strength among statewide MAT providers who responded to the survey conducted for this assessment, "low-barrier" is not standard of care. Mirroring prior research on MAT,[106] logistical hurdles for MAT patients were commonly related to:

- **Insurance** (being uninsured, delays while enrolling in Medi-Cal, waiting for prior authorization for private insurance, undergoing insurance transitions, and medications not being covered—e.g., injectables)
- **Transportation** (especially in rural areas)
- **Scheduling appointments** around competing priorities (work, school, childcare, parole requirements)

"You have to enroll in Medi-Cal, get assigned to your managed care plan, be assigned to your specific clinic, contact the clinic and get scheduled...There are a lot of pieces around having your ID, paperwork, access to a phone, transportation...and for individuals caught in that cycle of use and withdrawal...it is hard to say, 'I need you to show up Wednesday at 2:30 at this clinic in withdrawal to start buprenorphine.' It's almost impossible."

-MAT provider

In a statewide survey conducted as part of this assessment, MAT providers ranked **transportation as the third-biggest barrier to patient engagement in MAT**—despite "game-changing" Medi-Cal benefits supporting MAT-related transit.

2. Overlapping health and social conditions heighten logistical barriers to MAT

Of the many social and health conditions that may co-occur with opioid use disorder,[123,124] homelessness, mental health disorders, and methamphetamine use disorders were emphasized most among California MAT providers, experts, and clients who participated in this assessment.

Homelessness is a major barrier to MAT engagement

MAT providers in a statewide survey for this assessment ranked **houselessness as the top barrier to patient MAT engagement**.

In the statewide survey for this assessment, providers ranked "houselessness" as the top barrier to patient engagement in MAT. While surveyed providers held mixed opinions about whether homelessness inhibits MAT retention, providers interviewed for this assessment spoke at length about retention challenges due to transportation and communication barriers alongside competing basic needs. Similarly, an analysis of publicly funded substance use treatment facility data conducted for this assessment found that in California in 2022, unhoused people had 53% lower odds of having MAT in their treatment plan than those with housing at admission (95% CI 42-65% lower odds).[viii] Research based in San Francisco and nationally has called for MAT interventions tailored to homelessness, including the need for housing options to support MAT adherence, while providers interviewed for this assessment noted the negative impacts of policies that criminalize homelessness (such as encampment sweeps) on keeping patients engaged in care.[118,125]

MAT programs often lack sufficient mental health capacity to meet patients' needs

> **"Their mental health supersedes their substance use disorder, and when you mix them together, they don't have anywhere to go."**
>
> *-MAT provider*

Interviewed providers described MAT clients with "significant, severe, and persistent mental health issues," while interviewed patients described anxiety, PTSD, trauma, anger, and depression symptoms that make MAT engagement difficult. Supporting the mental health needs of patients was described by the interviewed providers as "essential," yet staff- and time-intensive. In addition, providers acknowledged that most MAT providers are not mental health professionals, requiring referrals for mental health services and creating additional hurdles for patients—especially challenging in rural areas with low mental health care capacity. Many interviewed clients described psychiatric and counseling experiences positively but cited access challenges due to limited provider capacity.

Polysubstance use—especially stimulant use—complicates MAT treatment

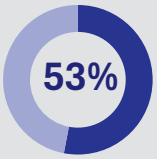
> **"Methamphetamine is tearing people's lives up, deteriorating people inside and out."**
>
> *-MAT provider*

An analysis of 2022 California treatment episode discharge data from publicly funded substance use treatment facilities indicated that 55% of people who listed opioids as their primary substance of choice also used other substances. Of these, 77% listed stimulants as their secondary substance of choice.[viii] Surveyed California MAT providers echoed these findings, noting polysubstance use as common among MAT clients and ranking stimulants—especially methamphetamine—as the most common non-opioid drug used by MAT clients. Interviewed providers described methamphetamine as popular because it is easily accessible, can help people stay awake and

[viii] Details for this analysis are in Appendix 2.

safe on the streets, and can support self-medication of conditions like ADHD. However, it poses longer-term health risks and may pose barriers to MAT if parallel support for stimulant use is not available.

Interviewed providers, experts, and clients highlighted the need for polysubstance use treatment in MAT programs—especially for stimulant use, but also for alcohol and other common drugs. However, only half of surveyed providers (53%, 23/43) felt that they could address polysubstance use, and fewer than half offered staff training on the topic (42%, 18/43). In addition, findings from an analysis of 2022 publicly funded substance use treatment facility data suggest that MAT may be underutilized for clients who use opioids secondary to another drug; patients with opioids as their secondary drug had 88% reduced odds of having MAT in their treatment plan (OR 0.13, 95% CI 0.12, 0.14) compared to those who used opioids as a primary drug.[ix]



of MAT providers in a statewide survey for this assessment have the **tools and resources needed to address poly-substance use**.

3. A lack of care coordination can interrupt MAT retention

Providers interviewed for this assessment described the care continuum for MAT as being "a bit disconnected," despite the importance of making it easier for patients to stay engaged while they are navigating various overlapping health and social conditions. While DMC-ODS counties are responsible for developing memoranda of understanding to build better MAT networks, providers were mixed as to the quality of partnerships within their county. MAT providers in relatively disconnected counties described situations in which patients were lost between residential and outpatient settings, between the emergency department and outpatient settings, between ambulance-based MAT and non-partner hospitals, between jail and outpatient settings, and when referred to supportive services. In contrast, those in more connected counties described robust referral systems and strong inter-agency relationships to prevent these losses.

> **"If there's no smooth hand off, there's no continuum of care, then all that work that they did, all that hope instilled in these clients goes to the wayside."**
>
> *-MAT provider*

Interviewed providers and experts noted that disjointed care is in part driven and exacerbated by silos, such as the way that "behavioral health happens outside of the medical system" and the pattern of funding programs to focus on one health issue. Ultimately, uncoordinated care limits both MAT-specific engagement and use of the other health and supportive services that facilitate MAT retention.

> **"We talk about whole person care, but then we silo it out, rather than... [having] a single point of contact and location that can follow them, track them, and meet their health needs."**
>
> *-Statewide expert*

[ix] Details for this analysis are in Appendix 2.

BARRIERS & OPPORTUNITIES

Fear of MAT diversion has prevented it from reaching those who need it most

While ensuring safety and high-quality care is a core value of opioid use disorder treatment, the bureaucratic hurdles to implementing MAT that programs face fall on staff and patients, creating high-barrier systems that ironically exclude those they are meant to serve.

> **"We need to take a hard look again at all the accreditation and regulatory requirements. What actually do you need to...safely give someone this medication?"**
>
> *-MAT provider*

1. Strict methadone regulations create steep barriers to treatment

In addition to being available in fewer locations, methadone is more tightly regulated than buprenorphine to prevent the risk of diversion.[126] At the time of this assessment, California's methadone regulations were stricter than those of the federal government, though recent state policy will bring California in closer alignment with federal allowances.[52]

Notably, several methadone providers interviewed in this assessment described organizational methadone rules even more stringent than California policy, such as highly restricted take-home doses and only providing methadone to those with a history of using the medication. In contrast, programs that had shifted to providing more take-home doses saw "an explosion in intakes" due to greater client interest.

Clients interviewed for this assessment shared that they simply are not able or willing to go to a methadone clinic every day, noting that tight regulations "interrupt" their lives. Moreover, when methadone program requirements are punitive—such as delaying dosing—they can push clients away by perpetuating stigma. One common example of a punitive policy occurs when treatment centers have policies to withhold medication if a urine screen shows drug use. Other clients, despite having interest in methadone, perceived doctors as "pushing buprenorphine" (likely because many doctors can only prescribe buprenorphine for long-term MAT), which fueled distrust and left them feeling like they only had one medication choice.

> **"The craziest expectation was to have somebody come in and test clean for a month. There's just no way. When you're ready to quit...things are not good. You probably don't have a home. You probably lost your family, don't have a car...so the fact they want you to do these other hurdles is outrageous."**
>
> *-MAT client*

2. While buprenorphine is relatively less regulated, it is still overregulated

Providers interviewed for this assessment appreciated that buprenorphine has emerged as a more available, accessible, and scalable medication compared to methadone. However, they noted that it is still not easily accessible. One provider found it "mind-boggling" and a "profound failure" that buprenorphine is kept "sequestered and under wraps" given its safety and minimal risk of abuse. U.S. research on diverted buprenorphine suggests that people commonly use non-prescription buprenorphine to self-medicate for opioid use disorder (avoiding withdrawals, reducing cravings) without the barriers of the clinical environment.[127,128]

> **"Buprenorphine is very different than any other treatment we have...It has virtually no abuse potential in our society, has virtually no potential for overdose in adults, and is incredibly overregulated and restricted."**
>
> *-MAT provider*

Providers and clients interviewed as part of this assessment also noted that long-acting injectable buprenorphine is guarded by tighter regulations than other forms of buprenorphine, such as prior authorization processes and availability at only specific pharmacy locations. These barriers prevent patients who seek long-acting injectable MAT from receiving their medication of choice and limit the impact of injectable MAT, which has potential to reduce the stigma and logistical barriers associated with daily methadone or buprenorphine through less frequent, monthly dosing.

> **"There are really tight regulations on injectable buprenorphine. They have to come from very specific pharmacies...in our system, [almost] everyone has to go to [a city] in the middle of our very large county."**
>
> *-MAT provider*

3. Required administrative paperwork harms MAT staff and patients

MAT providers interviewed as part of this assessment—especially those who offer methadone—frequently described the "red tape" of state, county, and federal entities that "audit them out of business" due to the amount of paperwork. The interviewed providers reported that staff spend hours per day filling out paperwork—sometimes for more hours than they are providing patient care—to be able to bill for services and adhere to regulations. One provider explained that the process of waiving certain requirements to make services lower-barrier and less time-intensive (such as an intake form that required patients to recall their traumas prior to receiving methadone) ironically requires intake staff to work with a physician to take the time to sign off for every patient.

> **"We have people sign a minimum of 11 forms on day one, when they are exhausted, sleep deprived, malnourished, sometimes a bit under the influence or crashing..."**
>
> *-MAT provider*

Notably, administrative burden impacts patients, who may drop off if MAT engagement is overly burdensome, repetitive, or traumatizing. While providers interviewed during this assessment explained how administrative burden limited their capacity to serve patients, patients interviewed during this process frequently used the term "waiting" to describe the impacts of bureaucracy, including:

- Waiting for an undetermined amount of time (e.g., on a wait list) to join a MAT program
- Waiting in line for one's turn to engage in services
- Waiting several hours during MAT intake and enrollment paperwork
- Waiting for a therapist to be available to schedule an appointment
- Waiting for medication refills to be approved
- Waiting to be connected to an outside service (e.g., stimulant use treatment, psychiatry)

As one interviewed provider acknowledged, these waits would be challenging to navigate for anyone, including those who have cell phones, Wi-Fi, housing, flexible work hours, stable mental health, and no disordered opioid use. Such a process is understandably insurmountable for many MAT clients, often being asked to complete initial processes while in opioid withdrawal, which can involve vomiting, shaking, diarrhea, and irritability, among other uncomfortable symptoms.

4. Bureaucratic barriers keep innovative MAT programs from launching

MAT providers interviewed as part of this assessment emphasized that bureaucratic processes can make it difficult to start innovative new MAT programs—such as mobile narcotic treatment programs (NTPs) and residential programs that offer MAT. One MAT provider's residential treatment facility, which had to get licensed for incidental medical services (IMS) to be able to offer MAT, described the application process as the "biggest hurdle" to launching MAT. They noted that the process required several months of back and forth, despite the organization having prior experience successfully submitting similar licensing applications for their other already-licensed residential treatment sites. Another MAT provider preparing to launch a mobile NTP noted the arduous process of receiving layers of approval through the Department of Health Care Services, Drug Enforcement Administration, and SAMHSA. Ultimately, while passionate California MAT providers are pushing through bureaucratic barriers, these barriers cause substantial delays and create an environment that stifles lifesaving, innovative MAT models.

> **"We are planning to license another [residential MAT] program. I asked, 'hey, how long?'... He said, 'well, the first one took us a year, and the second one took more than eight months'... it [should] be easier if it is something that is a gold standard treatment for substance use disorders, and we have more than 100,000 people dying from overdoses every year."**
>
> *-MAT provider*

BARRIERS & OPPORTUNITIES

MAT programs lack strategic support for sustainability and growth

In the last ten years in California the improvement in MAT access—primarily facilitated by unprecedented political will and funding—cannot be overstated, and some key innovative models have shown great success. Continued strategic support, including funding, is needed to sustain these services.

"When it comes to MAT policies and procedures, the main thing on everybody's mind is funding. Where is this money going to come from?'

