



European Monitoring Centre
for Drugs and Drug Addiction



2010 NATIONAL REPORT (2009 data)
TO THE EMCDDA
by the National Reitox Focal Point

AUSTRIA

New Development, Trends and in-depth
information on selected issues

REITOX

2010 NATIONAL REPORT (2009 data)
TO THE EMCDDA
by the National Reitox Focal Point

AUSTRIA

New Development, Trends and in-depth
information on selected issues

Marion Weigl
Martin Busch
Sabine Haas
Christine Knaller
Elisabeth Türscherl
Charlotte Wirl

Project assistant:
Monika Löbau

Translator:
Susanne Ofner
Translation editor:
Daniela Beuren

Vienna, October 2010

On behalf of the European Monitoring Centre for Drugs and Drug Addiction, Lisbon
and the Austrian Federal Ministry of Health, Vienna

ISBN-13 978-3-85159-153-8

Owner, editor and publisher: Gesundheit Österreich GmbH, Stubenring 6,
1010 Vienna, Austria. Phone +43 1 515 61; fax 513 84 72;
e-mail: firstname.lastname@goeg.at; website: www.goeg.at

Environmentally friendly publication: this report has been printed on paper bleached
without chlorine and without optical brighteners.

Summary

National reports on the drug situation in Austria are drawn up annually for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Federal Ministry responsible for health affairs. They deal with the subject of illicit drugs. This report gives an overview of current developments regarding the political and legal framework, the epidemiological situation and demand reduction interventions in the reporting period 2009/10. Every year specific issues are also highlighted; for this report, the history, methods and implementation of national treatment guidelines as well as the cost of drug-related treatment in Europe have been selected.

Summary and discussion of the most important trends

Drug Policy: Legislation, Strategies and Economic Analysis

In 2009 the Narcotic Drugs Decree was amended in order to modify the framework of opioid substitution treatment on the basis of the recommendations made last year. The amendments primarily relate to diagnosing and indication as well as take-home substitution medicines. The Further Training Decree also saw an amendment: now a distinction is made between doctors responsible for indication and doctors who deliver subsequent treatment, and the Austrian Medical Association is in charge of organising further training. Once again, prevention of drug-related deaths and opioid substitution treatment were among the focal themes of the drug policy discussion. Funding of drug treatment and support centres was another important topic. In several provinces, new addiction plans or programmes are under preparation but have not been adopted yet.

Drug Use in the General Population and Specific Target Groups

No new data on estimates of drug use are available, but more details can be given of the representative study on drug use in the general population carried out in 2008 as well as the ESPAD school survey of 2007: experience of illicit drug use differs according to gender and region, with above-average lifetime prevalence rates among men in urban areas with more than 50 000 inhabitants. The quitting rate is considerably higher for all illicit substances than for alcohol and nicotine, which confirms that use of illicit substances is a temporary phenomenon limited to certain stages in life. A qualitative survey carried out for validation shows that the questionnaire of the ESPAD survey needs to be revised (shortened, restructured and rephrased).

Prevention

The trend towards drawing up and implementing standardised prevention programmes has continued. Parallel to this, specific activities have been pursued to address children and young people for whom the risk of addiction is elevated, and proven programmes have been expanded to include additional target groups. For instance, now interventions in school settings more often aim at students in lower secondary schools and polytechnic schools. Moderated talks have been organised in private contexts in order to get into contact with parents who cannot easily be addressed otherwise. New activities undertaken in the reporting period have focused on young people taking part in programmes of the Public Employment Service, as well as early detection and early intervention.

Problem Drug Use

According to the most recent prevalence estimates of problem drug use (which in Austria primarily means poly-drug use with opioids), in Austria the number of problem drug users was between 25 000 and 37 000 in 2009. Compared to other data, this permits the conclusion that the prevalence rates have remained at similar levels in recent years. Another estimate indicates between 12 5000 and 18 500 problem drug users in Austria, with injecting as their preferred mode of administration.

