

# Medication Assisted Treatment Program Policies: Opinions of People in Treatment

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Martha Carter<sup>1</sup> , Jennifer Boyd<sup>1</sup>,  
Trey Bennett<sup>1</sup>, and Adam Baus<sup>1</sup>

## Abstract

**Introduction:** Medication assisted treatment (MAT) for opioid use disorder (OUD) saves lives and enhances quality of life for people in recovery. However, only a small percentage of people eligible for MAT in the United States receive treatment, and among those who do seek treatment, retention is a challenge. This study aims to understand factors that help individuals enter and stay in MAT from the perspective of those in recovery. The patient perspective is vital in efforts to improve care delivery and best support individuals in treatment. **Methods:** Survey development was driven by a review of current peer-reviewed literature plus information gained through 3 semi-structured interviews and follow-up discussions with 5 individuals who have lived experience in MAT, termed Participant Advisors. Survey questions focused in part on MAT participants' opinions relating to program policies such as drug testing, relapse protocols, duration of treatment, participant use of anti-anxiety medications and marijuana, and requirements for attendance in peer recovery groups such as Narcotics Anonymous and Alcoholics Anonymous. Responses were collected from West Virginia-based MAT programs from February through August 2021, with 1700 surveys distributed to 21 MAT programs. **Results:** At the close of data collection, 225 survey responses, including over 500 free-text comments, were received (13.2% response rate). Most (n=207, 95%) were currently in a MAT program and most (n=187, 88.6%) reported using buprenorphine/naloxone for MAT, though participants reported having used other medications for treatment of OUD as well. Questions about how long a person should have MAT prescribed, how long they should be able to stay in treatment, whether they can use marijuana or anti-anxiety drugs while in treatment, and whether they should use a 12-step program generated mixed opinions. Findings strongly support consideration of individual situations and shared decision-making with providers.

## Keywords

medication assisted treatment, opioid use disorder, patient perspective, practice-based research, West Virginia, Appalachia

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## Introduction

Despite extensive evidence that medication assisted treatment (MAT) for opioid use disorder (OUD) saves lives<sup>1</sup> and enables people to return to a productive, meaningful life, only a small percentage of people eligible for MAT in the United States participate in treatment. While the lack of uptake of MAT has been studied from the prescriber perspective, there is a dearth of literature that considers the perspectives of people in treatment.

In addition to low enrollment, MAT programs struggle with patient retention.<sup>2</sup> Current research indicates that better outcomes may be associated with longer duration of treatment.<sup>3</sup> To improve retention, it is important to

understand the factors that make an individual more likely to disengage from treatment as well as to listen to patient perspectives on how to improve services.

Patient satisfaction surveys for addiction treatment often find high levels of satisfaction among patients, but this does not necessarily mean that patients' needs are being met by

<sup>1</sup>West Virginia Alliance for Creative Health Solutions, Inc, Culloden, WV, USA

### Corresponding Author:

Martha Carter, West Virginia Alliance for Creative Health Solutions, Inc, 135 Community Rdg, Culloden, WV 25510, USA.  
Email: mcarterwv@gmail.com



the services they are receiving.<sup>4</sup> Additionally, many survey tools do not ask the right questions about what is really important to the patient. Including patient participation in the creation of surveys, along with a commitment to making meaningful improvements based on the results could help improve program quality and patient experiences.<sup>4</sup>

This paper adds to previously published work on factors that help and hinder entry and retention in MAT for OUD, which found that though the decision to enter treatment is largely based on personal readiness, programs and policies can facilitate entry into and retention in treatment by ensuring affordability of treatment, access to transportation, rapid access to medication and flexibility in dosing, enhanced community outreach, and reduced stigma.<sup>5</sup> In this West Virginia (WV) based study, we report on MAT participants' opinions relating to program policies such as drug testing, relapse protocols, duration of treatment, participant use of antianxiety medications and marijuana, and requirements for attendance in peer recovery groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA).

## Methods

This exploratory sequential mixed methods study was designed to elicit the opinions of individuals who are or have been in MAT for OUD regarding treatment of OUD. Survey development was driven by a review of current peer-reviewed literature plus information gained through 3 semi-structured interviews and follow-up discussions with 5 individuals who have lived experience in MAT, termed Participant Advisors (PAs). We acknowledged the input and expertise of the PAs by covering their costs and time related to participation in the project. We developed the 52-question survey through an iterative process focused on readability, reading level, and appropriate language to reflect commonly used and accepted terms from the PAs. External reviewers who are professionals in the field of addiction treatment provided additional content validation. The final survey, which was tested and approved for distribution by the PAs, included questions on barriers and facilitators to MAT presented in Likert-type response format with free text fields for added comments.