-MAT provider

1. Funding is typically insufficient to sustain, start, or expand MAT programs

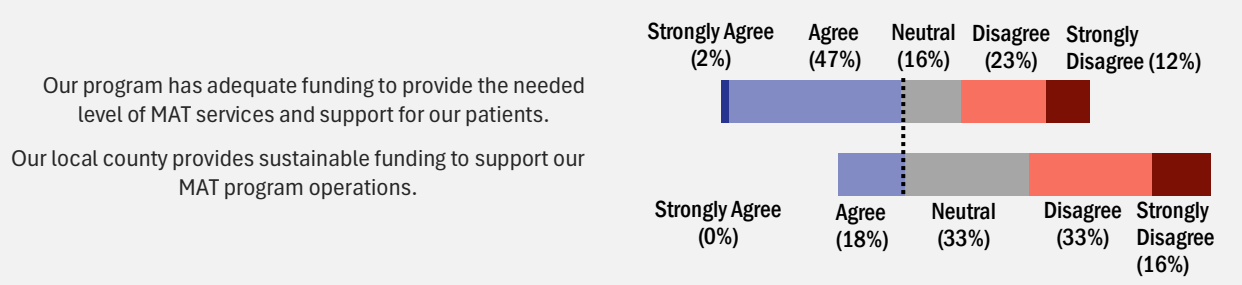
Providers and statewide experts interviewed as part of this assessment emphasized that the "heroic" clinicians and staff leading MAT expansion in California have been "driven by a sense of mission and ethics" while being consistently underpaid. Funding is often insufficient to cover their costs due to low Medi-Cal reimbursement rates for specific MAT services, inadequate negotiated county rates, and stagnant grant funding that remains critical but is not apace with increasing costs.

"Providers aren't reimbursed at the adequate rate, or even the rate that we were anticipating. We could potentially see a reduction of rates as counties encounter budget problems..."

-Statewide expert

As shown in Exhibit 17, a notable proportion of MAT programs participating in a statewide survey for this assessment disagreed or strongly disagreed that their program has adequate funding (35%) and that their local county provides sustainable funding for their MAT program (49%).

Exhibit 17: How MAT programs from the statewide survey for this assessment perceive funding adequacy *(n=43)*



Notably, while 93% of surveyed MAT providers said they wanted to expand their programs—particularly with respect to enrolling more patients and scaling up clinical staff—they ranked insufficient funding as the number one barrier to expansion.

In a statewide survey conducted as part of this assessment, 93% (40/43) of MAT providers said they want to expand; **insufficient funding was ranked as the number one barrier to expansion.**

2. Skilled MAT program staff are key; underinvestment leads to turnover

When asked about program strengths in the statewide survey conducted for this assessment, most MAT providers cited skilled and committed staff. Scaling up clinical and non-clinical staffing were two of the three top program expansion desires, along with admitting additional patients. Among MAT providers interviewed for this assessment, several emphasized their "multidisciplinary team" as key to success, including full- or part-time medical directors, prescribing and non-prescribing clinical staff, administrative staff, counselors, and peer support specialists.

4 in 5

MAT providers responding to a statewide survey for this assessment cited skilled and committed staff as a key program strength *(34/43 programs)*.

On the other hand, providers interviewed for this assessment frequently cited challenges in hiring and retaining high-quality staff. The challenges of the job—which include intense interpersonal interactions, vicarious trauma, and "insane" amounts of paperwork—often outweigh the compensation, especially for staff in entry-level positions and those providing particularly intense interpersonal services such as counseling. Patients participating in focus groups for this assessment described the impact of staff turnover on their MAT experience, such as the frustration of having to go through the vulnerable process of trust-building with one counselor after another.

> **"The workforce crisis is real... We just can't find people that are good that we can hire and can retain because they're going to be able to get paid way more [elsewhere]...and not have to deal with the paperwork."**
>
> *-MAT provider*

3. Funding that can be used flexibly is key for MAT equity, yet not the standard

MAT providers interviewed as part of this assessment frequently noted the importance of supporting clients' basic needs. Those with flexible funding sources shared that they can "think outside of the box" and provide a wide range of supplies, including food, clothing, hygiene kits, first aid kits, laundry, showers, transportation support, and harm reduction supplies, which fosters trust and makes MAT engagement less transactional. However, others had MAT funding that allowed for very little wrap-around support to meet clients' immediate needs, limiting their ability to be responsive to clients' circumstances.

> **"In one grant, we couldn't spend more than $3 per person per service day [on food]...getting some creamer and coffee might not seem inherently associated with a MAT program, but when the people you're serving have been sleeping outside in the rain ...making sure they have a little bit of warmth and some food in their belly can make all the difference in the world."**
>
> *-MAT provider*

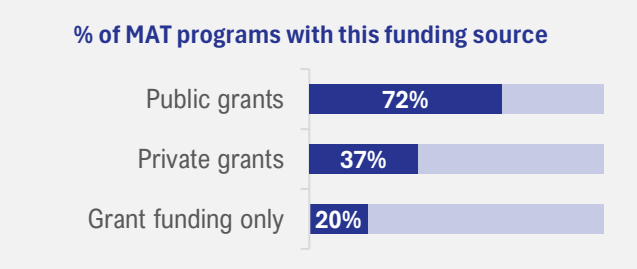
4. Dependence on grant funding limits MAT program sustainability

Many California MAT programs utilize grant funding (rather than Medi-Cal revenue, private insurance revenue, or out-of-pocket patient payments) to provide robust services and innovative care models. As shown in Exhibit 18, a notable proportion of MAT providers who participated in the statewide survey for this assessment reported using public and/or private grants to fund MAT, and one in five relied entirely on grants for MAT funding.

While grant funding is time-limited by definition, MAT providers interviewed as part of this assessment noted that repeated State Opioid Response grants have sustained their programs in the short term. However, providers and experts interviewed expressed uncertainty and concern about the future of federal funding for MAT.

> **"Dependence on grant funding for these services...can contribute to inequity. You might have something today and not tomorrow, and that's a really hard thing for a community that already doesn't have a whole lot."**
>
> *-MAT provider*

Exhibit 18: MAT programs that rely on grant funding in part or fully *(n=43 unique MAT programs)*



5. MAT funding choices are not always perceived as strategic or accountable

Interviewed providers and statewide experts described ways in which MAT funding in California has not been allocated strategically or accountably, including:

- Overlooking structural health systems change as a necessary piece of MAT service delivery
- Taking too long to approve new MAT-related Medi-Cal benefits
- Not investing enough in MAT programs directly (such as funding work groups to understand MAT vs. funding MAT implementation itself)
- Not being transparent about how opioid settlement funds are spent
- Lacking leadership to drive accountability for response to the opioid crisis

> **"State Opioid Response funds...are fundamentally like a Christmas present that comes to the states in this separate box. Whether or not you use it to rejigger long term benefits, long term entitlements, long term structures of care, is up to your discretion...It's been beautiful, but in many ways it's a showcase for the worst possible way to roll out that scale of money, because building structural change is an afterthought."**
>
> *-MAT provider*

PROMISING PROGRAMMATIC PRACTICES

PROMISING PRACTICES

Tailor MAT to the changing drug supply to improve patient experiences

Responsiveness to the changing drug supply, especially the prevalence of fentanyl and other synthetic drugs, creates better MAT experiences for patients. While evidence on alternative induction techniques is still emerging, California providers are exploring both low- and high-dose buprenorphine induction methods and improving how they communicate with patients and center patient preferences.

> **"Rapid inductions are critical right now."**
>
> *-Statewide expert*

1. Explore adjusted buprenorphine induction protocols in the era of fentanyl

A May 2025 review article describing the three main methods for administering buprenorphine in the era of fentanyl—low-dose methods, a rapid high-dose method, and high-dose following naloxone (Exhibit 19)—ultimately concluded that each method has limited empirical evidence.[129]

Exhibit 19: Common buprenorphine induction approaches and how they are being implemented in California

Approach	Examples	California data
Low-dose methods ("Microdosing"—patients receive low-dose buprenorphine with or without transitioning from methadone)	One California outpatient MAT program routinely uses the Bernese method,[130] which transitions patients from methadone to buprenorphine. Their local pharmacy develops custom daily bubble packs with the specific microdosing amounts.	San Francisco retrospective studies of outpatient buprenorphine induction using low-dose methods (without methadone) from 2021–2022 among 126 patients conclude that withdrawal is common (31%) but mostly mild (21% mild, 8% moderate, 2% severe), and precipitated withdrawal is rare (3% when adhering to protocol; 8% overall).[131] However, only 34% of patients completed induction, and only 22% were retained on buprenorphine at 28 days.[109]
Rapid high-dose methods ("Macrodosing"—patients receive an immediate high dose of buprenorphine)	A residential treatment program starts patients on 16 mg as a starting dose, with additional doses available if needed. The same program sometimes shifts patients from micro- to macrodosing protocols.	A study of high-dose buprenorphine in an Oakland emergency department (2018, n=492) concluded that the protocol was safe, addressed withdrawal symptoms rapidly, and resulted in similar 30-day retention for patients with and without fentanyl use. There were two cases of precipitated withdrawal among people who used fentanyl (4.5%).[132] Note: 2018 predated the height of fentanyl prevalence in the drug supply, which may limit these findings.[133]
High-dose buprenorphine following naloxone for overdose reversal	A multi-county emergency medical services MAT program provides high-dose buprenorphine to patients in transport who have undergone overdose reversal with naloxone.	A San Francisco study found 16mg buprenorphine doses during transport to improve patient symptoms without adverse effects. It reported one probable case of precipitated withdrawal in-hospital (among 131 patients from 2023 – 2024).[61]

In addition to the three buprenorphine induction approaches above, new and emerging protocols are being tested by MAT providers in and beyond California:

- San Francisco providers have piloted "direct-to-inject" techniques with buprenorphine, describing the process as "generally well tolerated" and supportive of retention.[134,135]
- In Philadelphia, hospital clinicians have used short-term acting opioid agonists, such as oxycodone or oral hydromorphone, to help "wash out" residual fentanyl and make patients more comfortable.[129,136]
- One statewide expert interviewed for this assessment focuses on patient comfort and prevention of withdrawal symptoms using benzodiazepines and fluids. Similarly, ketamine has been piloted to minimize withdrawal symptoms for buprenorphine in Washington state.[137]

2. Engage clients in decision-making around induction to boost trust and agency

While providers may not always be able to perfectly tailor a dose to their patient, they can support transparent communication and engage patient input in choosing their MAT induction path. One interviewed provider emphasized that this type of shared decision-making between patients and clients about MAT dosing builds trust and mitigates the negative experience of precipitated withdrawal if it does occur. Interviewed clients who had experienced doctors asking for—and listening to—their dosing needs recalled these MAT interactions positively.

> **"I'm getting better at making an assessment and really explaining to my patients what the risks and benefits are. If people do precipitate, and they were involved in that decision making process, it's a lot less scary and painful for them than if they feel like the decision-making process was forced upon them."**
>
> *-MAT provider*

3. Provide clients with their choice of medication

While MAT providers cannot individually overcome every barrier to medication choice—such as regulatory caps on methadone or insurance hurdles for injectable buprenorphine—they make several decisions that impact patient medication options, including whether they pressure patients towards a specific MAT option, whether they find ways to help patients who want methadone to access it (for buprenorphine-only prescribers), how much take-home methadone they provide, how flexible they are on buprenorphine refill timing, and, under more recent law, whether they prescribe methadone "bridge" doses. Interviewed providers who had made MAT—especially methadone—easier to access using options like these reported observing increases in the number of patients interested in MAT, without adverse consequences.

> **"[After we allowed more take-homes for methadone], word got out, and by 2023 it was just a big explosion of intakes. We went from an average for the previous 10 years of about 360 [new] patients a year. In 2023 we did 600 intakes, so it really started to grow our census...and kept snowballing."**
>
> *-MAT provider*

PROMISING PRACTICES

Provide continuous, whole-person care, including through partnership

MAT providers participating in this assessment emphasized the importance of continuous, whole-person care. Many agencies reported collaborating with community partners to boost the strength of their MAT program, as well as their whole-person services.

"In order to do this work, you really have to collaborate with other organizations…No one organization can provide everything, but if we act as one organization through collaboration, patients can get anywhere."

-MAT provider

1. Partner to fill gaps in MAT program capacity and continuity

MAT providers interviewed as part of this assessment noted that MAT programs—particularly those outside of more robust opioid treatment programs—often do not have the capacity to offer all aspects of MAT. Exhibit 20 provides examples of how partnership can boost MAT capacity.

Exhibit 20: Examples of how California MAT programs are partnering to augment their ability to provide MAT

Capacity gap	Partnership example (from interviewed providers unless otherwise noted)
MAT prescribing authority	• A rural grassroots harm reduction organization that has robust relationships with people who use opioids—but no MAT prescribing capacity—partners with MAT telehealth providers to bring MAT services to community members.
Methadone access	• A residential treatment program that only offers buprenorphine on site is partnering with a nearby methadone clinic to allow staff to work with patients to obtain their doses at the clinic and maintain treatment with their medication of choice.
MAT program promotion	• An opioid treatment program working within a broader county network relies on (i) the county for MAT referrals and (ii) the syringe services program for naloxone access.
MAT expertise	• Many organizations use partnering agencies for at least some MAT-related staff trainings, including 47% of programs responding to the statewide survey for this assessment. • Some clinicians informally partner with other clinicians or are involved in convenings or coalitions where there is an exchange of MAT-related expertise.
MAT access in pharmacies	• Several programs mentioned creating intentional relationships with pharmacies to lessen the chance that patients will experience stock or stigma issues and better ensure that programs can hold pharmacists accountable when pharmacy-level barriers do occur. • Some MAT clinicians and program staff have a phone or secure chat-based communication line with pharmacists so that patients do not face pharmacy barriers in the first place. • Some programs have had more success partnering with small pharmacies where they can build a closer relationship, while others preferred to partner with large pharmacies to ensure sufficient medication stock.
MAT care continuity	• One emergency department-based MAT program in a rural area uses personal relationships—developed both through individual outreach and participation in county substance use treatment convenings—to support smoother linkage between emergency department buprenorphine initiation and outpatient buprenorphine maintenance. • One MAT program partners with jails to visit people who are incarcerated pre-release and transition them to an in-person or telehealth outpatient provider.