Drug-related Treatment: Treatment Demand and Treatment Availability

As the number of doctors delivering opioid substitution treatment has shown a decline, the supply situation has become very critical in several regions. At provincial level, remuneration agreements have been concluded and restructuring measures adopted in order to improve the situation, which has not always had the desired effect, however. While the amendment to the Narcotic Drugs Decree adopted in December 2009 has undoubtedly increased the acceptance of the regulations for opioid substitution treatment, it will not be clear before the end of 2010 whether this has improved the motivation of established doctors to deliver opioid substitution treatment. Generally speaking, a trend towards integrated addiction treatment and support services as well as individualised treatment has shown. Massive deficits are still found with regard to services for older drug users as well as young people, in particular in the field of inpatient treatment.

Recent data from treatment services confirm that opioids continue to predominate as primary drugs and that a significant share of clients tends to snort opioids when they start to use these substances. Further analyses of gender differences show that women, contrary to several sources, are not underrepresented in drug support and treatment centres. For women, the risk of developing patterns of problem drug use

seems to be smaller, and apparently their prognosis is better as far as quitting is concerned.

Health Correlates and Consequences

The data quality regarding drug-related deaths and infectious diseases continues to be a problem and hardly permits statements on trends. In order to improve the situation, uniform guidelines for autopsies have been prepared, but the problem that autopsies are not performed in all cases of suspected drug-related deaths still remains. In 2009, a total number of 187 directly drug-related deaths could be verified, but there is another 19 cases which may possibly be drug-related. First results are available regarding directly drug-related deaths (i.e. death caused by overdoses) among people entering opioid substitution treatment between 2000 and 2008: the mortality rate is between 4.6 and 6.9 deaths per 1 000 person years. The mortality rate of women is significantly lower than the mortality rate of men.

The harm reduction interventions undertaken have primarily focused on hepatitis vaccination programmes, on improved treatment of infectious diseases and on specific services for pregnant users of opioids (aimed at raising their awareness of their own state of health and reducing adverse effects on the babies' health).

Social Correlates and Social Reintegration

Drug users still face social problems such as homelessness and unemployment, and also high debts, but if specific measures are taken these problems could be reduced. In 2009, the focus was placed on finding employment in line with the clients' needs as well as linking addiction and housing services. Furthermore, additional spare-time activities were organised to promote social reintegration.

Drug-related Crime, Prevention of Drug-related Crime, and Prison

The number of reports to the police because of drug offences has increased in the reporting year, with a more pronounced rise showing with regard to misdemeanours compared to felonies. A massive increase is also found in temporary waivers of reports as well as alternatives to punishment, paralleled by a decline in convictions. In prisons, OST is the most important form of drug treatment: here a general rise in the number of prisoner in treatment has shown.

Drug Markets

Cannabis continues to be the predominant substance seized, while 'research chemicals' have played an increasingly important role in the party and clubbing scenes. These substances are not controlled but also have psychoactive effects, which are

hardly known. This makes it impossible to assess the risks of use of research chemicals. Another problem is that they are easily available through the Internet, which makes it difficult to restrict the supply. The purity of ecstasy has declined massively, and the drug-testing service *ChEck IT!* had to warn many users that the drugs they had bought contained dangerous ingredients.

Selected Issue: History, Methods and Implementation of National Treatment Guidelines

As a consequence of the federal structure of Austria's administration, many public health tasks and competences are provincial matters, thus no national guidelines for addiction treatment exist. Another reason is that in Austria, the discussion of the theme of national quality standards for medical treatment has started later than in other countries. Since 2005, the Act on the Quality of Health-care Services provides the legal basis for guideline production. Meanwhile, a metaguideline has been prepared (GÖG under preparation) which defines the process of drawing up guidelines. Apart from this process, which is still in its early stage, several guidelines and standards exist that are relevant for the implementation of addiction treatment in Austria. Many of them focus on substitution treatment, and some on specific themes and settings, as well as organisational aspects (guidelines for the announcement and funding of treatment centres). Research evidence is taken into account indirectly rather than systematically, while practical experience plays a predominant role.

Selected Issue: Costs of Drug-related Treatment

No recent cost studies or economic analyses of drug-related treatment are available for Austria. It is a fact, however, that the majority of funds for drug treatment and support services comes from public sources, with the largest part provided by the provinces. Apart from the federal and provincial governments, also local governments and the social security institutions provide funding for addiction treatment. It is not possible to give detailed estimates on expenditure as the budgets do not have specific drug-related items, and because of the complex financing mechanisms, only data on certain subareas are available.