Data from the WV Department of Health and Human Resources, Office of Health Facility Licensure and Certification were used to recruit statewide MAT programs for participation, including programs offering different MAT modalities, and to reflect racial and ethnic diversity as well as people recently incarcerated or pregnant. Individuals were eligible to take the survey if they were age 18 or older and able to understand English. Participants were given the opportunity to take the survey on paper or online using papersurvey.io. This software allows for scanning, data validation, and collection of survey results.

Participating MAT programs received the survey materials in paper-based and electronic formats, including a cover letter detailing the study and implied consent to participate. Programs were offered \$100 for survey distribution, and survey respondents were eligible for a \$200 gift card prize drawing through a separate, secure data collection process.

We collected survey responses from WV MAT program participants from February through August 2021. All survey results were anonymous by individual and by MAT location to protect privacy and confidentiality. Quantitative data were analyzed via descriptive statistics using SAS Analytics Software, with results presented using valid percentages to account for non-response per survey question. Qualitative data were analyzed via content analysis using inductive open coding and synthesis. This study received West Virginia University Institutional Review Board Approval (Protocol #2001837052).

## Results

We distributed 1700 surveys through 21 WV MAT programs and received 225 responses (13.2% response rate), which included over 500 free-text comments. Because we do not know if sites handed out all surveys provided to them, the response rate may be higher based on the number of surveys actually distributed. The majority of responses were paper based ( $n=196$ , 87.1%). All quantitative results are presented in terms of valid percent. Respondent quotes are intermixed for added context.

Demographics and other social factors are presented in Table 1. Drug use, treatment history, and opinions regarding MAT are presented in Table 2. Qualitative results regarding participation in peer recovery groups like NA and AA are presented in Table 3.

Forty three percent ( $n=88$ ) of respondents reported that their drug use had been a problem for 2 to 10 years, and 52.2% ( $n=107$ ) reported problem drug use for 11 years or more. Most ( $n=207$ , 95.0%) were currently in a MAT program, with the majority ( $n=121$ , 59.7%) reporting they had been in MAT for over 1 year and 18.8% ( $n=38$ ) reporting they had been in MAT for 5 years or longer. Most participants ( $n=187$ , 88.6%) had used buprenorphine/naloxone. Respondents also reported using other medications for opioid use disorder (MOUD) at some point in their recovery: buprenorphine ( $n=41$ , 19.4%), methadone ( $n=32$ , 15.2%), naltrexone ( $n=27$ , 12.8%). While respondents could choose multiple responses to questions about how their visits with their prescribing provider, counseling visits, and MAT prescriptions were paid for, 66.7% ( $n=136$ ) indicated that Medicaid covered some or all of the cost of their care.

Several themes emerged from survey question responses and from written comments, including support for an individualized approach to treatment, the need to address

**Table 1.** Demographics and Social Factors.

| Response                                                       | n   | Valid % |
|----------------------------------------------------------------|-----|---------|
| Age category                                                   |     |         |
| 18 to 34 years                                                 | 83  | 39.2    |
| 35 to 54 years                                                 | 108 | 50.9    |
| 55+ years                                                      | 21  | 9.9     |
| Gender identity                                                |     |         |
| Female                                                         | 109 | 51.2    |
| Male                                                           | 102 | 47.9    |
| Transgender                                                    | 2   | 0.9     |
| Race                                                           |     |         |
| American Indian or Alaska Native                               | 1   | 0.5     |
| Black or African American                                      | 5   | 2.3     |
| Multiracial                                                    | 3   | 1.4     |
| White                                                          | 205 | 95.8    |
| Ethnicity                                                      |     |         |
| Hispanic, Latino/a, or Spanish                                 | 6   | 3.3     |
| Non-Hispanic, Latino/a, or Spanish                             | 177 | 96.7    |
| Payment source (check all)                                     |     |         |
| Medicaid                                                       | 136 | 66.7    |
| Medicare                                                       | 40  | 19.6    |
| Private insurance or insurance through employer                | 32  | 15.7    |
| Full cost out of pocket                                        | 25  | 12.2    |
| Sliding fee scale                                              | 9   | 4.4     |
| Medicaid plus Medicare                                         | 8   | 3.9     |
| Health system representation among participating organizations |     |         |
| Community health centers/ federally qualified health centers   | 11  | 52.4    |
| Hospitals/hospital affiliates                                  | 3   | 14.3    |
| Comprehensive behavioral health centers                        | 2   | 9.5     |
| Free clinics                                                   | 2   | 9.5     |
| Private, faith-based organization                              | 1   | 4.8     |
| Private medical group practice                                 | 1   | 4.8     |
| Private psychiatric practice                                   | 1   | 4.8     |

anxiety in people with SUD, and mixed opinions of peer recovery groups like NA/AA.