2. Integrate services into MAT programs—including through partnership

Among providers participating in the statewide assessment survey, a notable proportion reported offering services beyond MAT (Exhibit 21). In addition, several interviewed providers described success in implementing care for polysubstance use as part of their MAT program. This included implementing contingency management programs for stimulant use; offering medications for stimulant use, alcohol, and other substances; and integrating discussions about polysubstance use into provider-patient conversations and patient treatment plans.

Notably, MAT programs vary in their capacity to add services beyond those required for MAT. For programs with less capacity for whole-person care, partnership can offer a pathway to services that are not feasible in house. Surveyed providers commonly reported partnering with behavioral health providers, mental health providers, clinics, health departments, harm reduction organizations, and social services organizations (e.g., homeless shelters). These collaborations occurred through bi-directional referrals, outreach, community meetings, presentations, grant partnerships, and, less commonly, through co-location.

Exhibit 22 shows examples of how partnerships are supporting MAT programs in providing whole-person care.

> **"We put all this money into expansion of MAT, but people are whole humans, so what else is going on for people that we need to address?"**
>
> *-MAT provider*

Exhibit 21: % of MAT programs participating in a statewide survey for this assessment that integrate different services *(n=43 unique MAT programs)*

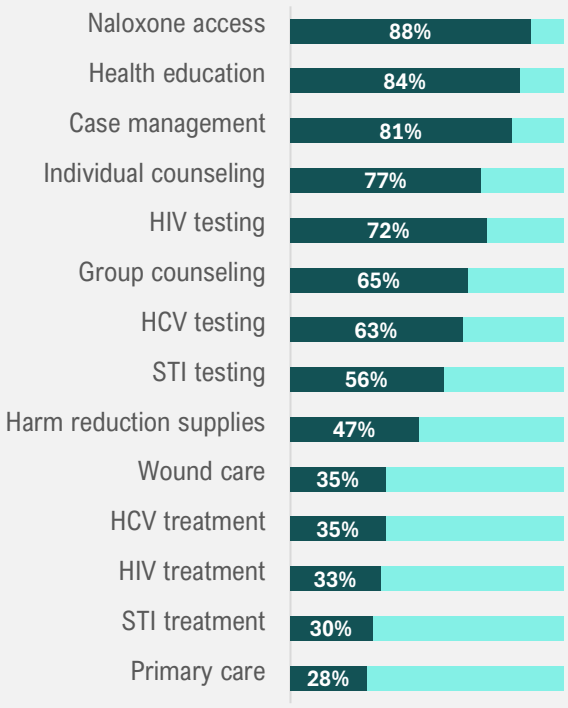


Exhibit 22: Examples of how MAT programs partner to provide whole-person services

Type of service	Example
Medical services	• A rural grassroots harm reduction organization co-locates near medical services by setting up its pop-up telehealth MAT program adjacent to a community health clinic.
Reproductive health services	• A syringe services program receives Plan B and condoms from a community clinic.
Social services	• A residential program links youth clients to a trusted community organization that provides employment support, education support, and jujitsu for emotional regulation support.
Harm reduction services	• A hospital-based program partners with a harm reduction program to provide MAT clients with lunches, harm reduction supplies, hygiene supplies, and first aid.

PROMISING PRACTICES

Apply a low-threshold, harm reduction lens in MAT implementation

MAT providers interviewed as part of this assessment noted the role of low-threshold, harm reduction-focused strategies in providing client-centered services and addressing underlying social inequalities that accompany opioid use disorder.

> **"Part of our access model [is] allowing patients to come as they are and get what they need to help them be safer and healthier, whether that's medicine, whether it's a sandwich, whether it's an unused pipe."**
>
> *-MAT provider*

1. Allow patients to define success—even if it does not include abstinence

MAT program providers interviewed as part of this assessment emphasized that client-centered goals allow clients to reframe what treatment success means in the context of their own lives, which may or may not include abstinence or a specific treatment end date. Interviewed providers noted that many clients have internalized shame based on an idea that treatment should be "one-time" or "linear," with a single focus on abstinence as success. By avoiding judgment and punishment for non-abstinence, providers can continue to engage and support clients—including those who do and do not seek abstinence—through whatever patterns of drug use occur, without losing them to stigma.

> **"Our harm reduction model [means] we're here for you, whatever it is you need, wherever you're at with your use, whatever you want out of your use, and whether that means being abstinent or continuing to use...They don't feel like they are messing up if they return to use or they want to continue using."**
>
> *-MAT provider*

2. Support patient choice in the services they seek for their opioid use disorder

Related to client-centered goal setting, interviewed MAT providers have experienced success in providing individualized treatment plans to people, rather than "copy-paste" or "rubber stamp" approaches. This includes providing choice of medication, choice of home or clinic induction for buprenorphine, choice of modules to accompany MAT (e.g., one-on-one counseling, group sessions, other support services), and choice of treatment facility or provider. This also involves providers trusting patients to identify for themselves what they seek from treatment, what work they want to do, and what that

> **"Historically ... everyone does the same thing. I'm trying to build out a system where people can have choices. They can say, 'I do want a counselor, and I want to work one on one on my recovery with that person,' or 'I don't want a counselor'... or 'I need a social worker. What I really need is housing and food and clothes and change my Medi Cal.' Or, 'I'd like to be in therapy'...A vision that people would come and be asked 'what would you like?'...just like when they're out on the street and they step up to the [syringe] exchange, and [staff] are like 'what would you like?'"**
>
> *-MAT provider*

means in terms of service engagement. Besides providing more tailored support for what clients need and want, the interviewed providers with a harm reduction focus noted that choice is destigmatizing because it gives agency to clients who are typically deprived of agency in substance use treatment settings.

One harm reduction-focused opioid treatment program is exploring the possibilities of patient choice for behavioral health services within opioid treatment programs, using low-barrier syringe exchange services as a model (quote on prior page).

3. Allow people with lived experience to shape MAT programming

Interviewed MAT providers commonly shared that hiring people with lived experience transforms the entire culture of how opioid use disorder is treated. Many MAT programs (especially harm reduction programs) are led and shaped by people with lived experience of drug use, and many staff without a history of drug use have personal connections to the topic through their own families.

One residential treatment program participating in a site visit hosts a Peer Support Specialist Academy that trains former patients to become employees. This strengthens the program through lived experience while providing employment pathways for alumni. Another interviewed MAT provider spoke at length about the critical role that peer Substance Use Navigators (SUNs) play in their program (see Exhibit 23 to the right).

> **"We all came to this work with experience using drugs, loving people who use drugs, being in that world...our origin story is need."**
>
> *-MAT provider*

Exhibit 23: Examples of MAT workflow improvements made by an urban outpatient-based MAT program interviewed for this assessment

EXAMPLE: SUBSTANCE USE NAVIGATORS (SUNs)

SUNs in the California Bridge program are peer allies and advocates for patients that do not "wear a white coat." SUNs are often patient's first point of navigation contact when calling in or arriving in the emergency department, and help patients navigate what they want, whether that be detox, residential treatment, MAT, or just a place to get food. SUNs then bridge the gap between patients and clinicians by helping care teams understand what patients want and helping patients feel trust that their needs will be met.

"The [peer] substance use navigators are the heartbeat of our clinic. They do everything. They're the only reason patients get what they need here."

-MAT provider

4. Recognize and address the consequences of systemic inequality

Interviewed providers emphasized the role of systemic inequality related to poverty, class, race/ethnicity, gender identity, and experience of trauma, among other factors, in shaping why people use drugs and how they engage with MAT. Exhibit 24 shows how interviewed providers are addressing these underlying barriers.

Exhibit 24: Examples of how California MAT programs are supporting whole-person needs

Area	Examples of practices	In their own words
Supporting **basic needs** that typically are top priority	• Provide food, clothing, hygiene support • Provide harm reduction supplies (naloxone, sterile syringes and pipes, fentanyl test strips, condoms, emergency birth control) • Provide a safe place to rest • Provide charging for phones	*"We're coming out of the winter…We have long pants and underwear and good socks. That's how you help build relationships with people, not this transactional relationship that is totally based on you engaging in medication…We build friendships with people— heck yes, socks and pizza all the time."* – *MAT provider*
Offering **social connection** to counter isolation and build trust	• Hosting groups of people navigating opioid use disorder who meet regularly • Celebrations for patients in residential treatment settings • Baking homemade cookies • Hosting informal community events outside of services (outpatient setting)	*"When you walk in here, you get smiles. These guys are like, 'Hey, what's up?' They don't care that we're using drugs…They just care that they're just happy to see us…they just care about us as people. They don't see us as drug addicts…just a normal person that's come in to make sure that we're healthy."* – *MAT client*
Providing **culturally responsive** services to mitigate past healthcare-related trauma and stigma	• Creating a non-clinical ambiance (casual facilities, crafts, music) • Demonstrating trust in patients (not requiring urine testing, allowing early buprenorphine refills) • Keeping services low-profile to support privacy in small, rural areas • Ensuring staff representation of patient identities and languages • Group-focused sites (e.g., LGBTQ+, justice-involved, pregnancy, youth) • Culturally specific MAT education	*"We have medicine wheel teachings …with different variations and meanings to different tribes…One of the teachings…is [the] whole person—the physical, the mental, the spiritual and the emotional… Patients might meet a provider [who says], 'here, take this medication. This is good for opioid use disorder.'…and they don't see the deeper understanding….so when we educate providers on how to speak about the medicine wheel teachings of why [MAT] is so important…people are able to reconnect with their culture.* – *MAT provider*
Minimizing logistical barriers to access	• Expanding clinic hours • Offering same-day/drop-in care • Providing insurance agnostic care • Leveraging funds (or Medi-Cal transport benefit) to support transportation • Locating sites in areas of need (or going there through mobile/satellite models) • Hosting warmlines (phone, text) for emergency refills and pharmacy barriers • Providing formal or "pseudo" case management to support holistic needs	*"The open-door policy, all the ways that barriers have been removed, the fact that we serve people, no matter if they're insured or uninsured…has been huge in really breaking down some of these barriers."* -*MAT provider*

PROMISING PRACTICES

Destigmatize MAT through audience-specific outreach

MAT programs in California are continuing to counter stigma through ongoing advocacy. Several providers and experts interviewed for this assessment shared ways they have successfully reduced stigma for certain audiences.

"We've really taken a hard run at stigma in so many different settings, and we continue to do so."

-Statewide expert

1. Explore peer-to-peer approaches for cultivating provider buy-in

In the statewide survey conducted as part of this assessment, only 60% (26/43) of MAT programs reported providing stigma-focused staff training. Several California research studies suggest that peer-to-peer learning—such as learning collaboratives and similar training models—may be a promising training approach for increasing buprenorphine prescribing among providers.[23,62,63,138] Mirroring these findings, MAT providers interviewed as part of this assessment described several ways in which peer-to-peer perspective sharing among MAT providers enhanced provider buy-in (Exhibit 25).

Exhibit 25: Examples of how peer-to-peer perspective sharing increases MAT provider buy-in

Audience	Example	In their own words
Prescribing providers	One statewide expert noted that prescribing clinicians support peer buy-in by emphasizing that MAT is just like any other medication, and, in some cases, is easier to use than medications for other conditions they treat. One MAT clinician suggested the value of peer-to-peer consultations (through formal case reviews or informal check-ins) for easing provider uncertainty about MAT specifics.	*"This medicine is easier than diabetes, it's easier than hypertension, it's easier than a lot of things that clinicians already are so capable and competent at."* -Statewide expert
Emergency medical services personnel	An emergency medical services-based MAT provider shared that paramedics who have firsthand experience with the way that buprenorphine can make patients comfortable during transport has spurred a paramedic-to-paramedic transfer of knowledge that boosts buy-in.	*"One of the paramedics...had a patient who was...fairly aggressive...He was offered buprenorphine, took it, and felt so significantly physically better that he was mentally and emotionally better. It changed the transport, and the entire experience for that paramedic, who then talked to other paramedics to say, 'Give this more often'...It makes it such a better experience for not only them, but also for us."* -MAT provider
Non-prescribing program staff	A MAT provider shared that implementing a tailored anti-bias training for program staff and community partners—which includes personal stories from community members—has a palpable impact on how providers in their program feel about people who use drugs.	"*Our anti bias intervention training...somebody's gonna cry every single time...it helps it make it real for people...When people get to hear people share their story...that changes people."* -MAT provider

2. Prioritize bringing accurate, destigmatizing information to patients

Interviewed providers, experts, and patients noted several instances in which patients had not received full information (e.g., whether medication was covered by insurance, dental side effects) or received recited misinformation (e.g., methadone gets in your bones, you can't treat an opioid with an opioid). These barriers highlight opportunities for improved patient health education, including the use of digestible, accessible education materials that are guided by the perspectives of people who use opioids.

Interviewed providers emphasized that reaching people who have not received accurate information about MAT—especially those experiencing homelessness and social isolation—requires going beyond traditional health education channels, using "boots on the ground" to give people the information they seek directly. Moreover, they acknowledged that in many communities of people who use drugs, the primary way that information spreads is through "word of mouth," reinforcing the importance of positive MAT patient experiences as a foundation for spreading accurate, destigmatizing information about MAT. This includes ensuring that providers listen to and validate patient concerns and take enough time to ensure that patients are informed about possible side effects of their treatment plan.

