Literature Review on Research on the Effectiveness of Medication-Assisted Treatment (MAT) / Medications for Opioid Use Disorder (MOUD)

Purpose

In May 2025, the AKA evaluation team determined additional information was needed to understand the effectiveness of MAT/MOUD in Tribal communities. Dr. Emily Beamon, an AKA Associate, conducted a literature review of MAT-related interventions for OUD. We were specifically focused on MAT/MOUD interventions with American Indian and Alaska Native (AI/AN) populations and interventions that targeted underrepresented groups and rural locations in the United States. This review aims to document the literature and support our evaluation of a MAT program at one rural Tribal treatment center. Information contained in this review may be used by other evaluators and Tribal programs interested in the effectiveness of MAT and MOUD in rural and AI/AN populations.

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Methods

We conducted the literature search using multiple search engines: PubMed, APA PsycINFO (EBSCO), and CINAHL Complete (EBSCO). Search terms were limited to 2000 to 2025. They

included combinations of: Medication-Assisted Treatment (MAT), Medications for Opioid Use Disorder (MOUD), AIAN Populations, physical/mental health outcomes, and culturally-based adaptations for MAT. We reviewed, sorted, and cross-referenced all research articles across search engines; we categorized and summarized them, and identified recommendations for our work with AI/AN communities and one rural location in Montana. In some cases, we use the authors' language to describe the recommendation or theme; in other cases, we explicate this information and apply it to our program evaluation context to better understand MAT-related treatment outcomes in a rural Tribal treatment center.

Results

General MOUD

Zeledon 2020- From 2006 to 2012, nearly 80% of AI/AN drug overdose deaths across Northwestern states (Washington, Idaho, and Oregon) were from prescription opioids (e.g., hydrocodone, oxycodone, oxycodone extended-release). Programs that capitalize on community and cultural strengths may be more successful in sustaining recovery and preventing relapse. [1]

Andraka-Christou 2021- Buprenorphine and methadone are the most effective treatments for OUD but have disproportionately low treatment initiation and retention levels among people of color.[2]

Dickerson 2021- DARTNA (Drum-Assisted Recovery Therapy for Native Americans) is an effective intervention for AI/ANs and provided benefits in cognition; however, participants consumed more drinks and cigarettes than the control group (who were not involved in DARTNA). Additional research is needed to explore the effects of drumming on addiction/brain regions and neural pathways that support healing. [3]

Gao 2022- Disparities in MOUD exist. Nonwhite/Hispanic women had a lower percentage of MOUD receipt during pregnancy and postpartum relative to non-Hispanic White women.[4]

Boyd (2021)- The OUD Cascade of Care offers unique ways to quantify community efforts to address the opioid epidemic. It can help identify intervention and policy priorities needed to address systemic failures. Existing state-level data can provide information about Cascade of Care stages for American Indian communities, particularly about treatment admission, initiation of medications for OUD, and treatment retention [5]

Chang 2023- Significant differences in healthcare utilization exist between type of disorder, race, and region. Tailored treatment regimens are required to bridge the gaps in care and combat the opioid crisis. Minorities (including AI/ANs) with opioid use disorder utilize healthcare the least,

possibly because of affordability, and need culturally sensitive and financially feasible treatment options.[6]

Richer 2022- Anticolonial strategies for addressing opioid use in Indigenous communities are necessary. The combination of culturally responsive treatment, Tribal sovereignty in the treatment of opioid use disorders, and effective resource allocation is necessary to affect positive change in Indigenous substance use trajectories.[7]

Scheidell 2024- Receipt of treatment is low among women with OUD, especially Black and Hispanic women. Intersectional intervention approaches are needed to increase access and reduce inequities.[8]

General research on MAT/MOUD suggests that the use of these therapeutic techniques is evidence-based, safe, and effective for the treatment of addiction and Opioid Use Disorder. Three main medications are primarily used: Methadone, Buprenorphine/Naloxone, and Naltrexone. Treatment outcomes are related to the patient's gender, being White, using a MAT/MOUD program, and not having co-occurring mental health/substance use conditions. Social support networks have been shown to improve program effectiveness, particularly close relationships with others (family, spouse).

