INTRODUCTION TO MAT

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Learning Objectives

1. What is MAT
2. The impact of MAT
3. How has MAT changed
4. Common issues in MAT
5. Future issues in MAT

Austin is a 29 yo male with 5 year history of alcohol and opioid use disorder. History included prior treatment with Suboxone but this was discontinued after he was found to be giving some of his medications to his girlfriend. He returned to heroin use after being discharged from the clinic . He now presents for treatment following near fatal overdose.

Is he a candidate for MAT again
Which MAT would be best
What should be done differently this time

WHAT DO WE MEAN BY MAT (Medication Assisted Treatment)

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders

- individual or groups therapy
- family therapy
- 12 step
- peer support
- others

KEY CONCEPT OF MAT

- Use disorders are complex diseases having both neurochemical abnormalities and behavioral components

- Optimal treatment should target both aspects of the disease

MEDICATIONS USED IN MAT

ALCOHOL USE DISORDER
- Antabuse
- Naltrexone
- Acamprosate

OPIOID USE DISORDER (MOUD-medications for opioid use disorder)
- Methadone
- Buprenorphine
- Naltrexone
- Naloxone (Narcan reversal)

TOBACCO USE DISORDER
-Nicotine replacement
-Wellbutrin
-Varenicline

WHY IS MAT SO CRUCIAL IN THE TREATMENT OF OPOID USE DISORDER

BECAUSE NON MEDICATION BASED TREATMENT IS MUCH LESS EFFECTIVE THAN MAT

What is the success rate of MAT in Opioid Use Disorder

Overall between 50-60%   6- 12 month abstinence
Without MAT 10-20%   6- 12 month abstinence

Major issue is retention, not failure of the medication
Short term treatment with MAT does not work

What is the success rate of MAT in Alcohol Use Disorder

About 1 in 8 patients placed on naltrexone will achieve recovery that they would not have achieved without medication

What is the success rate of MAT in Tobacco Use Disorder

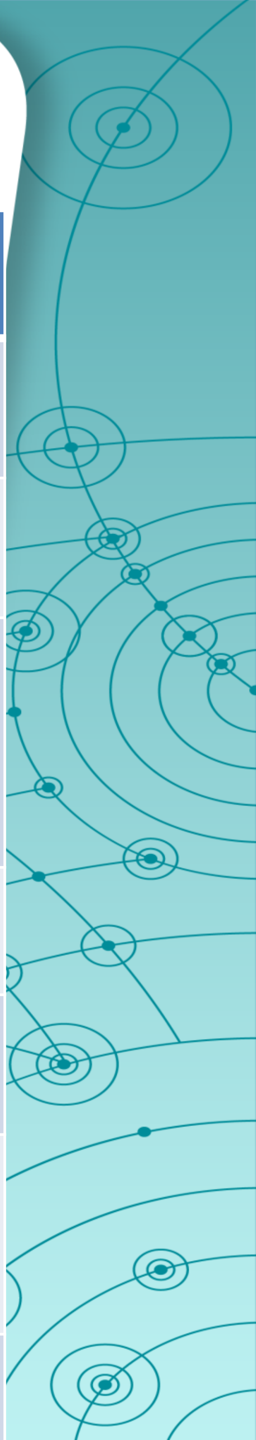
MAT increases the success of smoking cessation from approximately 5-10% to 25-30%

WHICH MAT ?

	METHADONE	BUPRENORPHINE/NALOXONE	IM NALTREXONE
EFFICACY	Most proven, higher retention	Close if not equal to methadone	Less but mostly due to dropouts during induction (25%)
SIDE EFFECTS	Prolonged QT Constipation Low testosterone Respiratory depression Sweating Pituitary suppression	Constipation Low testosterone(less) Nausea, LE edema, HA Insomnia Sweating Blistering in mouth	Nausea Liver function tests Dizziness, drowsiness Injection site tenderness
RISK OF OVERDOSE	+++ if dose is too high or patient mixes with sedatives (6x OD risk)	Very low, possible when mixed with sedatives but low	None
PAIN CONTROL	Yes (caveat)	Yes	No

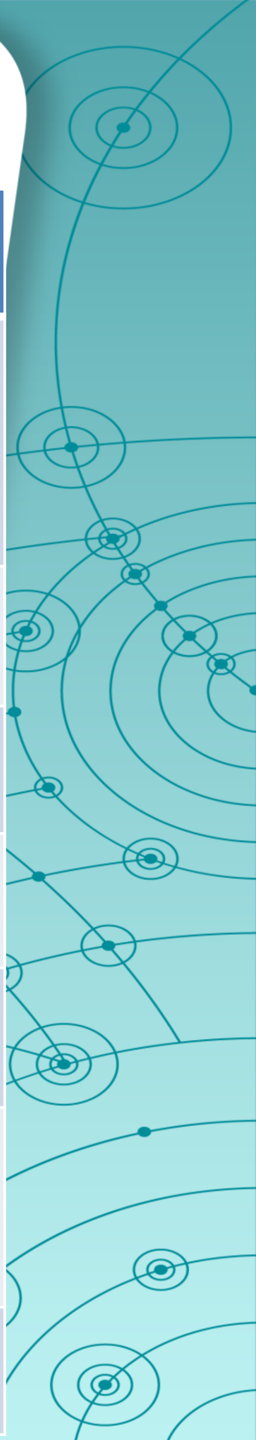
WHICH MAT ?

	METHADONE	BUPRENORPHINE/NALOXONE	NALTREXONE
MEDICATION INTERACTIONS	Yes (anticonvulsants, HIV meds, antidepressants…)	Few	Opioids
REGULATION	VERY High	Moderate	Minimal
CONVENIENCE	Daily visits for at least 3 months (Covid changes) Limited number of clinics-19	Monthly visits	Monthly visits
COSTS	Medicaid/? Insurance	Medicaid/Insurance	Medicaid/Insurance
WORK / MILITARY STATUS	Prohibited in certain job situations (CDL)	Less restrictive but often prohibited in CLD	None
DIVERSION RISK	Less difficult but still difficult	None	None



WHICH MAT ?

	METHADONE	BUPRENORPHINE/NALOXONE	NALTREXONE
EASE OF STARTING	Can be started without Fear of precipitated withdrawal	Typically requires a period of abstinence but can be started immediately with microinductions	MUST have a prolonged period of abstinence before starting
TIME TO STABLITY	Several weeks	Days	1 day once started
EASE OF WEANING	Difficult	Difficult	Easy
EASE OF TAKING	Daily	Daily dosing or monthly shot	Daily dosing or monthly shot



Buprenorphine vs Methadone vs XR-Naltrexone vs Abstinence

Prior experience of patient (or friends) frequently drives the decision
Many patients will not tolerate the withdrawal period for naltrexone
Prior use of diverted buprenorphine does not preclude OUD treatment with buprenorphine
Opioid agonist therapy should not be denied to patients solely because they take benzodiazepines or other drugs
Prior failure should not preclude another attempt but typically something needs to be adjusted
Many patients do well with medications as main treatment

HOW LONG?

The end goal is not getting off the MAT

You can remain on it as long as you feel it is working and you need it

Would not try to use it as a short term “detox agent”

Austin is a 29 yo male with 5 year history of alcohol and opioid use disorder. History included prior treatment with buprenorphine (Suboxone) but this was discontinued after he was found to be giving some of his medications to his girlfriend. He returned to heroin use after being discharged from the clinic . He now presents for treatment following near fatal overdose.

- ? Naltrexone if he was off opioids when he presented
- Buprenorphine injectable if diversion remains a concern
- Shared decision making