> **"We made sure word got out there on the street, not by posting on social media and hitting up a bunch of doctors, but by going around to people that we were talking to on the [MAT] van."**
>
> *-MAT provider*

3. Consider the role of MAT destigmatization for patients' families

MAT providers also emphasized the role of patients' families in stigma, shame, social support, and healing. Several programs connect family members to support groups designed for family members of people with opioid use disorders, and some residential programs provide options for children to live with a parent or guardian in treatment. One MAT provider spoke at length about their approach to destigmatizing MAT in patients' families through tailored education; that program plans to build a residential treatment facility that includes separate, neighboring family living space. Another MAT provider noted that families often do not know what steps to take when a loved one is experiencing opioid use disorder; that provider plans to create a centralized MAT hotline for an easy, one-stop shop for helpful and destigmatizing MAT information, mirroring California's successful tobacco cessation support hotline.[139]

> **"The biggest thing that matters when it comes to MAT services is educating the patient's family. In their addiction, people [usually] don't have any support. If you can get their family to be on board...you have a lot more success."**
>
> *-MAT provider*

4. When stigma cannot be avoided, create alternatives

Several interviewed providers cited pharmacy-level stigma as a substantial barrier. While some have been able to cultivate partnerships with pharmacies, others have adopted stigma workarounds through in-house pharmacies, pharmacy delivery services, accompanying patients to the pharmacy, and having on-call substance use navigators or nurses available to call pharmacies on behalf of patients.

PROMISING PRACTICES

Build resilience to anticipated funding and capacity changes

MAT programs in California are building resilience within the limited resource infrastructure and implementing strategies that will better prepare them for an uncertain funding environment. These include strategies to retain staff, improve internal systems, and cultivate buy-in at multiple levels.

"We're going to continue to push forward and work with multiple agencies to do this with very little money."

-MAT provider

1. Build a multidisciplinary staffing team with complementary skillsets

When asked about their staffing model, many MAT providers who participated in surveys and interviews emphasized their "multidisciplinary team" as key to success, with teams commonly including full or part time medical directors, prescribing and non-prescribing clinical staff, administrative staff, counselors, and peer support specialists.[x] While many MAT providers noted that on-site prescribing clinicians were key to their program, some organizations—especially those operating outside of traditional clinical settings (such as syringe services programs)—partnered with external clinicians. Many interviewed MAT providers emphasized that non-prescribing clinical staff, such as medical assistants, peer support specialists such as Substance Use Navigators (SUNs), licensed social workers, and nurses, were equally as important as prescribing clinicians due to their roles in explaining MAT options, providing counseling, completing needed paperwork, supporting clients with navigation around insurance, advocating for clients, and generally building a foundation of trust with clients. In addition, providers noted the trade-offs of different types of prescribing staff; for example, while it was beneficial to have a physician available, nurse practitioners were perceived as a more cost-effective prescriber.

"We have a pretty good integrated medical team with our clinicians. Besides having the prescriber, we have support staff...medical assistants, licensed nurses, vocational nurses... we have a whole medical team. Why this is key? The patient is meeting with the prescriber for 15 minutes, [and may be] very scared...so our medical staff...are asking them, what are their needs?...That relationship is more than 15 minutes, and they can really create a connection and educate them on what is available for MAT services. When these patients meet with our prescriber, they are already educated and aware what options are on the table for them.

-MAT provider

[x] Appendix 3 includes details on the percent of surveyed organizations who hosted different types of full- and part-time staff, as well as other survey data related to organizational infrastructure (e.g., budget).

2. Implement non-wage-related strategies to retain high-quality staff, if it is not feasible to increase salaries or fringe benefits

Given limited funding for staffing alongside the importance of high-quality staffing, providers interviewed as part of this assessment suggested promising strategies to retain high-quality staff that did not involve increasing wages. Exhibit 26 provides examples of strategies.

Exhibit 26: Examples of how California MAT programs are supporting high-quality staff retention

Area	Examples strategies	In MAT providers' own words
Screening during hiring for qualities that help staff thrive in the job for long periods of time	• Screen for characteristics like compassion, openness to harm reduction, and personal connections to the work • Consider candidates with relevant certifications, such as someone training to become an alcohol and drug use counselor	*"My boss does a really good job at screening people in the interview. Obviously, they do a work history, and they see who's a good match just based on their experience. But then during the interview, the questions were really pointed at harm reduction and the care model that we promote here, and just MAT in general, just having a good idea of what the work is."* – *MAT provider*
Making workloads manageable	• Provide staff training on topics needed to do one's job well, including harm reduction, internal systems, compliance, overdose prevention, and de-escalation[xi] • Set a cap for counselor caseloads to mitigate burnout	*"We keep our caseloads around 40 to 45 people for counselors…who work 36 hours a week. That's our full time. When we interview counselors coming from other places… it's pretty much the norm to hear that 60 to 90 people are their caseload."* – *MAT provider*
Providing professional development	• Allow staff to shadow, observe, and consult more experienced staff • Support certification pathways (e.g., peer support and addiction medicine specialists)	*"We try to offer training [for counselors]…it took us a long time to get there, but we're doing a much better job of promoting promise when we can give people a sense that there is a place that they can potentially go."* – *MAT provider*
Fostering a positive staff culture that mitigates burnout	• Cultivate an agency culture of passion and teamwork • Foster trauma-informed social support and self-care	*"If I didn't have the staff that work with us, doing their part and being really effective…it wouldn't all make sense. It comes from good staffing, good training, great passion, and communication with others."* – *MAT provider*

[xi] Appendix 3 includes a table showing the types of trainings that surveyed MAT providers use at their organization, as well as a break-down of how surveyed MAT providers source their trainings.

3. Identify places where internal MAT protocols can support efficiency or quality

Given funding limitations and heavy administrative burdens, many MAT providers have creatively improved their capacity by improving internal systems. These improvements include (i) reducing administrative burden, which frees up staff time, (ii) improving the patient experience with respect to paperwork and waiting times, and (iii) improving scheduling efficiency to ensure that all available slots are used.

One outpatient provider based in an urban area spoke in detail about their strategies (Exhibit 27).

Exhibit 27: Examples of MAT workflow improvements made by an urban outpatient-based MAT program interviewed for this assessment

MAT WORKFLOW IMPROVEMENTS (OUTPATIENT SETTING)

Reducing administrative burden:

- Streamlining paperwork, including with digital signing

Improving patient experience:

- Not requiring patients to re-do full intake process if they leave care and return at a later point
- Patient rooms where patients wait for their turn to do intake, rather than in a crowded waiting room

Serving more patients:

- No longer proactively holding spots for priority patients coming from the hospital, due to low turn-out (but still prioritizing them if they show up)
- Freeing up providers to help patients if they arrive during morning staff huddles or other staff convenings

4. Cultivate buy-in from those in internal positions of power

Numerous MAT providers and experts also emphasized that without someone "stepping forward" and "raising their hand" to make MAT access happen, it will not happen, regardless of the amount of funding poured into MAT. Among providers interviewed in this assessment, one spoke at length about how institutional buy-in was key to MAT success and sustainability. In contrast, another provider noted that a new CEO not being a champion for new services for people who use drugs led to their organization "giving up" on starting a contingency management program for stimulant use. These provider insights are supported by research demonstrating that MAT program champions and leadership buy-in are key elements to MAT provision.[92]

> **"Our biggest achievement is to get the provider buy in, the staff buy in, leadership buy in. That is the accomplishment because that's what makes this program grow."**
>
> *-MAT provider*

Interviewed providers routinely emphasized the importance of sharing MAT impact data as widely as possible to emphasize its lifesaving and morbidity-reducing potential. However, they presented mixed views about whether cost arguments should be made to make the case for MAT. While some touted financial savings—such as those related to emergency department visits for overdose, withdrawal, and drug-related harms—others emphasized that it needs to be acknowledged that curbing the overdose crisis and expanding MAT is a costly—yet urgent—endeavor, and driving down costs cannot be the motivating factor for program expansion.

5. Cultivate buy-in from the broader community

While the broader community is not traditionally in a position of power over healthcare settings, the nature of MAT programs—including the stigma that commonly surrounds them—means that community perceptions can impact program sustainability. One interviewed residential treatment provider shared a story about how their positive standing in the community led to an outpouring of support when a natural disaster caused a tree to fall through their bridge recovery house, allowing them to provide uninterrupted services. Another interviewed provider shared that their first steps to planning for post-grant sustainability of an emergency department-based buprenorphine program included "growing their fan club" and "making friends" with partner organizations with more sustainable funding structures. Interviewed MAT providers provided several examples of community engagement (Exhibit 28).

> **"[After a tree fell through our bridge recovery house], because of all the things we do in the community, trucks by the loads just started showing up and dropping things off. We still haven't even got through everything that was donated to support us."**
>
> *-MAT provider*

Notably, cultivating community buy-in may be more challenging or infeasible for certain organizations or settings. For example, one program participating in interviews for this assessment has faced intensive backlash from local coalitions and government due to the controversial nature of harm reduction services in a rural, politically conservative area. An organization that operates a mobile narcotic treatment program (MNTP) noted that they had experienced challenges parking the unit in their surrounding dense urban area, while a different organization interested in MNTP implementation noted that this would be impossible until local zoning policies shifted to allow for MNTPs.

Exhibit 28: Examples of broad community engagement shared by MAT providers interviewed during this assessment

COMMUNITY ENGAGEMENT EXAMPLES

- Sharing program impact data
- Hosting events (e.g., Overdose Awareness Day, naloxone distribution)
- Providing tours of facility space
- Presenting at community events
- Conducting community clean-ups (garbage, syringes, etc.)
- Partnering with and training community-based organizations
- Hosting social connection opportunities/social events
- Participating in community events run by others to build relationships
- Participating in multi-county, county-wide, population-specific (e.g., youth), and/or local MAT-related coalitions

CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS & RECOMMENDATIONS

Continued investment is needed to sustain and expand MAT gains

"I want policymakers to know that the addiction crisis isn't over. We shouldn't accept overdose deaths as an acceptable norm. Being back to the level when we declared the emergency is not a win. It's not done." *-Statewide expert*

1. California has had numerous MAT "wins," and yet continued investment is needed to address ongoing barriers

There is no doubt that MAT is an evidence-based, highly efficacious treatment that has a critical role in curbing the ongoing overdose crisis and improving the lives of people with opioid use disorder. This assessment highlights major MAT wins, including transformational policy changes to loosen MAT regulations, unprecedented financial investment, MAT expansion in diverse non-traditional treatment settings, and tailored efforts to bring MAT to those most marginalized by the healthcare system. MAT providers across California are implementing nimble and innovative approaches to counter MAT-related barriers. Despite these wins, findings from this assessment suggest that MAT is not living up to its potential due to persistent stigma, inadequate funding, restrictive regulatory practices, high-barrier engagement requirements, and the challenges of buprenorphine-related withdrawal. These findings suggest that **California must continue to invest in MAT both through funding and policy shifts** to increase access to MAT and improve the experience of people who choose to access MAT.

Considering this landscape analysis and the current funding environment, recommendations for MAT policy, funding, and technical assistance are outlined in this section.

NOTE: Recommendations for MAT *providers* are included in The Center at Sierra Health Foundation's MAT case study website, which distills findings from the landscape analysis for a MAT provider audience.

2. Policy Recommendations[xii]

POLICY

I. Explore options to further loosen MAT restrictions. Certain types of MAT are still highly regulated and hard to access, limiting patient choice. With respect to methadone, it is important that California expand access to the extent allowable by federal law as it implements modernized methadone policies (AB 2115).[52] In addition, given that many providers interviewed for this assessment imposed restrictions on methadone more stringent than the state's, the potential for minimums or mandates for take-home methadone among California MAT programs should be considered. With respect to injectable buprenorphine, insurance and availability barriers make this promising option out of reach for many, and these barriers should be examined and addressed.

[xii] Note: Brief recommendations for exploring policies are provided in this report; more detailed policy briefs expanding on these issues will be developed as a separate resource.

II. Explore options to increase buprenorphine stock at pharmacies. Many patients who use buprenorphine must access it from a pharmacy outside of their MAT program, yet fewer than half of California pharmacies reported having buprenorphine in stock in a 2022 study.[107] Mandating buprenorphine availability—as has been done in the City and County of San Francisco[145]—is one option that can be explored, though it is important to acknowledge that monumental stigma-related barriers also must be overcome to make MAT truly accessible in pharmacies.

III. Explore options to reduce the administrative burden for methadone programs. Streamlining MAT program efficiency is strategic in a scarce funding environment, and allows programs to spend more time serving patients, reduce barriers to engagement, and receive licenses to expand their services. Intake presents a particularly crucial moment for streamlining services so that patients are not lost at the critical and vulnerable moment of program entry, when they may be feeling their worst.

IV. Explore options to expand mobile narcotic treatment program (MNTP) implementation. MNTPs are an innovative approach to MAT delivery yet face regulatory challenges, especially in jurisdictions in which zoning laws prevent implementation. Examining the policy levers that impact MNTP implementation would provide insight into making MNTP access more geographically equitable in California.

3. Funding Recommendations

I. Ensure Medi-Cal reimbursements are sufficient for existing MAT programs. MAT providers should not have to be "heroes" who rely only on passion—rather than adequate compensation—to fuel their work. Ensuring that programs have sufficient staff reimbursement rates, that reimbursements stay apace with increasing costs, and that MAT costs are adequately encompassed in Incidental Medical Services is key to making sure existing programs can stay financially solvent and impactful. Standards or guidance that support all counties to have the needed level of reimbursement may improve equity in MAT access across jurisdictions.