Contents

- Summary III
- Introduction 1
- Part 1: New Developments and Trends**
- 1 Drug Policy: Legislation, Strategies and Economic Analysis 5
 - 1.1 Legal framework..... 5
 - 1.2 National action plan, strategy, evaluation and coordination 7
 - 1.3 Economic analysis 10
- 2 Drug Use in the General Population and Specific Target Groups 11
 - 2.1 Drug use in the general population 12
 - 2.2 Drug use in the school and youth populations 14
 - 2.3 Drug use among targeted groups/settings at national and local levels 16
- 3 Prevention 17
 - 3.1 Universal prevention..... 18
 - 3.2 Selective prevention in at-risk groups and settings 22
 - 3.3 Indicated prevention 25
 - 3.4 National and local media campaigns 26
- 4 Problem Drug Use 27
 - 4.1 Prevalence and incidence estimates of PDU 28
 - 4.2 Data on PDUs from non-treatment sources 31
 - 4.3 Intensive, frequent, long-term and other problematic forms of use..... 31
- 5 Drug-related Treatment: Treatment Demand and Treatment Availability 32
 - 5.1 Strategy/policy..... 33
 - 5.2 Treatment systems..... 35
 - 5.3 Characteristics of treated clients 44
 - 5.4 Trends of clients in treatment 50

6	Health Correlates and Consequences	54
6.1	Drug-related infectious diseases.....	55
6.2	Other drug-related health correlates and consequences	57
6.3	Drug-related deaths and mortality of drug users	59
7	Responses to Health Correlates and Consequences.....	64
7.1	Prevention of drug-related emergencies and reduction of drug-related deaths.....	64
7.2	Prevention and treatment of drug-related infectious diseases.....	66
7.3	Responses to other health correlates among drug users	69
8	Social Correlates and Social Reintegration	71
8.1	Social exclusion and drug use	71
8.2	Social reintegration	72
9	Drug-related Crime, Prevention of Drug-related Crime, and Prison	79
9.1	Drug-related crime	79
9.2	Prevention of drug-related crime	83
9.3	Interventions in the criminal justice system.....	84
9.4	Drug use and problem drug use in prisons	87
9.5	Responses to drug-related health issues in prisons	87
9.6	Reintegration of drug users after release from prison	88
10	Drug Markets	90
10.1	Availability and supply	90
10.2	Seizures	92
10.3	Price/purity.....	93

Part 2: Selected Issues

11	History, Methods and Implementation of National Treatment Guidelines	99
11.1	History and overall framework	99
11.2	Existing guidelines: Narrative description of existing guidelines	102
11.3	Implementation process.....	106

12	Cost of Drug-related Treatment.....	108
12.1	Funding sources.....	108
12.2	Cost of inpatient treatment.....	110
12.3	Cost of outpatient treatment.....	111
12.4	Cost of substitution treatment.....	112
12.5	Conclusions.....	113
	References.....	115
	Annex.....	141

Tables and Figures

Tables

Table 6.1	Data on hepatitis B, hepatitis C–Ab, hepatitis C–RNA and HIV infection rates, in 2009.....	56
Table 10.1	Assessment of the difficulty to obtain certain psychoactive substances (shares of answers from 'very easy' to 'fairly easy')	91
Table 10.2	Purity and price (EUR per gram/pill) of various drugs sold in the streets in 2009	95
Table 11.1	Austrian guidelines and standards for substitution treatment.....	103
Table 12.1	Estimated cost of inpatient hospital treatment of people with drug–related primary diagnoses, from 2001 to 2008	111
Table 12.2	Outpatients, estimated number of days of service delivery and funding sources, in treatment centres covered by DOKLI, in 2009.....	112
Table A1	Overview of selected general population surveys on drug experience among the Austrian population from 2004 to 2009	145
Table A2	Overview of selected youth surveys on drug experience among young people in Austria from 2001 to 2007.....	146
Table A3	Number of directly drug–related deaths in Austria by cause of death from 2000 to 2009.....	148
Table A4	Number of directly drug–related deaths in Austria by province from 2000 to 2009	148
Table A5	Number of directly drug–related deaths in Austria by age group and total by gender from 2008 to 2009.....	149
Table A6	Distribution of directly drug–related deaths in Austria by cause of death and age in 2009	150
Table A7	Distribution of directly drug–related deaths in Austria by cause of death and province in 2009.....	151
Table A8	Development of AIDS cases in Austria by risk situation from 2000 to 2009	152

