SUBSTITUTION GUIDELINES FOR PENAL INSTITUTIONS IN AUSTRIA

(Adapted from Pont, J., Resinger, E., & Spitzer, B. Substitutions-Richtlinien für Justizanstalten. Vienna, 2005)

Source: Kastelic, A., Pont, J., Stover, H. Opioid Substitution Treatment in Custodial Settings. A Practical Guide, Oldenburg,, 2008)

Purpose of substitution:

1. Emotional and physical stabilisation of severely opiate addicted individuals
2. Minimisation of drug related crime and debt
3. Reduction of intravenous opiate consumption and of transmissible diseases (hepatitis B/C and HIV/AIDS).

Substitution strategies:

- Long-term substitution: for months, years or for life-time
- Interim substitution: substitution on temporary basis until a well-planned treatment and withdrawal.
- Reduction substitution: substitution medication is carefully reduced step by step.

Substitution medication: use only drugs that are effective for at least 24 hours and are administered orally once a day:

1. Methadone is prepared and administered "magistraliter" as a syrup in order to make intravenous usage more difficult. The dependence potential is very high. The average oral maintenance dosage is around 40–100 mg a day. A dose exceeding 120 mg is not recommendable. Introductory dose: 30–40 mg daily, boosting by approx. 10 mg per week; tapering by 5–10 mg per week
2. Buprenorphine is a partial opiate agonist and antagonist to be administered sublingually once a day. Daily dose ranges between 8 mg and 32 mg. In contrast to other substitution drugs, patients remain rather lucid. This creates problems for those patients who clear-minded cannot stand themselves due to their psychosocial co-morbidity. The major reported side-effect is headache. When switching from pure opiate agonists to buprenorphine, it is important to stop the agonist for one day before starting buprenorphine, in order not to cause acute opiate withdrawal symptoms.
3. Slow release morphines are administered as tablets or capsules. The average morphine dose is around 600 mg per day, the highest recommended dose being approx. 800 mg. Patients on anti-retroviral therapy sometimes require a dose of up to 1200 mg due to drug interactions. The introductory dose is 200mg, boosted or tapered by 30–60 mg per week. The range of side effects attributable to retarded morphine is less than with methadone (less depression, less apathy, less increase in weight).

This document as well as the harmreduction.eu website, was created within the joint action '677085 / HA-REACT,' which has received funding from the European Union's Health Programme (2014-2020).

Drug interactions

With all opiate medications, interactions must be taken into consideration, in particular those due to competitive inhibition or induction of cytochrome P 450: The antibiotics ciprofloxazin, erythromycin, clarithromycin, oral contraceptives and SSRI (especially fluvoxamin) increase the opioid effect, while the HIV virostatics neviparine, efavirenz, nelfinar/ritonavir and rose of Sharon decrease it.

Obligatory agreements with the patient:

1. Declaration of consent and registration at the addictive drug monitoring department
2. Visual monitoring of the administration
3. Consumption control by means of urinalysis
4. Regular care support by treatment consultants
5. Exact information about substitution medication and the dangers of misuse and of accompanying consumption of other drugs

Indications for substitution:

1. The patient is already on substitution treatment when entering the penal institution
2. The patient has been dependent on opiates prior to imprisonment, and cannot withdraw inside the penal institution
3. The patient became dependent on opiates during imprisonment, and in spite of several withdrawal therapies, has not succeeded in becoming clean.

Security measures:

1. Exact control of administration of the substitution medication by medical staff
2. Obligatory random urine tests by medical staff

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