II. Carve out funding for innovation. Many successful MAT models implemented outside of opioid treatment programs began with seed funding. It may be unrealistic to think that innovation can occur otherwise, especially in high-potential settings that are not set up for low-barrier access (e.g., primary care). In a funding-scarce environment, innovation can also be supported by making existing funding more flexible, allowing programs to identify interventions and resources most needed for clients.

III. Fund capacity-building to help community-based MAT become self-sustaining. Supporting organizations that do not already bill Medi-Cal for MAT services in transitioning from grant funding to Medi-Cal revenue may help keep their MAT programs afloat in an uncertain grant environment. This support may include funding new technical assistance providers for this purpose and/or connecting community-based organizations with existing technical assistance providers.

4. Technical Assistance Recommendations

TECHNICAL ASSISTANCE

I. Develop standard guidance around buprenorphine induction options. Though efforts have been made to publish different buprenorphine induction options,[129,140] many providers engaged in this assessment appeared unfamiliar with the range of options. While precise best practices will vary by patient, creating resources that share up-to-date evidence-based options with providers is critically needed. Sharing interim findings can increase provider buy-in while improving equity in areas with less access to large healthcare and research systems that tend to share and encourage use of "cutting edge information." This recommendation reinforces a 2025 Los Angeles-based study examining MAT among people who use fentanyl that called for "comprehensive prescription and dosing guidelines for [MAT] specific to fentanyl that address the withdrawal and pain related symptomology [for people who use drugs]."[141]

II. Consider how MAT programs can support patient-defined success criteria. A notable finding from this assessment was the disconnect between provider and patient perspectives about the importance of buprenorphine-related withdrawal as a barrier to MAT. This finding resonates with a small body of prior U.S. research suggesting that clinically meaningful metrics of MAT success (e.g., opioid use reduction, preventing overdose) may not fully reflect patient-important measures of success (e.g., avoiding withdrawal, relationships, employment, self-worth).[142-144] It is crucial for providers to understand patient-important measures so that MAT programs do not run counter to patient goals. For example, being required to accept even a small risk of precipitated withdrawal is counter to avoiding withdrawal. Visiting a methadone clinic daily can be counter to acquiring stable employment. Being stigmatized by one's 12-step community for using MAT is counter to social support. Experiencing poor treatment by a pharmacist is counter to feelings of self-worth. Ultimately, designing MAT programs to achieve patient-centered success measures is crucial, and requires patient input. The "promising programmatic practices" section of this report includes options for centering client goals.

> **"You could start saving up money for housing, but how?...I can only even get a part time job, and only certain hours I can work, because I can't miss my [9 hours per week of] groups, because if I miss my groups, then I'm not in compliance...how are we supposed to move up and get stabilized in our lives?"**
>
> *-MAT client*

III. Provide support for scenario planning amid uncertain funding environments. MAT providers and statewide experts in this assessment expressed a palpable sense of uncertainty about the future of MAT and Medi-Cal funding. MAT programs will be best equipped to navigate this uncertain future if they plan for it. Scenario planning support for MAT programs might explore how different funding scenarios would impact services, how agencies can streamline efficiency to offset funding cuts, and the types of partnerships that could fill capacity gaps or ensure service continuity under severe funding shortages.

5. Additional questions to explore

While this landscape analysis uncovered many key findings and recommendations related to MAT, it also brought forth new questions that warrant future examination (see table below).

Future Questions to Explore

POLICY	• To what extent will recent California legislation (AB 2115) bring state methadone practices in alignment with federal law? • What models have been used in and beyond California to improve buprenorphine stock in pharmacies? • What policy levers are involved in the pricing of different formulations of buprenorphine (e.g., sublingual vs. injectable)?
FUNDING & SUSTAINABILITY	• What are the true costs of operating different California MAT program models?[xiii] • What would a detailed map of California's MAT funding ecosystem look like? • What models exist for MAT program sustainability within community organizations? • How can funders offset changes to the funding landscape that may make MAT resources more scarce?
TECHNICAL ASSISTANCE	• What types of trainings do MAT programs need most, and to what extent do these trainings exist? • What are the specific protocols by which MAT programs can make services low-barrier? • What role does the technical assistance marketplace play in addressing this report's recommendations?

[xiii] Appendix 3 (Exhibit A-10) of this report includes survey data on the costs of MAT programs represented by survey respondents.

6. Closing thoughts

When considering the future direction of MAT in California, it is worth noting that the groundbreaking changes to MAT regulations during the COVID-19 era showcased how quickly MAT access could expand through policy change and financial investment. As California enters a more limited funding environment, providers and statewide experts interviewed for this assessment emphasized that **the only way to counter the overdose crisis is to treat it like the emergency it is, with a commensurate level of leadership, funding, and collaboration.** There is opportunity to re-examine and build upon strides made during the COVID-19 pandemic, taking into account the findings and recommendations of this report.

> **"COVID demonstrated to us as a healthcare system that we can move mountains. We can do anything to prevent people from dying...We need to be applying that same tenacity to preventing overdose deaths."**
>
> *-MAT provider*

> **"In order for someone to seek drug treatment, you can't just make it available...The policy work is intrinsically related to decriminalization, housing, accessing safety, accessing care, no matter what your status of immigration... availability does not mean access."**
>
> *-MAT provider*

While the recommendations from this assessment focus on MAT-specific strategies, a key finding of this assessment was that **MAT alone cannot address the adverse consequences of federal, state, and societal systems and policies that stigmatize and marginalize people who use drugs**, especially those who are part of other systematically marginalized groups. Policies, funding priorities, and cultural change that shift the overall well-being for people who use drugs are needed to maximize MAT's impact.

APPENDICES

Appendix 1: Overall Report Methods

The Center at Sierra Health Foundation funded this statewide MAT assessment, collaborating with Facente Consulting—a health equity public health consulting firm with expertise in overdose prevention, mixed methods research, stakeholder engagement, and community needs assessment—to implement it. The assessment included (i) a literature review, (ii) secondary data analysis, (iii) a statewide survey for MAT providers, and (iv) qualitative data gathered through observational site visits to MAT programs as well as in-person and virtual interviews and focus groups with statewide experts, MAT providers, and people with a history of opioid use throughout California.

1. Literature review methods

Facente Consulting designed the literature review to assess peer-reviewed and gray literature sources that were responsive to these four questions posed by The Center at Sierra Health Foundation:

1. What is the availability, accessibility, and use of MAT across different regions of the state?
2. What disparities exist in MAT services by geography, race and ethnicity, age, and gender?
3. What changes have there been to the policy and funding landscape for MAT delivery in California since 2017, including how these things have changed as a result of COVID?
4. What are the primary barriers hindering individuals from accessing MAT for OUD treatment?

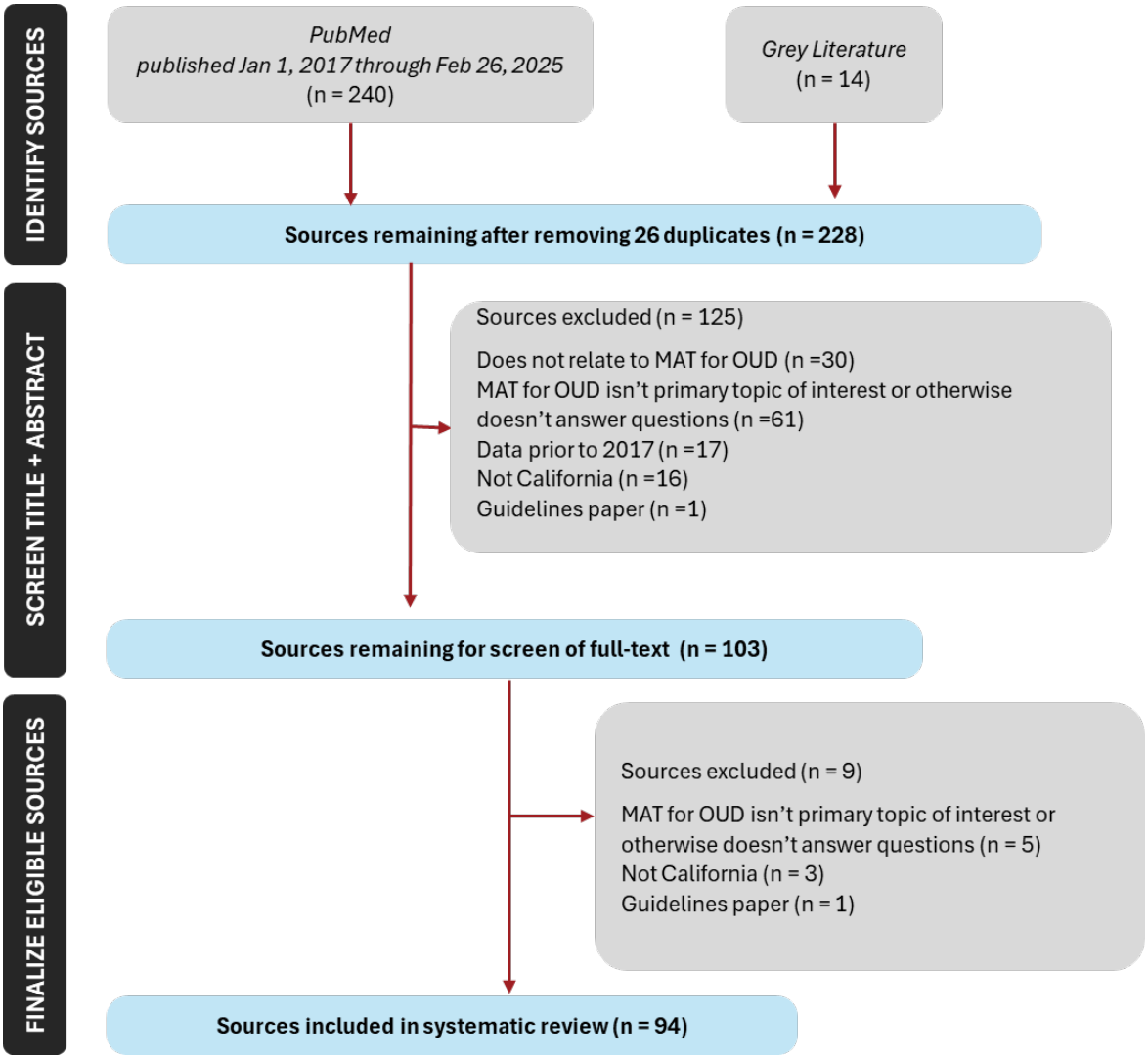
Initial literature review. To review the peer-reviewed literature, a search strategy[14] was developed for each question of interest and conducted on PubMed. Studies were included if their primary topic of interest was MAT for opioid use disorder in California, and if they examined availability, accessibility, use, disparities, and/or barriers to access. The search was conducted 2/1/25–2/26/25, and studies with data collected prior to 2017 were excluded. Articles were entered into EndNote, and, after duplicates were removed, records were extracted into Microsoft Excel for title/abstract screening and full text screening. Articles remaining after title/abstract screening had full text downloaded and read for relevance. Those meeting the inclusion criteria after full text screening were included in this report. Paralleling the approach to the peer-reviewed literature, a search strategy was developed for each question of interest and conducted using the Google search engine. Gray literature sources were initially screened for relevance, and sources deemed relevant were reviewed in full against the inclusion criteria. Key points from each literature source were summarized for each of the four questions and triangulated with other findings from other methods in this assessment. Exhibit A-1 on the next page includes a PRISMA flow diagram showing the literature review screening and inclusion process.

Addition of literature not identified in initial literature review. While synthesizing findings across all report sources, additional literature was reviewed and included when (i) a new article (published since the initial literature review, not included in the initial literature review, or published before 2017) was

[14] Search strategy and syntax are available upon request from Facente Consulting

identified as highly relevant, and (ii) to contextualize findings on topics that were not examined in the initial literature review (such as buprenorphine induction techniques). In addition, not all sources were cited in the report, depending upon their relevance to the overall findings.

Exhibit A-1: PRISMA flow diagram showing literature review screening and inclusion process



Literature review limitations. One limitation was developing a search strategy that was sufficiently comprehensive, due to the varied ways in which MAT is described. For example, MAT may be considered "Medications for Addiction Treatment," "Medication Assisted Treatment," "Medications for Opioid Use Disorder," buprenorphine, naltrexone, methadone, "medication-assisted opioid therapy," "opioid agonist therapy," or "opioid substitution therapy," among others. While we included a wide range of ways in which MAT can be described, there was the possibility of overlooking key studies. A second limitation was the relatively low numbers of studies with California-specific MAT findings. While the literature provided insights into the MAT landscape in California, it was clear after the literature

review that other data sources from the assessment would be critical to adequately answering the questions of focus. A third limitation was that many studies covered data collection periods more than five years ago due to the lag between research implementation and publication. Given the major changes that have occurred with MAT, from policy and funding shifts to the liberalization of methadone during COVID-19, these studies may have limited insights into what MAT access looks like in 2025. For these reasons, while the literature review was an important data source, it was primarily used to triangulate data from other sources, rather than as the primary frame for the assessment findings.

2. Secondary data analysis methods

Facente Consulting collaborated with The Center at Sierra Health Foundation to identify secondary data sources with the potential to provide insights into the landscape for MAT in California, specifically with respect to two questions:

1. What is MAT service availability, accessibility, and use across different regions of California?
2. What disparities exist in MAT services by geography, race and ethnicity, age, and gender?