Biondi 2020- Studies of MOUD are necessary in order to establish treatment efficacy and effectiveness; however, there is a lack of standardization regarding what outcomes are measured and how they are measured. MOUD (buprenorphine, methadone, XR-NTX) is evidence-based, safe, and highly effective for treating OUD across outcome measures, but no standardized approach exists to assess outcomes in MOUD studies, so researchers and clinicians cannot compare or generalize findings.[9]

Lillie 2021- Three medications are currently FDA-approved for OUD: methadone, buprenorphine/naloxone, and naltrexone. Results from clinical trials demonstrate that MAT produces superior abstinence and treatment retention outcomes compared to psychosocial treatments without medication or with placebo.6 For example, in the general population, buprenorphine/naloxone is highly efficacious for treating OUD, with 3 to 8 times the abstinence rates compared to placebo or detoxification treatment alone,7–9 and it is most effective when used long-term.[10]

Adenrian 2025- Younger age is a predictor of treatment dropout among patients who are dependent on opioids. Dropping out of MAT increased the risk of opioid use relapse

Males were more likely to complete treatment. Compared to Whites, other races were 25% less likely to report treatment completion. Compared to youth who did not receive MAT, those who received MAT were associated with a lower likelihood of treatment completion.
Compared to those without co-occurring mental health and SUD diagnoses, those with these diagnoses had an increased likelihood of treatment completion.[11]

Kumar 2021- Results suggested that MOUD outcomes were generally improved using social network support interventions. Despite the extensive work on the efficacy of administering psychosocial interventions alongside pharmacological treatment, and the numerous reviews, very little work examines psychosocial interventions that specifically involve significant others in patients' networks. While one study used network mapping methods to identify others to participate in therapy, the most prominent positive effects of interventions involving network members seemed **relationship-specific, such as couples therapy between partners** or parent skills training between parents and children.[12]

Lim 2021- All pharmacotherapeutic strategies were associated with a higher likelihood of treatment retention compared to the control arm, which consisted of placebo, standard of care, or no treatment. Based on SUCRA rankings, methadone appeared to be the most effective pharmacotherapy for treatment retention, followed by SROM, buprenorphine, and naltrexone. Buprenorphine outperformed naltrexone, and naltrexone outperformed non-pharmacotherapeutic interventions in treatment retention. SROM was compared only with methadone, and all other pairwise comparisons involving SROM were indirect; buprenorphine and methadone were associated with higher treatment retention than non-pharmacotherapeutic controls, and methadone was associated with higher treatment retention than buprenorphine.[13]

Research for MAT/MOUD Outcomes Among AIAN Populations

There is minimal literature on explicit outcomes of MAT/MOUD in AIAN populations. The research that does examine racial differences suggests that people of color receive OUD treatment at a fraction of the rate of non-Hispanic White people with the same disorder. Notably, AIAN populations have greater vulnerabilities to OUD- younger age of onset, less education, higher rates of unemployment, lack of stable housing, other concurrent substance use issues, and are more likely to be referred to treatment due to a court-mandated or community program (and not self-referred). Studies found [10]that **poorer treatment outcomes were associated with being younger and having co-occurring substance use**. Co-occurring substance use has been associated with the use of MOUD treatment, which comes with an increased risk of AIAN patients dropping out of treatment.

Some studies have found effects of AIAN reductions in opioid use potentially due to a concerted effort from IHS to increase resources to OUD treatment programs. The **likelihood of MOUD usage increases when patients can utilize IHS resources but often forgo treatment if their IHS does not have these OUD resources**. Work on MOUD in Canada and Australia has shown the value of culturally specific, integrated care and a focus on family and community wellness. [14]

Mauro 2022- Nearly one-third of non-Hispanic White people with OUD treatment need received MOUD, compared with approximately 20% of people identifying as non-Hispanic Black or other non-Hispanic or multiracial groups and 15% of Hispanic people. Compared with receiving non-MOUD services, receipt of MOUD was more likely among adults with at least some college (vs high school or less; RRR, 2.94;95%CI, 1.33-6.51) and less likely in small metropolitan areas (vs large metropolitan areas, RRR, 0.41;95%CI, 0.19-0.93). While contacts with the health care system (85.0%) and criminal legal system (60.5%) were common, most people encountering these systems did not report receiving MOUD (29.5% and 39.1%).[15]