### Program Policies

Forty-four respondents (22.2%) reported they had been kicked out or involuntarily discharged from a MAT program. Of those who gave a reason, many (n=21, 56.8%) indicated it was because they had used illicit substances, and that was against program rules. However, people surveyed largely held that relapse indicated a need for more intensive treatment, with 68 (33.3%) and 120 (58.8%) respectively saying that “People who relapse once/multiple times should receive a higher level of care.” A minority of respondents (n=61, 29.9%), held the opinion that people

who relapse should never be kicked out of the program. In the words of 1 respondent, “*Never give up on someone, especially an addict. You may save their life.*” However, others (n=53, 26.0%) thought that those who relapse multiple times should be kicked out of the program. For example, 1 respondent said, “*If they keep messing up then they don’t want it.*”

When asked how frequently they thought people should have drug testing while in MAT, 70 (34.8%) respondents said, “More in the beginning, less as they stay longer” and 69 (34.3%) responded “Often, every week or 2.” A small minority, 26 (12.9%) said, “Only randomly, unscheduled” and 1 respondent chose “Never.”

Respondents valued an individualized approach when determining how long people should stay in MAT and have medication prescribed. Ninety-five people (47.5%) responded that, “People should be able to choose for themselves when they are ready to wean off medication,” 67 (33.5%) said that, “This should be decided between the prescriber and the patient,” and 23 (11.5%) said, “People should be able to stay on medication for the rest of their lives.” Only 12 (6.0%) said that, “People should be weaned off all medication as soon as possible.”

A respondent commented, “*One of the biggest problems that kept me from a lot of programs was that they had “time frames” for how long (sic) person could be “treated.” For example you could only attend for a year or 2 then they’d kick you out regardless of the patient’s current condition or state of mind. And I hope 1 day I’ll be able to say I’ll (sic) left knowing I would never have to return, and that I’ll live without turning back to the life of addiction, drugs, and reckless. (I really hope to see that day.)*”

Another respondent said, “*At some point would like to consider reducing dose and stopping treatment but it is too hard get back in treatment if you leave. That affects my decision.*”

### Treatment for Anxiety and Use of Marijuana

In response to the question, “What is your opinion about the use of anti-anxiety medications like Benzodiazepines (benzos) while in MAT?” 42 (20.7%) said they should not be allowed, while 80 (39.4%) said they should be allowed if prescribed, and 81 (39.9%) said they should be considered on an individual basis. One respondent noted, “*The other meds [prescribed for anxiety] don’t always help then we have to choose between mental health or MAT and it sucks.*”

Regarding the use of marijuana or hashish while in MAT, only 19 (9.7%) of respondents indicated that use of these drugs should not be allowed, while 70 (35.9%) said they should be allowed for any reason, 47 (24.1%) said they should be allowed for medical reasons, and 59 (30.3%) said they should be considered on an individual basis. Our