Secondary data sources. Secondary data sources are shown in Exhibit A-2 below, along with how each data source was analyzed by Facente Consulting in this assessment.[15]

Exhibit A-2: Data sources used in secondary analysis

Data source	Use in report
California Overdose Surveillance Dashboard (https://skylab.cdph.ca.gov/ODdash/?tab=CA) This dashboard includes quarterly and annual data on opioid-related fatal overdose rates, hospitalizations, and emergency department visits, as well as buprenorphine prescriptions at the state and county level. For some measures, data can be stratified by age, sex, and/or race/ethnicity.	This dashboard was used to export data about opioid-related fatal overdose rates/counts and buprenorphine prescriptions by county, stratified by age, sex, and race/ethnicity (where possible) to indicate potential disparities. Data were visualized descriptively through maps and charts created in ArcGIS and Excel, respectively.
Treatment Episode Data Set (TEDS) (https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles) This dataset has client-level admissions and discharge data for people ages 12 and older who underwent substance use treatment at facilities receiving public funding (including public and private facilities) in California in 2022. The dataset includes whether a client used MAT as part of their substance use treatment plan and whether a client completed their treatment plan, along with demographic and substance use characteristics.	TEDS discharge data from 2022 was downloaded and cleaned to yield a sub-sample (n=39,149) of California clients who had opioids listed as their primary or secondary substance at admission or discharge. Descriptive statistics were run on both the California-specific version and national version of the cleaned dataset, for comparison between the state and national level. Pearson's Chi-squared tests, followed by a complete case logistic regression, were used to compare those who did and did not have MAT in their treatment plan. A

[15] Resources screened, but not manipulated through secondary analysis due to lack or relevance, insufficient specificity to California, and/or redundancy included: the California Narcotic Treatment Programs Provider Directory, the Hub & Spoke System grantee map (as of March 2025), a directory of California Bridge Navigator Program hospitals, the California Health Care Foundation 2022 Substance Use Disorder Almanac, data from the 2022 National Survey on Drug Use and Health, the California Correctional Health Care Services dashboard, the Congressional District Health Dashboard, the California Health Places Index, the Social Weather Database, and the National Equity Atlas. Some of these were cited as relevant grey literature in the body of the report.

	second complete case logistic regression was used to examine whether having MAT in one's treatment plan was associated with likelihood of completing the plan.[16]
SAMHSA Treatment Locator (https://choosechangeca.org/locator/) This treatment locator indicates opioid treatment programs and buprenorphine providers by their geographic location (latitude, longitude).	Locations of specific opioid treatment programs and buprenorphine providers were exported and uploaded into ArcGIS to create descriptive California maps of MAT availability overlaid with fatal overdose data.
MAT in Medi-Cal dataset (https://sandbox.data.ca.gov/dataset/medication-assisted-treatment-in-medi-cal-for-opioid-use-disorders-by-county) This dataset shows individual-level claims data for Medi-Cal beneficiaries by county and MAT type through 2023.	Quarterly Medi-Cal claims for methadone vs. buprenorphine were charted from 2015 to 2023, as rates among the Medi-Cal-enrolled population each quarter, to descriptively visualize methadone and buprenorphine trends over this time period.

3. Interview and Focus Group Methods

Interview and focus group recruitment. Facente Consulting collaborated with The Center at Sierra Health Foundation to identify key stakeholders, including statewide subject matter experts, MAT providers, and people with a history of drug use (including both MAT and non-MAT clients), to participate in virtual or in-person interviews and focus groups. Each stakeholder was invited by e-mail, with multiple attempts to follow-up if they did not respond. Invitations included a link to sign up for an interview slot through the Calendly platform, which sent automated calendar invitations with the physical location or Zoom link. Most statewide experts were interviewed by Zoom, whereas most MAT providers and clients were interviewed in person at the site providing MAT. Participants were compensated for their time and expertise ($50 cash for clients, $75 electronic gift card for providers, and $500 in cash or check to sites participating in site visits).

Interview and focus group guide development. Facente Consulting collaborated with The Center at Sierra Health Foundation to develop a series of interview and focus group guides for different stakeholder types. Questions centered around how MAT access has changed over time, current barriers and opportunities to MAT access, and promising practices for expanding MAT access. For MAT providers and clients participating in a videotaped site visit, additional questions were included to learn more about the organization's specific model.

Interview and focus group implementation. Facente Consulting led virtual interviews and focus groups via Zoom, and conducted in-person interviews and focus groups across 15 MAT organizations in the counties of Alameda, Butte, Contra Costa, Humboldt, Imperial, Inyo, Kern, Los Angeles, Nevada, and San Francisco. While most sites included engagement with MAT providers and clients, four of the sites just hosted focus groups with clients who used opioids but were not using MAT. Facente Consulting

[16] Methodological limitations for these analyses are detailed along with the analyses themselves in Appendix 2.

recorded all interviews (audio or video), with explicit consent of the interviewee. They imported interview transcripts into the otter.ai platform to be automatically transcribed, and cleaned the transcripts manually to ensure accuracy. Video footage was separately reviewed and edited for integration in video case studies (not described in this report). Exhibit A-3 summarizes the total interviews and focus groups conducted, and their characteristics.

Exhibit A-3: Overview of interviews and focus groups

Method	Stakeholder	# Conducted
Virtual interviews	Statewide experts	• 9 virtual interviews
In-person interviews	Mostly MAT providers, some clients	• 81 provider interviews (66 filmed, 12 not filmed) • 14 client interviews (12 filmed, 2 not filmed)
Virtual focus groups	MAT providers	• 3 focus groups
In-person focus groups	People with a history of drug use (both MAT clients and non-MAT clients)	• 15 in-person focus groups (9 for MAT clients, 6 for non-MAT clients)

Primary setting type	# of interviews	% of interviews
Outpatient	30	32%
Syringe services program	22	23%
Residential	18	19%
Hospital-based	11	12%
Native	9	9%
Emergency medical services	5	5%

Geography	# of interviews	% of interviews
Rural	36	38%
Urban	31	33%
Neither	28	29%

Medication	# of interviews	% of interviews
Both methadone and buprenorphine	37	39%
Buprenorphine only	36	38%
Navigation to MAT only	22	23%

Qualitative analysis. Cleaned interview transcripts were uploaded into the Dedoose qualitative analysis platform, along with descriptors such as stakeholder type, MAT program type, and setting (urban, rural, or neither). Two Facente Consulting staff members who had conducted interviews developed two initial codebooks—one for statewide experts and providers, and another for participants with a history of drug use. The staff members deductively developed high-level codes within key interview topic areas (major shifts in the MAT landscape, MAT barriers, promising organizational practices, and opportunities for funding and policy change). Within each high-level code, sub-codes were developed inductively, with all coding taking place within the Dedoose platform. The two staff members, plus a third staff member who did not conduct interviews or focus groups, refined the codebook after coding a subset of interviews to ensure its adequacy, resolving discrepancies by consensus, before recoding the original interviews as needed and then coding the remaining transcripts. The third staff member reviewed all coded data, identified key themes emerging from the codes (thematic analysis), and triangulated qualitative themes with other data sources (survey data, literature review, secondary analysis) to shape the findings in this report.

Limitations of interview and focus groups methods. Though interviews did not span every California county or every MAT program, they reached a large number of stakeholders, and interview themes were perceived to reach saturation, suggesting that the sample was adequate. One potential limitation among client representation was the low number of Black clients in focus groups (3/77) relative to their population size and fatal overdose rates. In addition, while efforts were made to conduct interviews and focus groups in jail settings, this ultimately was not possible.

Demographics of focus group participants (MAT and non-MAT clients). Additional demographic data was collected from clients in focus groups to understand representation. Exhibit A-4 summarizes the characteristics of 77 clients participating in focus groups, which made up approximately 75% of the clients participating in this assessment.[17]

Exhibit A-4: Focus group participant demographics (n=77)

Currently using MAT	#	%
No	36	42.86%
Yes	48	57.14%

Race/ethnicity[6]	#
White	38
Hispanic/Latine[7]	28
Black	3
Native	3
Mixed Race	3
Asian	2
Indian	1

Currently unhoused?	#	%
No	27	35.06%
Yes	50	64.94%

Gender[5]	#	%
Female	28	36.36%
Male	49	63.64%

Age group	#	%
20-24	4	5.19%
25-29	9	11.69%
30-34	13	16.88%
35-39	11	14.29%
40-44	12	15.58%
45-49	10	12.99%
50-54	6	7.79%
55-59	2	2.6%
60-64	4	5.19%
65-69	4	5.19%
70-74	2	2.6%

4. Survey Methods

Survey instrument development. Facente Consulting collaborated with The Center at Sierra Health Foundation to develop an online survey (Qualtrics platform) to explore the perspectives of MAT providers across California on MAT barriers, opportunities, and program strengths. The survey included questions about the MAT program's service types (medication types provided, setting, complementary services), operations (staffing, funding, scheduling, capacity), patients (demographics, use of MAT), community partnerships, strengths, barriers, and expansion-related desires. Questions were closed-ended, with the opportunity for respondents to add "other" responses that did not align with the closed-ended options, as well as specific numbers for certain program metrics (e.g., number of patients enrolled in MAT per year).

Survey recruitment and response. Facente Consulting collaborated with The Center at Sierra Health Foundation to identify key distribution channels for the statewide survey. These included sending the survey link to MAT, overdose prevention, and harm reduction listservs, sending the link directly to The Center at Sierra Health Foundation funded partners, and advertising on social media. To boost the response rate, five $100 Visa gift cards were raffled among survey respondents. The survey was open between March 4 and June 6, 2025, with repeated communications and reminders sent through distribution channels during this period.

Survey analysis. Survey data were cleaned to remove incomplete responses and duplicate responses for a given organization. Ultimately, 101 responses were recorded, with a total of 43 complete, unique responses representing 43 MAT programs across California. Survey data were analyzed descriptively in Excel through pivot tables and charts using frequencies, percents, ranges, and averages. Data were triangulated with data from other sources (interviews, focus groups, literature review, secondary analysis), and select relevant data were integrated into the report to illustrate key findings.

Limitations of survey methods. Due to a small sample size, those who did respond to the survey are not representative of MAT providers throughout California, and the findings cannot be generalized. In addition, the sample size of 43 was lower than expected (target: 100), despite extensive efforts to distribute the survey. Reasons for the low response rate might have included insufficient incentivization rate (three raffled gift cards) to compensate providers' time, that the survey was too lengthy, that there were simply too many demands on respondents' time, or other factors.

5. Survey Respondent Demographics

Survey representation. Exhibits A-5 and A-6 (beginning on the next page) detail the programs and providers who provided complete survey responses. Data from the survey are included in Appendix 3.

Exhibit A-5: Survey respondent demographics (n=43)

Race/ethnicity	#	%
White	19	44.2%
Latine/o/a	11	25.6%
Black or African American	9	20.9%
Asian	5	11.6%
American Indian or Alaska Native	4	9.3%
Something else *(Hollander, Black/Afro Arab, and Middle Eastern)*	3	7%
Native Hawaiian or Pacific Islander	0	0%

Gender Identity	#	%
Cisgender female	19	44.2%
Cisgender male	14	32.6%
Nonbinary	4	9.3%
Prefer not to answer	4	9.3%
Transgender man	1	2.3%
Transgender woman	1	2.3%

Age	#	%
18-24	2	4.7%
25-34	5	11.6%
35-44	15	34.9%
45-54	4	9.3%
55-64	8	18.6%
65+	9	20.9%

Program Role	#	%
Administrative/management	28	65.1%
Administrative/front desk	4	9.3%
Counselor	9	20.9%
Non-prescribing clinician	6	14%
Prescribing clinician	4	9.3%

Exhibit A-6: Surveyed MAT program basic characteristics (n=43)

Program Type	#	%
Outpatient opiate treatment program (OTP/NTP)	21	48.8%
Residential drug treatment	15	34.9%
Syringe services program	12	27.9%
Street medicine	7	16.3%
Hospital	6	14%
Primary care	5	11.6%
Jail	0	0%

Years of Operation	#	%
Less than one year	7	16.3%
1-2 years	7	16.3%
3-5 years	14	32.6%
5 years+	15	34.9%

# of patients receiving treatment annually	Buprenorphine	Naltrexone	Methadone
Average	800	657	1186
Median	60	59	20
Minimum	1	1	1
Maximum	20K	10K	30K

Medications Administered	#	%
Bupe	40	93%
Naltrexone	34	79.1%
Methadone	14	32.6%

Appendix 2: Secondary Analysis Methods

This appendix summarizes the approach to analyzing the 2022 round of SAMHSA's Treatment Episode Data Set, including discharge data (TEDS-D), which was one of the secondary analysis methods in this report and the only one that used inferential, rather than descriptive, statistics.

About the TEDS dataset

The TEDS-D dataset is publicly available on the TEDS website (https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set/datafiles). It includes:

- Data for individuals who are 12 years old or older
- Records for an admission or discharge ("treatment episode"), not for individual people
- Demographic information, such as age, sex, race/ethnicity, and employment status
- Substance use characteristics, such as substances used, age at first use, route of use, frequency of use, and number of previous admissions

TEDS data in California includes records from facilities that receive public funding, which includes both public and private facilities.

Primary research questions for this dataset

1. When we look at people who enter treatment with an OUD, what predicts them being put on MAT?
2. When we look at people who enter treatment with an OUD, is MAT associated with them completing the treatment successfully, and what other co-variates influence likelihood of success?