Krawczyk 2021- Analyses of treatment episodes also highlighted differences between characteristics of AI/AN clients and other race groups seeking care for OUD. For one, over half of AI/AN admissions to OUD treatment were female, which is rarely found in substance use treatment-seeking samples. **This group also tended to have a stronger presence of multiple vulnerabilities, including younger age, less education, higher rates of unemployment, and lack of independent housing, which may exacerbate substance use harms and challenge MOUD access and treatment outcomes**. Similar to other race groups, AI/AN clients with concurrent use of methamphetamine, alcohol, or marijuana were less likely to receive MOUD, which is concerning given guidelines still recommend MOUD among persons with polysubstance use. These findings emphasize a critical need to develop and integrate interventions that address polysubstance use into MOUD programs as part of comprehensive responses to the opioid crisis.[16]

Another key difference between AI/AN clients and other racial groups was that they were less likely to be self-referred or referred by a personal contact and more likely to be referred by a criminal justice agency, school, employer, or other **community referral**. AI/AN admissions with these referral sources, especially criminal justice, were significantly less likely to include MOUD, and this association was even stronger among AI/ANs than in other groups. This may indicate preferential referral to programs that do not offer MOUD, as has been the case among criminal justice referrals in the general population of persons seeking OUD treatment.

Lillie 2021- Culturally-centered MAT services have been implemented with Indigenous people in Australia and Canada. In Australia, success of the MAT program was attributed to the culturally-specific design, integrated care, and a focus on family and community wellness. In Canada, **Indigenous patients reported positive treatment outcomes, improved housing, employment, and family support, as well as overall satisfaction and acceptance of MAT**. [10]

Pro 2020- Compared to those who did not receive MAT, **the odds of reducing opioid use among those who received MAT were more than six times higher among AI/AN women, and more than five times higher among AI/AN men**.[17]

Venner 2018- More published research on facilitators, barriers, and outcomes of MAT among Indigenous patients exists in Canada and Australia. In Australia, **researchers attributed success to culturally specific design, integrated care, and a focus on family and community wellness. In Canada, patients reported positive treatment outcomes, improved housing, employment, and family support, as well as overall satisfaction and acceptance of MAT**. Reported barriers were similar to other methadone-maintained populations (e.g., lack of take-home doses, community stigma).[14]

Venner 2020- Participants improved from baseline to the 12-month follow-up point, but there were no significant treatment group differences in percent days abstinent (PDA) from all substances except tobacco between the two arms (MICRA and TAU). **These findings indicate that SUD treatment may be effective in AI adult samples when EBTs are culturally tailored, and TAU is delivered in a reservation-based setting by staff who are cultural educators and community members**.

Application of Existing Research to Tribal Community MAT Program

Program data (Nov 2025) suggest multiple improvements from intake to 6-month follow-up appointments. AIAN clients reported increases in positive measures of abstinence from alcohol and illicit drugs, making more social connections, housing stability, finding employment, or going to school. Mental Health and Behavior Outcomes showed improvements in self-reported depression, hallucinations, and trouble concentrating. There were decreases in use of injected drugs and use of "other stimulants." Clear evidence shows that MAT/MOUD programming is supporting clients and

their treatment needs. Culturally grounded techniques, as recommended in previous literature, continue to have a positive impact and drive the program's success. Based on National Outcome Measures, in this community we observed the following:

- Increase in abstinence from alcohol or illegal drugs
- Increase in social connections
- Increase in housing stability
- Increase in those currently employed/attending school
- Decrease in past 30-day arrests
- No experiences reported (at intake or follow-up) with alcohol- or drug-related health, behavioral, or social consequences