**Table 2.** Drug Use, Treatment History, and Opinions Regarding MAT.

| Response                                                                                         | n   | Valid % |
|--------------------------------------------------------------------------------------------------|-----|---------|
| Duration of drug use as a problem                                                                |     |         |
| Up to 2 years                                                                                    | 10  | 4.9     |
| 2 to 10 years                                                                                    | 88  | 42.9    |
| 11+ years                                                                                        | 107 | 52.2    |
| Currently in a MAT Program                                                                       |     |         |
| Yes                                                                                              | 207 | 95.0    |
| No                                                                                               | 11  | 5.0     |
| Duration in MAT over time                                                                        |     |         |
| <2 weeks                                                                                         | 11  | 5.4     |
| 2 weeks to 3 months                                                                              | 23  | 11.3    |
| >3 to 12 months                                                                                  | 48  | 23.6    |
| >1 to 2 years                                                                                    | 30  | 14.8    |
| >2 to 5 years                                                                                    | 53  | 26.1    |
| >5 to 9 years                                                                                    | 20  | 9.9     |
| >9 to 20 years                                                                                   | 17  | 8.4     |
| >20 years                                                                                        | 1   | 0.5     |
| Medications ever used for MAT (check all)                                                        |     |         |
| Buprenorphine/Naloxone                                                                           | 187 | 88.6    |
| Buprenorphine alone                                                                              | 41  | 19.4    |
| Methadone                                                                                        | 32  | 15.2    |
| Naltrexone                                                                                       | 27  | 12.8    |
| Types of treatment utilized (check all)                                                          |     |         |
| Outpatient MAT program                                                                           | 176 | 78.2    |
| Detox facility                                                                                   | 111 | 49.3    |
| Residential treatment program                                                                    | 93  | 41.3    |
| Inpatient (hospital) treatment facility                                                          | 91  | 40.4    |
| Intensive outpatient program                                                                     | 85  | 37.8    |
| Outpatient program without MAT                                                                   | 71  | 31.6    |
| Sober living setting                                                                             | 63  | 28.0    |
| Ever kicked out of or discharged from MAT                                                        |     |         |
| No                                                                                               | 154 | 77.8    |
| Yes                                                                                              | 44  | 22.2    |
| If Yes, reasons for being kicked out or discharged from MAT                                      |     |         |
| I used, and that was against program rules                                                       | 21  | 56.8    |
| I missed too many appointments                                                                   | 10  | 27.0    |
| I could not follow other program rules                                                           | 5   | 13.5    |
| I needed more intensive treatment (higher level of care)                                         | 1   | 2.7     |
| How often should people have drug testing while in MAT?                                          |     |         |
| More in the beginning, less as they stay longer                                                  | 70  | 34.8    |
| Often, every week or two                                                                         | 69  | 34.3    |
| Often at the beginning, then only randomly                                                       | 35  | 17.4    |
| Only randomly, unscheduled                                                                       | 26  | 12.9    |
| Never                                                                                            | 1   | 0.5     |
| How long should a person be able to stay in MAT and have medication prescribed?                  |     |         |
| People should be able to choose for themselves when they are ready to wean off medication        | 95  | 47.5    |
| This should be decided between the patient and prescriber                                        | 67  | 33.5    |
| People should be able to stay on medication for the rest of their lives                          | 23  | 11.5    |
| People should be weaned off all medication as soon as possible                                   | 12  | 6.0     |
| People should be able to stay on medication for a long time                                      | 3   | 1.5     |
| What do you think MAT programs should do when people in the program continue to use? (check all) |     |         |

(continued)

**Table 2. (continued)**

| Response                                                                                                   | n   | Valid % |
|------------------------------------------------------------------------------------------------------------|-----|---------|
| People who relapse should never be kicked out of the program                                               | 61  | 29.9    |
| People who relapse once should be kicked out of the program                                                | 2   | 0.9     |
| People who relapse multiple times should be kicked out of the program                                      | 53  | 26.0    |
| People who relapse once should receive a higher level of care                                              | 68  | 33.3    |
| People who relapse multiple times should receive a higher level of care                                    | 120 | 58.8    |
| What is your opinion about the use of anti-anxiety medications like Benzodiazepines (benzos) while in MAT? |     |         |
| Should be considered on an individual basis                                                                | 81  | 39.9    |
| Should be allowed if prescribed                                                                            | 80  | 39.4    |
| Should not be allowed                                                                                      | 42  | 20.7    |
| What is your opinion about the use of marijuana or hashish while in MAT?                                   |     |         |
| Should be allowed for any reason                                                                           | 70  | 35.9    |
| Should be considered on an individual basis                                                                | 59  | 30.3    |
| Should be allowed for medical reasons                                                                      | 47  | 24.1    |
| Should not be allowed                                                                                      | 19  | 9.7     |
| If you have used NA, AA, or a program like it, how well did it work for you?                               |     |         |
| Very helpful                                                                                               | 67  | 42.4    |
| Somewhat helpful                                                                                           | 61  | 38.6    |
| Not helpful                                                                                                | 30  | 19.0    |

**Table 3.** Free Text Responses and Representative Quotations for: “If you have used NA, AA, or a program like it, how well did it work for you?” and “If you have not used NA, AA, or a program like it, please describe why.”