Data cleaning steps[18]

- We downloaded the relevant dataset(s) from the TEDS website and imported them into R version 4.3.1 to run these analyses. Code is available upon request.
- We created a subset of data for only treatment episodes in California (STFIPS=6).
    - Then we kept only those that had "Heroin," "Non-prescription methadone," or "Other opiates and synthetics" listed as (1) their primary substance use at admission, (2) their secondary substance at admission, (3) their primary substance at discharge, or (4) their secondary substance at discharge. This left 39,149 records.
- We created an indicator variable (PRIMARY) for episodes that included opioids (same three categories as above) as the primary substance at admission (yes) vs. not (no).
- We recategorized AGE into ~10-year bins (12-20y, 21-29y, 30-39y, 40-49y, 50-64y, 65+y).

[18] Code is available upon request from Facente Consulting

- We recategorized RACE and ETHNIC into a simplified variable (RACE2) with the following levels: American Indian/Alaska Native, Asian/Pacific Islander, Black, White, Latine, Multiracial, Other.
- We recategorized EMPLOY so that episodes for people "unemployed" and "not in labor force" were both considered unemployed.
- We recategorized EDUC so that episodes for people with less than grade 8 of schooling and people who had highest education level of grades 9 to 11 at admission were all considered to have "less than GED/HS diploma."
- We recategorized SERVICES so that the 8 categories were collapsed into "Detox," "Residential," and "Outpatient" (Ambulatory).

Predicting MAT as part of client treatment plans

To answer research question 1, we first ran chi-square tests comparing those episodes where MAT was part of the treatment plan to those where it was not by age, sex, race/ethnicity, highest education obtained at time of admission, employment status at admission, and whether the person was a U.S. veteran. We then restricted that same analysis to only the people who reported opioids as their primary substance used at time of admission (n = 34,796, with 4,353 excluded compared to the main analysis) and found very similar results. In both cases, the p-values were highly statistically significant ($p<0.001$) for all categories for the Pearson's Chi-squared tests for independence.

We also found that almost no episodes in detox or residential programs had MAT listed as part of the treatment plan, so we then ran a complete case logistic regression with **MAT being part of their treatment plan as the outcome**, only for episodes in outpatient settings where MAT prescription was more likely (n=28,622). Independent variables were housing status at admission, sex, age (further collapsed into <21y, 21-39y, 40-64y, 65+y), race/ethnicity, and whether or not opioids were their primary substance at admission (Exhibit A-7, next page).

Exploring predictors of "treatment success"

To answer research question 2, we ran a complete case logistic regression with **treatment success as the outcome**. We recoded treatment success from the TEDS-D "REASON" variable, which indicates the reason for discharge. With the recoding, an episode was considered to have **succeeded** in treatment if treatment was completed or the person was transferred to another treatment program or facility. If the person dropped out of treatment or was terminated by the facility, they were considered to have **discontinued** treatment. If they were incarcerated, died, or were coded as "other" we considered them as having **undetermined** treatment success status. The main exposure variable was whether MAT prescription was part of their treatment plan. We also controlled for sex, age (same categories as the first regression above), race/ethnicity, housing status at admission, employment status, whether or not they were a U.S. veteran, highest education obtained at time of admission, whether or not opioids were their primary substance at admission, and type of service setting (detox, residential, or outpatient)(Exhibit A-8, page after next).

Exhibit A-7: Variables predicting whether an episode for SUD treatment for opioids as a primary substance in California outpatient settings in 2022 corresponds to MAT in the treatment plan

Characteristic	OR[19]	95% CI	p-value[20]
Housing status at admission			
Experiencing homelessness	*ref*		
Housed	1.53	1.42, 1.65	<0.001***
Arrested in 30 days prior to admission			
No	*ref*		
Yes	0.90	0.78, 1.04	0.2
Sex			
Male	*ref*		
Female	1.00	0.94, 1.06	0.9
Age			
12-20	0.38	0.33, 0.45	<0.001***
21-39	*ref*		
40-64	2.00	1.87, 2.13	<0.001***
65+	4.55	3.61, 5.82	<0.001***
Race/ethnicity			
White	*ref*		
AI/AN	1.19	0.91, 1.57	0.2
API	0.86	0.68, 1.09	0.2
Black	1.31	1.16, 1.47	<0.001***
Latine	0.79	0.74, 0.84	<0.001***
Multi	0.93	0.78, 1.11	0.4
Other	0.99	0.83, 1.20	>0.9
Opioid use primary at admission			
No	*ref*		
Yes	7.82	7.10, 8.62	<0.001***

[19] Abbreviations: CI = Confidence Interval, OR = Odds Ratio

[20] *p<0.05; *p<0.01; ***p<0.001

Exhibit A-8: Association between MAT prescription and treatment success in episodes of substance use treatment for opioids (primary or secondary substance) in California, 2022

Characteristic	OR[21]	95% CI	p-value[22]
Prescribed MAT			
Not on MAT	*ref*		
On MAT	0.83	0.78, 0.88	<0.001***
Sex			
Male	*ref*		
Female	0.90	0.86, 0.94	<0.001***
Age			
12-20	0.80	0.70, 0.92	0.001**
21-39	*ref*		
40-64	1.10	1.05, 1.15	<0.001***
65+	1.11	0.98, 1.26	0.11
Race/ethnicity			
White	*ref*		
AI/AN	0.90	0.74, 1.09	0.3
API	1.10	0.92, 1.33	0.3
Black	1.19	1.09, 1.29	<0.001***
Latine	0.89	0.84, 0.93	<0.001***
Multi	1.09	0.95, 1.26	0.2
Other	1.05	0.91, 1.21	0.5
Housing status at admission			
Experiencing homelessness	*ref*		
Housed	1.07	1.01, 1.13	0.016*
Employment status at admission			
Unemployed	*ref*		
Employed full-time	1.01	0.95, 1.08	0.7
Employed part-time	0.93	0.85, 1.01	0.10
U.S. veteran			
No	*ref*		
Yes	1.00	0.86, 1.17	>0.9
Highest education level			
GED/HS diploma	*ref*		
Less than GED	0.98	0.93, 1.03	0.4
Partial college	1.14	1.07, 1.20	<0.001***
Bachelor's degree or higher	1.15	1.03, 1.28	0.015*
Opioid use primary at admission			
No	*ref*		
Yes	0.79	0.73, 0.86	<0.001***
Type of service setting			
Outpatient	*ref*		
Detox	4.96	4.51, 5.47	<0.001***
Residential	3.97	3.66, 4.30	<0.001***

[21] Abbreviations: CI = Confidence Interval, OR = Odds Ratio

[22] *p<0.05; **p<0.01; ***p<0.001

Limitations. Key limitations of this analysis include:

- The TEDS dataset includes only treatment episodes for people discharged from facilities receiving public funding, which include some, but not all substance use facilities that provide MAT in California (which excludes substance use treatment facilities that are only privately funded).
- The TEDS dataset is cross-sectional, representing a point in time for a patient as they are discharged from a given treatment episode, regardless of when they were admitted.
- The TEDS dataset counts treatment episodes, not individuals; some people may have been discharged from treatment, then admitted and discharged again within 2022, and they would be counted as two people in this analysis, potentially biasing results in an unknown way.
- California and other states may collect TEDS data differently, posing limitations on comparisons between California and the U.S. overall.
- With respect to MAT as part of a treatment plan, the TEDS dataset does not differentiate between methadone, buprenorphine, and naltrexone. As noted in the body of this report, patients may have varying access to different medication types depending on racial, income, and geographic disparities. Without differentiating by medication type in the analysis, differences in MAT as part of one's treatment plan may be confounded by race/ethnicity, income, or geography.
- Treatment completion and transfer may not fully define treatment success, for several reasons:
    - MAT, relative to other treatments for opioid use disorder, differs in nature. For example, it is designed to be longer-term, making cross-sectional snapshots of discharge data and comparison to non-MAT services limiting. For example, it is possible that our analysis is counting more people who dropped out of treatment than those who were still in MAT treatment in 2022 (and beyond), biasing results to appear that MAT inhibits treatment success more than is true in reality.
    - In this analysis, treatment "success" was counted as treatment completion *or transfer* to another setting, which could have occurred for any reason. Further, treatment completion and transfer (implying retention) do not necessarily reflect the extent to which MAT impacted someone's opioid use disorder or quality of life, or additional success measures that patients may define.
    - There may be several confounding factors that are not controlled for in the analysis, such as the severity of opioid use disorder, geography, income, and other variables.

Appendix 3: Summary of Additional Survey Data

This appendix shares survey data not fully described in the body of the report, representing 43 unique MAT providers and programs in California who responded to an online survey between March 4 and June 6, 2025. Much of this data has been integrated into the body of the report along with key findings, while some tables provide additional data. Details of survey respondents are included in Appendix 1 (Exhibits A-5, A-6). For many tables, counts total more than 43 (100%) due to the ability to choose more than one option.

Exhibit A-9: Client demographics among participating MAT organizations (n=43 organizations)

Age	Average % of clients with this age group across all organizations
18-24 years	10%
25-34 years	27%
35-44 years	27%
45-54 years	18%
55-64 years	11%
65+ years	3%

Gender identity	Average % of clients with this gender across all organizations
Cisgender male	53%
Cisgender female	34%
Transgender female	5%
Nonbinary	4%
Transgender male	3%

Race/ethnicity	Average % of clients with this race/ethnicity across all organizations
White	40%
Latine/o/a	30%
Black or African American	12%
Multiracial	8%
American Indian or Alaska Native	8%
Asian	3%
Native Hawaiian or Pacific Islander	2%

% of clients speaking primary language other than English*	# of organizations	%
Less than 5%	14	33%
5-10%	10	23%
10-25%	7	16%
25-50%	8	19%
50%+	4	9%

% of clients unhoused	# of organizations	%
Less than 25%	12	28%
25-50%	13	30 %
50-75%	10	23%
75%+	8	19%

Top 3 patient substances	# of organizations	%
Methamphetamine	41	95%
Alcohol	40	93%
Cocaine/crack	21	49%
Benzodiazepines	20	47%
Ketamine	3	7%
Hallucinogens	2	5%

Exhibit A-10: Funding (n=43 organizations)

Annual MAT budget	#	%
Under $250,000	14	33%
$500,001 – $1,000,000	6	14%
$1,000,001 – $2,000,000	5	12%
$250,000 – $500,000	13	30%
$3,000,001 – $4,000,000	3	7%
$4,000,001 or more	2	5%
$500,001 – $1,000,000	6	14%

Funding sources for MAT	#	%
Public grants	31	72%
Medi-Cal	29	67%
Private insurance	18	42%
Private grants	16	37%
Patients paying out of pocket	14	33%

Funding sources for organization	#	%
Public grants	34	79%
Private grants	28	65%
Medi-Cal	20	47%
Private insurance	20	47%
Patients paying out of pocket	1	2%

Services funded besides MAT	#	%
Naloxone access	38	88%
Health education	36	84%
Case management	35	81%
Individual counseling	33	77%
HIV testing	31	72%
Group counseling	28	65%
HCV testing	27	63%
STI testing	24	56%
Harm reduction supplies	20	47%
Wound care	15	35%
HCV treatment	15	35%
HIV treatment	14	33%
STI treatment	13	30%
Primary care	12	28%
Other *(Emergency medical services, fentanyl testing supplies, behavioral health treatment)*	2	5%

Exhibit A-11: Staffing and capacity (n=43 organizations)

Staffing	#	%
Medical director PT	6	14%
Medical director FT	19	44%
Prescribing clinical staff PT	18	42%
Prescribing clinical staff FT	20	47%
Clinical staff (nurses) PT	9	21%
Clinical staff (nurses) FT	21	49%
Admin staff PT	12	28%
Admin staff FT	30	70%
Counselors PT	13	30%
Counselors FT	27	63%
Peer support PT	11	26%
Peer support FT	24	56%

Staff training topics	#	%
MAT 101	28	65%
Harm reduction 101	32	74%
Overdose prevention/response	35	81%
Motivational interviewing	33	77%
Other forms of therapeutic interventions	20	47%
Recovery modalities	17	40%
Internal systems training	22	51%
Regulation/compliance	23	53%
Trauma/mental health	27	63%
Polysubstance use	18	42%
Navigation/Case management	26	60%
Wound care	10	23%
Understanding stigma/stigma reduction	26	60%

Staff training format	#	%
In-house by our agency staff	39	91%
Community partner provides the trainings for compensation	21	49%
Community partner provides the trainings in-kind	20	47%
Health department provides the trainings	15	35%

Have a wait list	#	%
No	38	88%
Yes *(3 estimated the wait at 3-5 days, and 1 estimated the wait at more than 2 weeks)*	4	9%
Unsure	1	2%

Initiation of MAT occurs through	#	%
Referral from other providers	25	58%
Drop in during clinic hours	22	51%
By appointment only (self-referral included)	14	33%
Other *(emergency department, after screening during residential)*	14	33%
Drop in before or after clinic hours	7	16%

Exhibit A-12: Resource strengths and gaps (n=43 organizations)

Our program has adequate funding to provide the needed level of MAT services and support our patients.	#	%
Strongly Disagree	5	12%
Disagree	10	23%
Neutral	7	16%
Agree	20	47%
Strongly Agree	1	2%

Our MAT program has the tools and resources needed to address polysubstance use among our patients.	#	%
Strongly Disagree	1	2%
Disagree	7	16%
Neutral	12	28%
Agree	21	49%
Strongly Agree	2	5%

Unhoused patients are generally able to successfully maintain their treatment in our MAT program.	#	%
Strongly Disagree	2	5%
Disagree	7	16%
Neutral	22	51%
Agree	11	26%
Strongly Agree	1	2%