Table A9	Distribution of reports of violations of the Narcotic Substances Act in Austria by first offenders and repeat offenders, development from 2000 to 2009.....	152
Table A10	Distribution of reports of violations of the Narcotic Substances Act (narcotic substances only) in Austria from 2000 to 2009.....	152
Table A11	Distribution of reports of violations of the Narcotic Substances Act in Austria by drug type from 2000 to 2009	153
Table A12	Distribution of reports of violations of the Narcotic Substances Act in Austria by drug type and province in 2009	153
Table A13	Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria from 2000 to 2009	154
Table A14	Final convictions under the Narcotic Substances Act (SMG) in Austria by age, gender and basis of conviction in 2009	154
Table A15	Final convictions under the Narcotic Substances Act (SMG), young people and adults, basis of conviction and type of punishment in 2009	155
Table A16	Development of alternatives to punishment applied in Austria from 2000 to 2009.....	156
Table A17	Number of seizures of narcotic drugs/substances in Austria from 2000 to 2009.....	156
Table A18	Seizures of narcotic drugs/substances in Austria by quantity from 2000 to 2009.....	157
Table A19	Ingredients of samples bought as ecstasy and analysed by the ChEck iT! project at parties and clubbing from 2000 to 2009.....	157
Table A20	Ingredients of samples bought as speed and analysed by the ChEck iT! project at parties and clubbing from 2000 to 2009	158
Table A21	Number of persons currently registered for substitution treatment in Austria in the BMG monitoring system by treatment/continued treatment and province in 2009.....	158

Table A22	Persons starting drug treatment or requiring addiction services in 2009, by age and gender; percentages	159
Table A23	Persons starting drug treatment or requiring addiction services in 2009, by gender and livelihood, percentages.....	160
Table A24	Persons starting drug treatment or requiring addiction services in 2009, by place of residence and gender; percentages	161
Table A25	Persons starting drug treatment or requiring addiction services in 2009, by present housing situation and gender; percentages	162
Table A26	Persons starting drug treatment or requiring addiction services in 2009, by primary drug and gender; percentages	163
Table A27	Persons starting drug treatment or requiring addiction services in 2009, by injecting drug use and age; percentages	164
Table A28	Exchange and use of syringes by provinces in 2009	164
Table A29	Current health problems of clients of Vienna's drug treatment and support centres (BADO), 2004–2008	165
Table A30	Become Independent, school year 2009/10	166
Table A31	The plus programme, school year 2009/10	167
Table A32	movin, 2009.....	168
Table A33	Selected prevention activities in different settings.....	169
Table A34	Austrian population statistics by age group and gender in 2009	171

Figures

Figure 1.1	Overview of the organisational structure of drug policy in Austria	9
Figure 2.1	Lifetime experience of illicit drug use among the general population according to gender, place of residence and educational level (percentages).....	13
Figure 2.2	Experience of cannabis use among school students: lifetime use, 30-day prevalence, 12-month prevalence and regular use by age, gender and region (percentages)	16