1. Don't need NA/AA (14 respondents)
  - *Because I have family & friends & friends I can talk to that's a great support*
  - *Because I'm comfortable with my group and counseling I have.*
  - *I for one wouldn't have the time for another program and I have a good support system without it. I do feel some people thrive from it & that's great. It's just not for me.*
2. Don't like NA/AA (12 respondents)
  - *Have never found a program that feels like a fit for me.*
  - *Haven't heard anything good about either*
  - *Most were helpful but had strict guidelines/rules or time frames of which they'll offer their help. Some would make your “kick outs” publicly dramatic and had little to no privacy.*
3. Fear of relapse/using (6 respondents)
  - *I felt people were only there to talk about being high and how they liked it. I wanted to get high more when I left.*
  - *Didn't think they would really help much and I really don't want to be around any other addicts. Sometimes meeting other addicts can lead to using.*
  - *Some meetings had people there only to sell drugs not get better.*
4. Unable to attend and COVID-related barriers (4 respondents)
  - *Don't have transportation, child care. or knowledge of the programs. (Location. dates, times)*
  - *I don't like being around lots of people. I live a hour or so away from anything like that.*
  - *Currently in treatment, cannot go to outside meetings because of Covid. I plan on going once discharged.*
5. Judgmental attitudes (3 respondents)
  - *But a lot of people judge you for using subs*
  - *feel like NA doesn't agree Suboxone*
6. Lack information about NA/AA (2 respondents)
  - *There are no programs in my area that I'm aware of. MAT treatment works best for me.*
7. Other/ neither positive nor negative (7 respondents)
  - *Because this is the first time I reached out for help*
  - *I should have but was in denial about being alcohol(ic)*
8. Using or has used NA/AA (3 respondents)
  - *Somewhat helpful. But I feel M.A.T. has a better chance for staying off drugs.*

survey did not ask why people chose to use marijuana. This quote from one respondent demonstrates that people may be using marijuana to address problematic physical or mental health conditions: *"When I did smoke I slept better & was able to gain weight."*

### Peer Recovery Groups

A majority of respondents (n=140, 67.3%) indicated they had used a program like NA or AA. Of those, 67 (42.4%) said it was very helpful, 61 (38.6%) said it was somewhat helpful, and 30 (19.0%) said it was not helpful. Reasons respondents had not used NA/AA were varied, ranging from lack of knowledge about programs in their area to feeling they had enough support through family & friends, their MAT program, or counseling without going to meetings. Several comments referred to stigma; for example, 1 respondent said, *"If by chance they find out your (sic) in a program you are judged."* Six respondents indicated that attending meetings might put them at risk for relapse. For example, 1 respondent commented, *"I stopped going because after the meeting and hearing everyone's stories it made me think about relapsing."* Two respondents said that other people were there just to sell drugs. Additional qualitative responses are presented in Table 3.

### Discussion

This study contributes to the literature by taking into account the perspectives of individuals with significant lived experience with problem drug use and long-term experience with MAT. An overarching theme from initial interviews with our Participant Advisors and in our survey responses is that care for people in recovery from addiction needs to be individualized to be considered successful by those in treatment. Narrative comments strongly supported consideration of unique situations and shared decision-making with the provider. The responses show that despite evidence-based guidelines from the American Society of Addiction Medicine (ASAM)<sup>3</sup> and the National Institute on Drug Abuse (NIDA),<sup>6</sup> which recommend individualized care that adapts to the person's needs, some people in MAT programs have a different experience.

### Program Implications

The vast majority of respondents agreed that program participants should be held accountable through drug testing for not using illicit substances during treatment. Participant Advisors strongly indicated the importance of supporting people who are struggling with relapse and a majority of survey respondents said that a higher level of treatment should be offered when somebody "messes up," rather than involuntarily discharging that person from the program.

These opinions point to the importance of continuing care for people who relapse, as opposed to dismissal from a program and are consistent with recommendations from the NIDA.<sup>6</sup>

Respondents clearly felt that the length of time a person stays in the program should be individualized and that the participant's opinion should be taken into account with respect to continuation of treatment. Current ASAM guidelines<sup>3</sup> point to the evidence that a longer duration in treatment, for example, greater than 3 months, is associated with better outcomes and urge that medication not be discontinued at a predetermined time but, rather, that treatment duration be individualized based on a number of factors that may indicate successful treatment. Programs and payers should neither incentivize MAT programs and prescribing providers to quickly wean people off MAT nor incentivize long-term MAT. Instead, the incentive should be to create a plan with the person in recovery that is re-evaluated periodically to meet the individual's goals and definition of success.