Community partnerships adequately support patients' access to a variety of psychosocial needs.	#	%
Strongly Disagree	5	12%
Disagree	7	16%
Neutral	7	16%
Agree	23	53%
Strongly Agree	1	2%

Our local county provides sustainable funding to support our MAT program operations.	#	%
Strongly Disagree	7	16%
Disagree	14	33%
Neutral	14	33%
Agree	8	18%
Strongly Agree	0	0%

Top program strengths	#	%
Skilled and committed staff	34	79%
Low-barrier services	25	58%
High reported levels of patient satisfaction	21	49%
Improved treatment retention	16	37%
Strong community partnerships	16	37%
Integrated prevention and/or clinical services	12	28%
Financial health	4	9%

Race/ethnicity	# of organizations saying they could serve this group better	% of organizations saying they could serve this group better
American Indian or Alaska Native	16	37%
Black or African American	16	37%
Latine/o/a	12	28%
Asian	12	28%
N/A (serving those who need it)	11	26%
White	9	21%
Native Hawaiian or Pacific Islander	7	16%

Exhibit A-13: Community engagement (n=43 organizations)

Our program has engaged in tours of our space.	#	%
Have done it but it wasn't effective	4	9%
Have done this and found it to be effective	12	28%
Have done this and it was somewhat effective	17	40%
Haven't done this	10	23%

Our program has engaged in community clean ups of garbage and/or inappropriately discarded syringes.	#	%
Have done it but it wasn't effective	10	3
Have done this and found it to be effective	8	8
Have done this and it was somewhat effective	12	9
Haven't done this	10	23

Our MAT program has experienced opposition from local community members/neighbors.	#	%
Strongly Disagree	10	23%
Disagree	8	19%
Neutral	12	28%
Agree	10	23%
Strongly Agree	3	7%

Our program has engaged in information sessions/presentations at community events.	#	%
Have done it but it wasn't effective	2	5%
Have done this and found it to be effective	16	37%
Have done this and it was somewhat effective	20	47%
Haven't done this	5	12%

Our program has engaged in having satellite MAT induction/prescriber hours at other community organizations (e.g., syringe service sites, shelters, etc.).	#	%
Have done it but it wasn't effective	3	7%
Have done this and found it to be effective	5	12%
Have done this and it was somewhat effective	7	16%
Haven't done this	28	65%

Other examples of proactive engagement shared by survey respondents:

- Community roundtable collaboration
- Have other providers and organizations shadow us on outreach
- Committees, conferences, table events, outreach
- Outreach, expos, fairs
- We attend community events and outreach where we distribute Narcan
- Organizing forums in which our MAT staff can highlight the importance of MAT in the continuum of care
- Partnering with nonprofits
- Actively engaging community-based organizations that serve our patient populations in overdose prevention and stigma reduction trainings
- Education programs in schools
- Engage ambulance companies and other partners to help distribute naloxone
- Engage medical residency program to provide residents to participate in program
- Reach out to partner for outreach activities and formalize relationships that support referral process

Exhibit A-14: Partnerships (n=43 organizations)

Collaboration partners	#	%
Behavioral/mental health providers	33	77%
FQHCs/medical clinics	28	65%
Harm reduction orgs	27	63%
Shelters/homeless service orgs	27	63%
Health department	22	51%
Other (*Examples include emergency medical services, law enforcement, emergency rooms, and county detox centers.)*	4	9%

Collaboration format	#	%
Bi-directional referrals	33	77%
Outreach	33	77%
Community meetings	25	58%
Presentations	24	56%
Grant partnership	17	40%
Data sharing	7	16%
Co-location	3	7%

Exhibit A-15: Expansion desires and barriers (n=43 organizations)[xxiii]

Expansion barriers	#	%
Lack of funding	25	58%
Inadequate physical space	15	35%
Inadequate provider capacity	12	28%
Inadequate counselor staffing	8	19%
Regulatory caps	2	5%
NIMBYism or other political challenges	5	12%
Other *(staffing with skill set necessary/qualified staff/unable to find qualified staff, challenges in identifying resources for the unhoused)*	8	19%

Expansion desires	#	%
Admit additional patients	22	51%
Scale up nonclinical staffing	22	51%
Scale up clinical staffing	21	49%
Add additional counseling services	14	33%
Open a second location	12	28%
Add outreach services	12	28%
Offer additional MAT options	8	19%
Add mobile services	8	19%
Add a drop-in center	8	19%
Integrate infectious disease testing and treatment	6	14%
Add telehealth services	4	9%
We are not interested in expanding	3	7%
Other *(consistently addressing social determinants of health, expanding Incidental Medical Services designation to more facilities, support for employment and housing, respite services, need to recruit more patients, staging area or detox for residential treatment)*	24	56%

[xxiii] NIMBY ("not in my backyard") is a casual term used to describe community sentiment of not wanting something to operate in one's neighborhood—in this case, not wanting MAT programs to operate locally

Appendix 4: Data Tables for Map Figures

This appendix shares county-level data tables for figures in the report that include maps, including:

- Exhibit 2 (map of fatal overdose counts and rates) → See Exhibit A-16
- Exhibit 8 (map of locations of MAT providers) → See Exhibit A-17
- Exhibit 9 (MAT provider density and fatal overdose rates) → See Exhibits A-17 and A-16
- Exhibit 10 (buprenorphine prescription rates) → See Exhibit A-18

Exhibit A-16: Fatal overdose rates and counts by county, 2023. *Data source: California Overdose Surveillance Dashboard*

County	Fatal Overdose Rate per 100K	95% LCL	95% UCL	Fatal Overdose Count
Alameda	21.825	19.298	24.637	309
Alpine	151.16	164.74	1690.28	1
Amador	18.85	9.96	55.15	5
Butte	42.695	33.492	53.858	82
Calaveras	28.168	15.442	52.91	13
California	20.812	20.34	21.29	7847
Colusa	23.332	11.48	73.203	4
Contra Costa	16.572	14.172	19.288	178
Del Norte	42.73	22.992	79.98	11
El Dorado	19.567	13.085	28.473	32
Fresno	13.815	11.495	16.5	127
Glenn	35.968	26.54	85.357	11
Humboldt	50.272	38.808	64.488	67
Imperial	10.37	5.682	17.902	15
Inyo	16.258	11.105	78.715	3
Kern	36.987	32.983	41.377	321
Kings	10.307	5.867	17.355	14
Lake	43.8	28.708	65.12	28
Lassen	39.68	20.062	74.78	12
Los Angeles	17.098	16.252	17.977	1603
Madera	8.685	4.445	15.59	12
Marin	16.078	10.982	23.06	40
Mariposa	16.7	27.89	138.65	2
Mendocino	41.245	28.4	58.388	36
Merced	15.672	11.31	21.332	44
Modoc	0	0	0	0
Mono	0	0	0	0
Monterey	11.955	8.835	15.922	49
Napa	11.812	6.565	20.265	15
Nevada	37.667	25.102	55.062	33
Orange	19.21	17.632	20.895	576
Placer	14.56	10.9	19.145	54
Plumas	10.467	3.803	62.297	3
Riverside	24.188	22.21	26.308	580
Sacramento	22.058	19.725	24.613	331
San Benito	19.348	10.175	34.362	13
San Bernardino	19.755	17.87	21.802	420
San Diego	19.97	18.445	21.595	654
San Francisco	54.798	49.965	60.065	509
San Joaquin	23.843	20.51	27.6	191
San Luis Obispo	30.02	23.54	37.932	78
San Mateo	12.472	9.867	15.627	85
Santa Barbara	16.265	12.422	20.992	64
Santa Clara	10.982	9.488	12.668	203
Santa Cruz	45.87	37.303	56.042	112
Shasta	40.148	30.812	51.7	67
Sierra	84.218	109.95	798.86	2
Siskiyou	40.123	22.328	69.3	14
Solano	15.99	12.402	20.368	68
Sonoma	21.26	17.127	26.19	99
Stanislaus	28.04	23.618	33.11	147
Sutter	19.055	11.01	31.317	17
Tehama	45.14	29.52	67.13	27
Trinity	0	0	0	0
Tulare	14.692	11.21	18.983	62
Tuolumne	37.215	21.718	61.835	15
Ventura	27.88	24.17	32.045	215
Yolo	12.905	7.877	20.402	24
Yuba	12.905	7.877	20.402	24

Exhibit A-17: MAT provider locations, 2025. *Data sources: SAMHSA Treatment Locator, data downloaded Feb. 2025; California Department of Finance Population Estimates, 2025.*

County	Buprenorphine Providers	Methadone Providers	Provider Rate per 100K People
Alameda	227	9	14.2
Alpine	0	0	0
Amador	7	0	17.69
Butte	41	1	20.24
Calaveras	2	0	4.47
Colusa	1	0	4.54
Contra Costa	171	6	15.28
Del Norte	5	0	18.84
El Dorado	30	0	15.73
Fresno	74	8	7.91
Glenn	1	0	3.4
Humboldt	55	1	41.85
Imperial	37	2	20.91
Inyo	18	0	95.74
Kern	80	6	9.31
Kings	18	0	11.69
Lake	13	0	19.33
Lassen	7	0	24.38
Los Angeles	1064	53	11.31
Madera	5	0	3.08
Marin	48	1	19.25
Mariposa	2	0	11.82
Mendocino	34	1	38.96
Merced	25	1	8.87
Modoc	1	0	11.78
Mono	6	0	47.3
Monterey	51	2	12.08
Napa	12	0	8.82
Nevada	25	0	24.91
Orange	354	4	11.27
Placer	47	1	11.39
Plumas	5	0	26.48
Riverside	201	9	8.41
Sacramento	192	6	12.34
San Benito	3	0	4.49
San Bernardino	155	4	7.2
San Diego	388	11	11.98
San Francisco	478	10	57.96
San Joaquin	61	5	8.19
San Luis Obispo	35	1	12.89
San Mateo	83	0	11.09
Santa Barbara	59	3	13.87
Santa Clara	189	4	10.04
Santa Cruz	79	2	30.72
Shasta	62	1	34.96
Sierra	2	0	63.09
Siskiyou	20	0	46.18
Solano	47	2	10.89
Sonoma	112	2	23.61
Stanislaus	41	3	7.92
Sutter	16	0	15.96
Tehama	5	2	10.8
Trinity	1	0	6.3
Tulare	38	3	8.42
Tuolumne	15	0	27.6
Ventura	79	5	10.13
Yolo	26	1	11.98
Yuba	19	2	24.7

Exhibit A-18: Buprenorphine prescription rates per 1K people. *Data source: California Overdose Surveillance Dashboard*

County	Prescription Rate per 1K	95% LCL	95% UCL	Prescription Count
Alameda	17.994	17.767	18.224	28421
Alpine	9.297	6.355	19.912	9
Amador	66.464	63.698	69.339	2674
Butte	110.205	108.621	111.808	20467
Calaveras	72.555	69.654	75.56	3112
California	21.737	21.689	21.785	834768
Colusa	32.013	29.429	34.783	621
Contra Costa	27.057	26.744	27.372	31149
Del Norte	121.316	116.871	125.908	3011
El Dorado	71.473	70.099	72.869	12249
Fresno	14.203	13.958	14.451	13380
Glenn	54.833	51.792	58.022	1387
Humboldt	146.047	143.91	148.21	18939
Imperial	16.266	15.579	16.98	2345
Inyo	75.405	70.951	80.078	1153
Kern	16.238	15.96	16.52	13528
Kings	26.783	25.924	27.664	3773
Lake	116.954	114.133	119.834	7642
Lassen	40.978	38.659	43.425	1258
Los Angeles	11.822	11.751	11.893	113988
Madera	18.794	18.083	19.528	2790
Marin	35.387	34.556	36.235	9152
Mariposa	42.288	38.701	46.15	621
Mendocino	110.463	108.139	112.827	9534
Merced	15.492	15.008	15.989	4024
Modoc	82.333	74.941	90.553	531
Mono	22.673	19.984	25.678	279
Monterey	37.32	36.725	37.922	15888
Napa	36.582	35.501	37.69	4869
Nevada	82.611	80.529	84.738	7284
Orange	18.963	18.803	19.124	57023
Placer	40.972	40.33	41.623	17058
Plumas	74.645	70.101	79.46	1350
Riverside	19.149	18.969	19.33	45778
Sacramento	32.257	31.969	32.548	50287
San Benito	30.51	29.157	31.915	2041
San Bernardino	14.315	14.149	14.483	29772
San Diego	18.05	17.902	18.199	59968
San Francisco	26.867	26.515	27.222	24236
San Joaquin	14.519	14.244	14.799	11140
San Luis Obispo	32.38	31.668	33.106	8691
San Mateo	18.453	18.13	18.781	14433
Santa Barbara	25.208	24.711	25.713	10489
Santa Clara	12.612	12.449	12.777	24662
Santa Cruz	55.176	54.203	56.165	14215
Shasta	110.695	109.02	112.391	18377
Sierra	64.853	53.818	77.746	166
Siskiyou	55.49	52.945	58.135	2100
Solano	30.309	29.782	30.843	13490
Sonoma	53.935	53.245	54.633	26312
Stanislaus	28.569	28.094	29.051	14451
Sutter	68.411	66.665	70.195	6235
Tehama	57.124	55.125	59.181	3428
Trinity	74.346	69.375	79.624	968
Tulare	18.113	17.704	18.53	7743
Tuolumne	98.904	96.027	101.855	5345
Ventura	24.91	24.553	25.272	20336
Yolo	32.417	31.535	33.321	5814
Yuba	60.41	58.682	62.178	4782

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