Figure 4.1	2-sample CRC estimates with and without correction for ghost cases, 2001–2009.....	29
Figure 4.2	2-sample CRC estimates with correction for ghost cases, 2001 to 2009 (age stratified)	30
Figure 5.1	Number of people entering drug treatment in 2009, by age and type of service.....	45
Figure 5.2	People entering drug-related treatment, by primary drug and type of service	46
Figure 5.3	Preferred form of use of heroin (n = 2 237) and cocaine (n = 2 440) among people entering long-term outpatient treatment in 2009, by age.....	47
Figure 5.4	Share of women registered in the DOKLI system, undergoing OST, among people reported to the police because of opioid offences, in the 2009 prevalence estimate and among drug-related deaths 2007–09, respectively; percentages	48
Figure 5.5	Age distribution of men and women registered in the DOKLI system, among people undergoing OST, among drug-related deaths and among people reported to the police because of opioid offences, respectively (percentages)	49
Figure 5.6	Development of annual reports of the number of people currently undergoing OST in Austria, by first treatment and continued treatment, 2000–2009	50
Figure 5.7	First substitution treatment in life, by age, 2000–2009	52
Figure 5.8	Trends regarding substitution substances used for first treatment, 2000–09, percentages.....	53
Figure 6.1	Share of directly drug-related deaths in Austria, by cause of death, 2000–2009	60
Figure 6.2	Age distribution of directly drug-related deaths in Austria, percentages; 2000–2009.....	61
Figure 6.3	Directly drug-related deaths per 1 000 person years of men, women and total number, of people entering OST for the first time in the period between 1 January 2000 and 31 December 2008.....	62
Figure 7.1	Syringe exchange and syringe sales in Austria; 2005, 2007 and 2009	67

Figure 9.1	Development of reports relating to violation of the Narcotic Substances Act, by misdemeanours and felonies in Austria, 2000–2009	80
Figure 9.2	Development of reports relating to violation of the Narcotic Substances Act in Austria by type of substance, 2000–2009	81
Figure 9.3	Convictions according to Sections 27 and 28 of the SMG in Austria, 2000–2009	82
Figure 9.4	Results of examinations by district administration authorities according to Section 12 of the SMG, by primary drug, percentages, 2004–2007.....	84
Figure 9.5	Development of statutory alternatives to punishment applied in Austria from 2000 to 2009	85
Figure 9.6	Comparison of the index–related development of reported drug offences, convictions and application of statutory alternatives to punishment in Austria, 2000–2009	86
Figure 10.1	Number of seizures of narcotic drugs and psychotropic medicines in Austria, 2000–2009.....	93

Maps

Map 5.1	Specialised providers of inpatient treatment services for drug users and addiction patients, 2010	37
Map 5.2	Specialised providers of outpatient treatment services for drug users and addiction patients, 2010	38
Map 7.1	Specialised low–threshold providers of harm reduction services for drug users, 2010.....	65
Map 8.1	Specialised providers of inpatient and outpatient drug support services focusing on social (re)integration	74
Map A1:	Overview of provinces, provincial capitals and districts	172

Introduction

This is the 15th time that the REITOX Focal Point at GÖG/ÖBIG (Austrian Health Institute) presents its annual report to the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and the Austrian Federal Ministry responsible for health affairs. The REITOX Focal Point is a central link in Austria's data and information network of drug-related matters and closely cooperates with the relevant federal and provincial authorities in this field as well as addiction and drug treatment and support centres.

This report deals with illicit drugs and serves both as a national report on the situation in Austria and as Austria's contribution to describing the drug situation in the European Union (EU). Similar reports are submitted by the REITOX Focal Points in all EU member states and by the EU candidates, according to guidelines issued by the EMCDDA. These reports are essential as a basis of the EMCDDA's Annual report on the state of the drugs problem in Europe (latest publication: EMCDDA 2009).

Part A of this report discusses new developments and trends with regard to the drug policy framework, the epidemiological situation and health-policy interventions aiming at demand reduction. It is based on previous reports (latest previous report: GÖG/ÖBIG 2009b) and refers to the reporting period from summer 2009 to summer 2010, while routine statistics refer to the year 2009. In Part B of the report, two selected issues are presented in more detail. In the present report the corresponding chapters deal with the history, methods and implementation of national treatment guidelines as well as the cost of drug-related treatment. The Annex includes a number of additional tables with detailed information and data.

Every year the REITOX Focal Points also submit to the EMCDDA annual standard tables and structured questionnaires. These data and information have also been integrated in this report, with references to these sources given in the text. For an overview of all standard tables (= ST) and structured questionnaires (= SQ) please consult Annex C.