Mental Health Outcomes

- Decrease in depression, hallucinations, trouble understanding/concentrating/remembering
- Decrease in patients prescribed medication for psychological or emotional problems
- NO change in anxiety (33.3% at intake and follow-up)
- Risky Behavior Outcomes
- 100% decrease in use of injected drugs
- Drug Use Outcomes
- Decrease use of "Other Stimulants"
- Increased use of alcohol and tobacco/nicotine

Considerations and Key Takeaways for American Indian / Alaska Native Using MAT/MOUD

Serious considerations have been recommended for MAT/MOUD programs with AIAN populations. Nearly every AIAN study examining this has recommended culturally-based adaptation for MAT/MOUD. Recommendations have included storytelling, traditional healing traditions as treatment options, sweat lodges, healing ceremonies, prayer, meeting with traditional healers, Wellbriety, using AIAN depictions in educational materials, and using traditional medicine in pharmacologic interventions. It is also important to include family units and community members to support social connection through community activities (like beading and drumming) or therapeutic talking circles. The community is also encouraged to help plan these interventions by participating in the planning, implementation, and evaluation of MOUD support efforts.

Stigma of MAT/MOUD programs places a significant limitation on the availability of these programs in Native communities. Studies found that increased stigma from medical providers made them less likely to implement these options. [16,18] Perceived stigma of the treatment itself by clients in need is also a significant barrier to receiving effective treatment options. [19] Having regular clinic visits to obtain medication also increases perceptions of stigma for the individual.

- Access to MAT/MOUD may be significantly limited due to the rural nature of services, lack of medications available in the rural area, lack of medical providers able to prescribe these medications, or high turnover rates of medical prescribers. Often, insurance companies will not reimburse services not overseen by specific, licensed physicians; this often makes clients rely on outside providers to access necessary medication.
- Considering cultural implications of Native peoples, many individuals have strong feelings against taking medications (especially long-term). They view MAT/MOUD with objection, as it would "substitute one drug for another".[19]This clinical solution is grounded in Western medicine, and often ignores the important relationship of the mind, body, and spirit for Native people.
- Native people may also object to the injectable nature of some MAT/MOUD options and prefer non-injectable formulations (intranasal, sublingual, buccal). Due to the stressed importance of traditional medicine, injectable options for MAT/MOUD may run counter to their beliefs about traditional medicine.

Culturally Based Adaptations for MAT

- AI/AN-specific MAT services may be more effective in reducing opioid use than services available to other racial/ethnic groups. [17] **Many AIAN practices involve gathering family units and**

community members to participate in cultural activities, such as beading and drumming, in a drug-free environment to allow for positive cultural engagement. Although resources for implementing MAT are growing, support for interventions specifically adapted to serve AI/AN communities is lacking. [20]There is a need to address cultural factors in treatment. **This includes drawing on AI/AN traditions, such as an emphasis on storytelling, and incorporating traditional AI/AN healing practices as treatment options.**[21] These practices include **sweat lodges, prayer-based healing ceremonies, meetings with traditional healers, and Wellbriety**. [21,22]

Stigma

Krawczyk 2021- Most AI/ANs who seek treatment for OUD in specialty settings do not receive MOUD as part of care. Analyzing substance use treatment facilities, they found that facilities explicitly serving AI/AN clients offer MOUD at similar rates to other facilities. However, these facilities are less likely to offer methadone or buprenorphine maintenance, which are most effective in reducing overdose risk. [16] The lowest use of agonist maintenance was in facilities run by Tribal governments, the IHS, and with staff that speak Native languages.[16]

Mpofu 2021- AI/AN communities' perceived reliance on MAT unintentionally stigmatizes users as personal and family/community failures, making it unlikely they would seek or adhere to treatment. This was the case **especially for MAT that required regular office visits (methadone, buprenorphine) compared to those that required fewer clinic visits**. Moreover, AI/AN would likely adopt use of MAT with providers whom they might perceive to not discriminate against them on grounds of culture and ethnicity.[19]

Rieckmann 2017- Some **physicians hold negative views** of MAT because of their specialty training or their perceptions about efficacy. In these cases, patients may not receive information about MAT from their providers. Research suggests that counseling staff members with higher education levels (master's degree or higher) are more supportive of MAT.[18] Programs that reported MAT fit staff expertise and training were more likely to implement it.