### Use of Antianxiety Medications and Marijuana

It is well recognized that persons with substance use disorders often have associated mental health comorbidities and that these should be addressed and treated.<sup>3,6</sup> In this study, responses that were favorable to the use of antianxiety drugs while on MAT point to an unmet need for effective anxiety treatment in some MAT patients, especially in light of the known risks of benzodiazepines in combination with buprenorphine and methadone. Attention should be paid to addressing co-existing behavioral health needs, especially anxiety, without the use of benzodiazepines. Treatment using classes of medications other than benzodiazepines should be offered. Additionally, there is some indication from previous studies that complementary and alternative modalities may offer benefit for people with anxiety in treatment of OUD. For example, several small but encouraging studies have found that yoga may help reduce stress for people in addiction treatment.<sup>7-9</sup> Responses also indicated a general acceptance of the use of marijuana while in treatment. Again, respondents emphasized the need for consideration on an individual basis. MAT participants could benefit from ongoing education about the risks of benzodiazepines for people on MAT, as well as information on the most current evidence about use of cannabis for people in recovery.

### Requirements for NA/AA

In spite of evidence for the benefit of NA/AA programs for people in recovery,<sup>10</sup> survey participants indicated that NA/AA meetings may not be useful in all situations. Many respondents did not feel a need for NA/AA because of the

support they get from counseling, their MAT program, or family and friends. A large number did not feel comfortable in a group or had had a negative experience with such a program. Several replies indicated discomfort related to judgmental attitudes of NA/AA toward MAT. Most concerning were several comments about the risk of relapse associated with attending NA/AA meetings.

Reducing stigma around MAT could make NA/AA more helpful to people in MAT programs.<sup>11</sup> MAT programs should inquire about participants' experiences with local NA/AA meetings and support meetings that provide a non-judgmental and safe environment. Ultimately, MAT programs should consider a shared decision-making model regarding NA/AA meeting requirements.

### **Policy Implications**

The results of our study have implications for addiction treatment policy. Because Medicaid is the primary payer for a majority of our respondents, the results have particular implications for Medicaid program policy.

While Medicaid program policy has become more flexible in the past few years, in part due to Congressional action like the SUPPORT Act, Medicaid beneficiaries still face barriers to individualized addiction treatment in many states, including medication quantity limits and prior authorization requirements.<sup>12</sup> In addition, Medicaid coverage of adjunctive therapies has gained minimal traction, despite some evidence that integrated therapies can be effective in addressing the mental health, structural, and trauma-related issues often associated with addiction.<sup>13</sup>

Although our respondents were less likely to have services paid for by private insurance and Medicare, the ability to individualize treatment plans may be hampered by restrictions put in place by these payers.<sup>14</sup> As people in treatment age into Medicare, it will be increasingly important to eliminate barriers, such as formulary and quantity restrictions, and prior authorization requirements that may delay care when the person is ready to seek treatment.<sup>5</sup>

### **Limitations**

The individuals surveyed were recruited from West Virginia MAT programs and results may not be applicable to other populations. Notably, few respondents were people of color, reflecting the demographic composition of the population in West Virginia. Results could not be analyzed by race or ethnicity due to the small number of responses. Of the practices that agreed to help distribute surveys to their MAT program participants, over half ( $n=11$ , 52.4%) were Community Health Centers/Federally Qualified Health Centers; therefore, the results may not be representative of other treatment settings. None of the methadone programs in the state agreed to help distribute surveys and the

majority of responses came from participants in Suboxone (buprenorphine/naloxone) programs, so respondent experience with methadone programs is under-represented. However, this study gives voice to MAT program participants in a wide range of program settings and across many years of individual experience in MAT.

### **Implications for Future Research**

This study was designed to capture the experiences and opinions of MAT program participants over the course of their entry and retention in treatment. We did not specifically examine the effects of the COVID-19 pandemic and this information could be useful in the future. Additional research is needed to explore methods to manage stress and anxiety, such as yoga, meditation, and mindfulness training, without the use of benzodiazepines and other medications that can be dangerous when mixed with MAT.

### **Conclusion**

This study adds the perspectives of people in recovery on MAT program policies regarding drug testing, relapse, retention, use of anxiolytics and marijuana, as well as their opinions and experiences with peer recovery groups. The responses indicate a preference for individualized care and shared decision making. In many cases, incorporating patient perspectives will serve to bring programs into alignment with current evidence-based guidelines. Results from this survey can inform program guidelines and policy decisions to increase chances of recruitment and retention into treatment and optimize people's experiences in MAT programs, which can ultimately lead to improved outcomes for people with OUD.

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### ORCID iDs

Martha Carter  <https://orcid.org/0000-0002-2740-2785>

Adam Baus  <https://orcid.org/0000-0001-8993-3680>

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