This report is based on many different data and information communicated to GÖG/ÖBIG by various experts in the field of drugs. In this respect, the reports on the drug situation in the individual Austrian provinces drawn up by the Drug Coordination and Addiction Coordination Offices have been especially significant. In addition, a number of experts provided background information and specific data for individual chapters of this report (see Selected Issues). We would like to express our gratitude for their cooperation.

We are especially indebted to the members of the advisory working group of the REITOX Focal Point Austria for their helpful comments and invaluable input.

Part A

New Developments and Trends

1 Drug Policy: Legislation, Strategies and Economic Analysis

Since 1998 the Narcotic Substances Act (SMG), as amended in December 2008, has constituted the main framework of Austria's drug policy. The SMG primarily focuses on quantities and not on kinds of substance — with the exception of a special provision concerning cannabis and mushrooms containing psilocin, psilotin or psilocybin — and provides a wide range of alternatives to punishment. At the federal level the central actors in the field of drug policy include the Federal Drug Coordination Office and the Federal Drug Forum, which coordinates policies with the provinces (see Figure 1.1). Due to the federal structure of Austria's health and social care system, the provinces play important roles with regard to the adoption and implementation of drug policy measures. All nine provinces have drawn up drug strategies or addiction plans and nominated Drug or Addiction Coordinators. For a detailed discussion of the political and organisational framework please consult SQ32.

Drug policy measures are financed primarily by the Provincial Governments, the social insurance funds and the Federal Government. The COFOG classification¹, which is promoted by the EU, has not fully been implemented in Austria, and in the individual budgets expenditure related to drugs or addiction is hardly specified (see GÖG/ÖBIG 2007b). Therefore, no conclusive statements regarding expenditure in this field can be given for Austria.

1.1 Legal framework

December 2009 saw a modification of the legal basis for opioid substitution treatment (OTS). The amended provisions aim at a balance between aspects of security on the one hand and treatment on the other, in line with the recommendations of a working group composed of the regional Drug and Addiction Coordination Offices, which assessed the effects of the amended legal framework that entered into force in 2007 (see GÖG/ÖBIG 2007b and 2009b).

1

COFOG, or Classification of Functions of Government (public expenditure broken down by areas of activity) comprises ten divisions, which are further divided into groups and classes. In Austria, only expenditure according to the 10 COFOG divisions, without groups and classes, is available.

The amendment to the Narcotic Drugs Decree (BGBl II 2009/485 v. 23. 12. 2009) primarily regulates changes of the conditions for take-home substitution medicines as well as the requirement to obtain a second opinion for indication and diagnosis (see also Chapter 5.1).

Section 23a regulates diagnosis and indication, among other aspects. The most relevant changes are the following:

- » A modification of the regulation that in the case of patients younger than 20, the attending doctor shall obtain a second opinion if necessary: now, this consultation does not have to take place before the start of treatment but may also be scheduled in the course of the diagnostic process, but before the start of regular administration of medicines (Para. 5).
- » In the case of patients younger than 18, experts in the new specialised discipline of child and youth neuropsychiatry shall be consulted whenever possible so that, for the purpose of indication, a second opinion may be obtained from the field of child and youth (neuro)psychiatry as an alternative to a psychiatrist's opinion (Para. 6).

Section 23e lays down the conditions for dispensing substitution substances that patients may take at home:

- » In the case of buprenorphine patients may get a maximum of seven daily doses at once and do not have to take them under supervision in the pharmacy (Para. 1).
- » In the case of a change of attending doctor, the period of past treatment may be taken into account so that patients do not again have to wait for the required minimum period before they are allowed take substitution substances at home (Para 3).
- » If several daily amounts of substitution substances are dispensed because of temporary absence (in particular holidays), an annual maximum of 35 daily doses (in terms of calendar days) shall not be exceeded (Para. 4).
- » In addition to exceptions that are subject to special regulations, it has now become admissible to depart from the requirement of daily supervised administration but only for reasons that deserve special consideration, in particular therapeutical reasons, and in agreement with the attending doctor and the public health officer in charge (blanket clause, Para. 5).

Another new development is that matters of opioid substitution treatment may be deliberated by either the Committee on Quality and Security or the Federal Drug Forum and that the Addiction or Drug Coordination Offices and the Provincial Governments of all provinces are represented in the Quality and Security Committee, which makes it easier to take into account the regional differences in organisational structures with regard to OST.

