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► **[Home- versus office-based buprenorphine inductions for opioid-dependent patients.](#)**



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Sohler N.L., Li X., Kunins H.V. et al.

Journal of Substance Abuse Treatment: 2010, 38, p. 153–159.

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Is is safe and will heroin-dependent patients complete the process and stay in treatment if they start buprenorphine maintenance at home rather than being observed and doses adjusted at the clinic? This US study suggests this is feasible, saving time for all concerned, but also hints at possible (in this case, rare) complications.

Summary This US study from the Bronx district of New York documents the induction safety and retention record of a primary care health centre providing buprenorphine/naloxone maintenance treatment for addiction to heroin or other opioids. After two years of offering this treatment, the clinic switched from requiring all patients to start treatment under supervision at the clinic (entailing two to four hours during which the dose was adjusted), to allowing the doctor and patient between them to agree instead that the patient would be given a 'take-home' induction kit to enable them to start their treatment at home. The kit contained enough buprenorphine/naloxone pills for patients to themselves build up their doses over three days so they no longer felt withdrawal symptoms, other medicines to help control withdrawal symptoms, plus instructions. They were scheduled to return to the clinic within the week to discuss longer term treatment.

In the first two years 28 patients were inducted on to buprenorphine/naloxone at the clinic. In the next two, 51 patients opted with their doctors for home-based inductions and 36 were inducted as before at the clinic. The study compares initial experiences of all those inducted at the clinic with those inducted at home, 115 patients in all. About 70% had been using heroin, nearly all were Hispanic or black, and over two thirds were unemployed.

Main findings


In the second two years when home inductions were available, patients who with their doctors opted for these were more likely to have had previous experience of buprenorphine treatment. Those who opted to be inducted at the clinic were more often of Hispanic descent, unemployed, had only state-provided health insurance, and had recently used cocaine or sedatives or benzodiazepines.

Across all the patients, about 17% experienced **difficult** inductions regardless of whether inducted at home or at the clinic. Only one patient (in the home-based induction group) was hospitalised immediately following induction. This was due to complications secondary to benzodiazepine abuse which the patient had not fully disclosed. Tests did not reveal any clinically significant disturbance of liver function following inductions. A month later virtually the same proportions of patients (78%) remained in treatment regardless of the induction site. This result was essentially unaltered when differences between patients who opted for induction at home versus at the clinic were taken in to account.

The authors' conclusions

In a health centre that serves an economically disadvantaged community, people treated for opioid dependence with home-based buprenorphine inductions were as likely to be retained in treatment for 30 days as those with traditional clinic-based inductions. There was also no indication that either induction type was associated with greater difficulties with the induction process. The implication is that both office- and home-based buprenorphine inductions are feasible in the primary care setting.

The findings reflect the ability of patients and providers to select the induction type best suited to the patient's needs, abilities, and beliefs about health care. Given the importance of the induction process for longer term opioid addiction management, these data should be encouraging providers to consider treating opioid-dependent patients in primary care.

 Relevant [British primary care guidance](#) makes no specific mention of home-based buprenorphine induction, and seems to caution against such procedures when it stipulates that doctors should "see the patient daily if possible" and "ensure frequent review of the patient and supervision of doses, where available, through induction and until stability".

This US study suggests that when doctor and patient agree this is safe and appropriate, patients can be given enough of the buprenorphine/naloxone formulation – a combination designed to deter injection – to themselves complete the initial titration at home. In this study it seems together doctors and patients selected out the higher risk and less stable patients for clinic-based induction and the more stable and more experienced patients for home-based induction. The result even in this highly disadvantaged caseload was that most were able to start their treatment at home with apparently no greater difficulty or less success than when supervised at the clinic, more convenient for the patient and offering considerable time and cost savings for both patients and clinics.

In the British context many heroin users have experimented with diverted methadone

and buprenorphine and have a sophisticated empirical knowledge of how to do this, and what doses will work for them. With a relatively less toxic drug such as buprenorphine, it should be expedient, safe and efficient to develop the Bronx experiment more widely.

However, the one home induction patient (from 51) who had to be hospitalised after withholding information about his substance use is suggestive of the potential for such problems to arise when patients are not directly observed and have not been adequately assessed or have not adequately cooperated in their assessment.

Thanks for their comments on this entry in draft to Gordon Morse, a general practitioner treating substance users in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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