Soto 2023- Stigma and discrimination can be partially attributed to a lack of culturally specific training for providers. Training that reduces stigmatizing attitudes among providers by providing information about AIAN communities' history and its role in SUD and treatment outcomes is imperative to improve MOUD program adoption among AIAN community members.[21]

Types of Medication- Injection Versus Oral Option

Mpofu 2021-There is a need to determine user MAT administration preferences among AI/AN. While the research evidence suggests a preference for non-injectable formulations (intranasal, sublingual, buccal) over injectable (intravenous, intramuscular the more traditionalist **AI/AN members with strong beliefs in bodily and spiritual integrity may be reticent to injectable administration (intravenous, intramuscular), as traditional medical treatments they are familiar with may be non-injectable (intranasal, sublingual, buccal).** The evidence indicates the need to adapt MAT to how AI/AN manage recovery from chronic illness and disease. These interventions include group therapy led by traditional lay counselors or honored practices, along with traditional medicine practices such as nettle soup or peyote.[19]

Access to Resources/Rural locations

In some rural locations, there may not be a medical provider available to prescribe MAT/MOUD to AIAN populations.

Farago 2023- Nearly 60% of rural counties in the U.S. do not have any eligible prescribers of buprenorphine in office-based settings. This same trend likely exists in Tribal nations, many of which are rural.[23]

Rieckmann 2017- Access to physicians is particularly important for MAT use because **most insurance companies will not reimburse for services that a licensed physician does not oversee.** Although 59% (N=31) of programs providing MAT reported having a staff member with prescribing authority (physician, advanced practice nurse, nurse practitioner, or physician assistant), the remaining 42% (N=22) **relied on an outside provider**. This finding underscores the critical role outside providers play in MAT services and suggests multiple avenues for accessing medical expertise. Without access to prescribers, treatment programs serving AI/ANs will continue to experience disparities in access to high-quality substance abuse treatment.[18]

Gibbons 2024- Unlike other groups, MOUD access and use disparities for AIAN decreased after controlling for social determinants and provider characteristics. The decline suggests that social determinants and provider characteristics may explain the disparities in MOUD access and use in the base models without these factors among American Indians/Alaska Natives with OUD. [24]

"Just Another drug"

Krawczyk 2021- In non-detoxification settings, MOUD use was lower among AI/ANs, suggesting that many AI/ANs may be receiving treatment with MOUD for withdrawal management rather

than maintenance. More work is needed to understand the nature of MOUD use, motivations for medication use as maintenance vs. withdrawal management, and how these trends compare among AI/ANs relative to other race/ethnic groups.[16]

Mpofu 2021- While some AI/AN communities do use MAT with supervision, the distrust of MAT within AI/AN communities is clearly apparent. A pointed objection was to the effect that MAT merely served to substitute one drug for another, especially since use of MAT was long-term rather than short-term. Moreover, AI/AN communities perceived MAT to carry the risk of dependency, and to be unsafe for pregnant mothers who risk unwanted neonatal addiction to MAT. AI/AN perceived MAT as too grounded in Western understandings of disease and illness, ignoring the interactive relationship between mind, body, person, and spirit in wellness.[19]

Future Work

This review highlights current MAT practices and research with AI/AN populations to address high rates of overdoses and opioid use. Research presented in this review shows that combining MAT with psychosocial therapy and culturally centered care improves recovery outcomes. In many rural Tribal communities, there is a need for detox beds, coordinated care among agencies and prescribers, and gaps in cultural practices and MAT treatment. Rural communities also need more waivered physicians. Systems must continue addressing stigma and expand outreach through culturally tailored educational materials, improved recruitment and retention of culturally responsive providers, and access to MAT consultations for providers, patients, and families. With the significant focus on MAT, some of the basic needs of individuals have been overlooked. These include things like transportation, housing, adequate nutrition, and addressing stigma around SUD and MAT.

Borrowed Wisdom/Literature Cited

All literature below is available here.
General MOUD literature is available here.
New MAT literature (2021-2024) is available here.

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