The most relevant changes resulting from the amendment to the Oral Substitution Further Training Decree (BGBl II 2009/487 v. 23. 12. 2009) include the following (see also Chapter 5.1):

- » Regarding requirements for further training, now a distinction is made between doctors in charge of indication and doctors who only deliver continued OST (Section 1, Para. 1): the basic further training required for doctors who only continue treatment has been reduced from 40 to six training units; however, for intensified further training, six units per year are required also for the latter group (Section 3, Para. 1a).
- » Public health officers who have not undergone this further training are allowed to approve prescriptions of substitution substances only if it is not possible to consult another, qualified public health officer, and only under supervision (of another public health officer), for a maximum period of six months. Another requirement is that they have to start basic further training immediately and furnish proof of having concluded at least half of the training units within six months (Section 1, Para. 4).

Late in August 2010, the Narcotic Drugs Decree was amended: since then, also 4-methylmethacathinone (mephedrone) and levo-(R(-))methadone (Polamidone) have been classified as narcotic substances (BGBl II 2010/264 v. 20. 8. 2010). Before, mephedrone had been sold as a legal alternative to ecstasy, amphetamines and cocaine (see Chapter 10.3), but there were indications that this substance had strong psychoactive effects and possibly also undesirable cardiovascular effects. In August 2010 another amendment to the Oral Substitution Further Training Decree was drafted and presented to experts for assessment. This amendment focuses on maintaining a central list of doctors qualified for administering OST on a secure website of the Federal Ministry of Health (BMG).

1.2 National action plan, strategy, evaluation and coordination

The political and administrative framework (see SQ32) has not seen major changes in the reporting period. The Federal Drug Forum (see Fig. 1.1) held two regular meetings in the relevant period (November 2009, April 2010). The points on the agenda included an evaluation of the framework for opioid substitution treatment (see Chapter 1.1), improvements in the documentation of drug-related deaths, harm reduction measures and funding of drug treatment and support centres (see also Chapter 12). The working group convoked by the Federal Drug Forum to draw up guidelines for a nationwide uniform implementation of Section 12 of the SMG (see GÖG/ÖBIG 2008c) and the steering group discussing possible ways of reducing the number of drug-related

