Study addresses treatments for waited-listed opioid-dependent individuals

April 10 2014

addiction to heroin and prescription painkillers – has reached epidemic levels across the country, with treatment waitlists also at an all-time high. However, ensuring timely access to effective treatment – particularly in rural states like Vermont – has become a substantial problem. University of Vermont (UVM) Associate Professor of Psychiatry Stacey Sigmon, Ph.D., has taken a stand to address this issue and has a new grant to support her campaign.

Nearly 1,000 Vermonters are currently wait-listed for treatment in Vermont and many more desperately need treatment but don't bother to join a waitlist once they learn of the lengthy delay to treatment, says Sigmon, who directs Vermont's first and largest methadone clinic and is a founding co-investigator of the Vermont Center on Behavior and Health (VCBH) at UVM. In a recent *JAMA Psychiatry* "Viewpoint" editorial, she states that as opioid-dependent patients remain on waitlists year after year, their risk for illegal drug use, criminal activity, overdose, and death increases. These consequences impact not only the abusers, but the economy and public safety as well.

Sigmon's latest project, funded by a National Institute on Drug Abuse (NIDA) award, will develop a novel Interim Buprenorphine Treatment (IBT) to help opioid-dependent Vermonters bridge challenging waitlist delays. She's proposed a treatment "package" of five key components designed to maximize patient access to evidence-based medication for opioid dependence while minimizing common barriers to treatment success, including risks of medication non-adherence, abuse and

diversion.

The first piece of Sigmon's five-pronged approach involves three months of maintenance therapy using buprenorphine (Suboxone®), an opioid agonist medication FDA-approved for treating opioid addiction. "Buprenorphine is a partial agonist with a more favorable safety profile and less abuse potential than full agonists such as methadone," explains Sigmon. "There is also greater regulatory flexibility associated with buprenorphine, which will permit us to provide the medication without the rigid restrictions in place for methadone."

The study's second component leverages innovative technology to ensure safe and timely medication administration. She will use a state-of-the-art, computerized portable device manufactured in Finland called a Med-O-Wheel, which dispenses each day's dose at a predetermined time, after which all medication is locked away and inaccessible. "To my knowledge, no one in the U.S. is using this technology for opiate dispensing," says Sigmon. Use of this device will permit patients to take their medication at home, without the frequent trips to the clinic often required by opioid treatment clinics.

Clinical support – the study's third feature – will come from a mobile health platform that uses technology to deliver patient monitoring and support beyond the confines of the medical office. Sigmon's study will utilize a phone-based, Interactive Voice Response system – an approach studied extensively by UVM behavior and addiction experts – to provide basic monitoring and support to patients by phone.

The fourth feature of the package, says Sigmon, involves an automated call-back procedure during which participants are contacted by the IVR system at randomly-determined intervals and directed to visit the clinic for a pill count and urinalysis.

The fifth and final piece is the development and provision of an HIV and hepatitis educational intervention delivered via a portable iPad platform.

Taken together, Sigmon hopes her study will provide an effective model for helping reduce drug-related risks and costs and contribute to what she refers to in her "Viewpoint" article as "a fundamental shift in how treatment of opioid dependence is conceptualized and delivered in the United States." These technologies are particularly compatible with rural settings, says Sigmon, where there are multiple burdens – including long distances and transportation barriers – that can make it hard for a patient to come to a treatment center on a daily basis.

"Once developed, these treatment components also don't need to be limited to people on wait lists. In fact, they can also be used to support the physicians with patients already enrolled in a methadone, office-based buprenorphine or pain management clinics," says Sigmon.

Provided by University of Vermont

Citation: Study addresses treatments for waited-listed opioid-dependent individuals (2014, April 10) retrieved 20 April 2024 from https://medicalxpress.com/news/2014-04-treatments-waited-listed-opioid-dependent-individuals.html