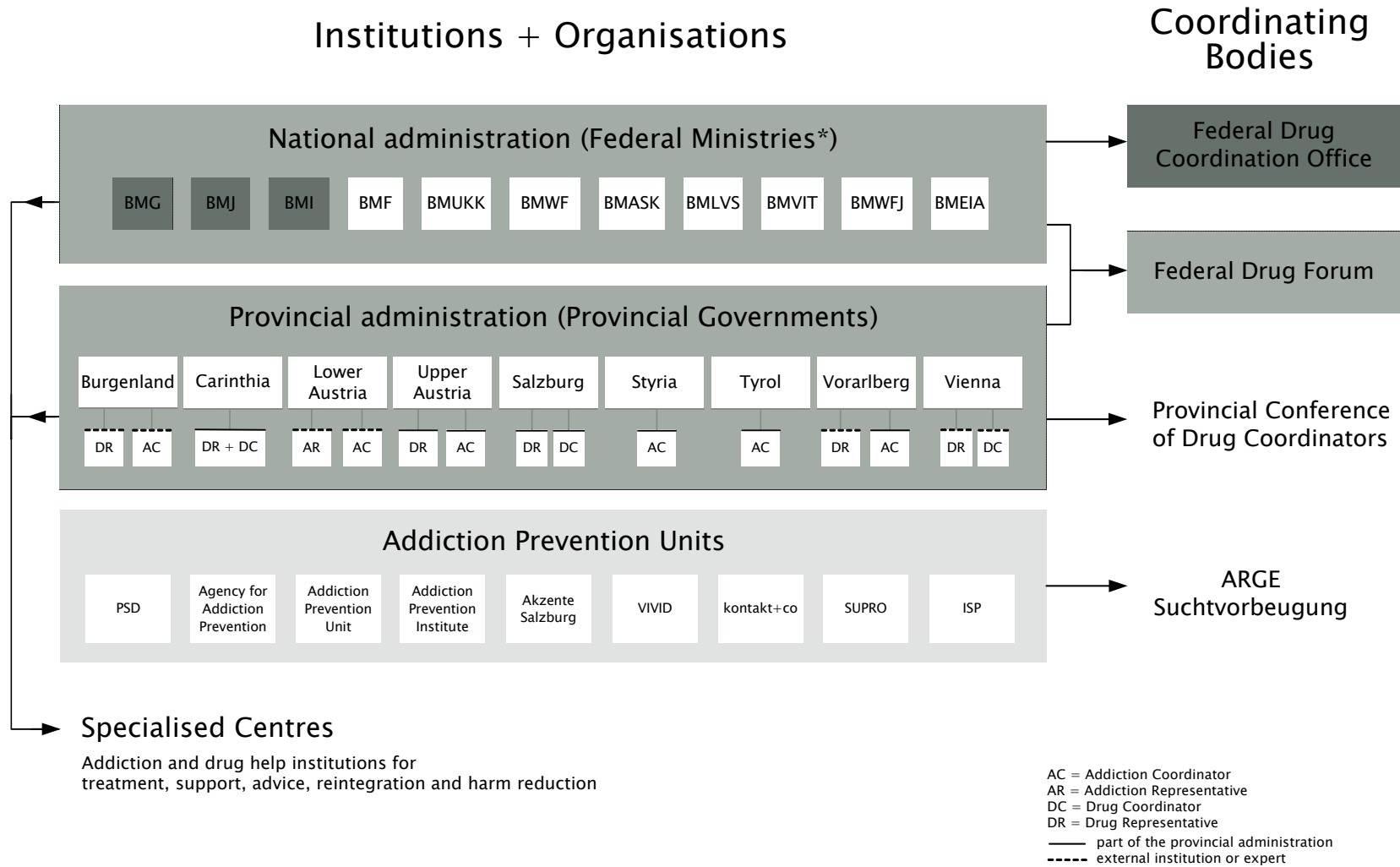
deaths (see GÖG/ÖBIG 2009b) continued their activities. In addition, a working group focusing on federal funding of drug treatment centres was established (see also Chapter 12.1).

The theme of measures to reduce the number of drug-related deaths in Austria (see also Chapter 7.1) was also discussed in an extraordinary meeting of the Federal Drug Forum on 15 October 2009, with input provided by numerous national and international experts. Furthermore GÖG/ÖBIG, on behalf of the Federal Ministry of Health, drew up a position paper on health policy measures aimed at harm reduction in drug-related interventions, which is now being discussed by the Ministry of Health and by the Provinces. In May 2010 the Ministry of Health organised a hearing on opioid substitution treatment (see Chapter 5.2).

A number of provinces have started, or are planning, to review their drug and addiction policy approaches. The addiction plan of Upper Austria as well as Styria's addiction strategy paper (see GÖG/ÖBIG 2009b) have already been drafted but have not yet been adopted by the respective Provincial Governments. In the Tyrol, an analysis of social environments was carried out to serve as a basis for a new addiction strategy paper, the preparation of which will soon be started. Lower Austria's addiction plan will expire in 2010 and a new addiction plan will be decided upon by the Provincial Government in autumn 2010. It will include a position paper outlining basic approaches to the issue of addiction in Lower Austria on the one hand, and a set of measures for the period from 2011 to 2015 on the other (Hörhan, personal communication). In Carinthia, the Addiction Advisory Board was asked to prepare a proposal for the implementation of harm reduction measures with special regard to regional demand. The proposal will be available by autumn 2010.

Also in Carinthia, as a response to critical media coverage of OST, an 'addiction summit' was held on 21 June 2010: it was agreed that opioid substitution treatment evidently is an essential aspect of health care for drug patients and that the specific demands of young clients should be taken into account at all levels of care (Prehslauer, personal communication).

Figure 1.1
 Overview of the organisational structure of drug policy in Austria



* see List of Abbreviations

Source: GÖG/ÖBIG; representation by GÖG/ÖBIG

In the reporting period, no new developments in drug policy regarding new forms of services took place. Vienna, however, discusses intravenous substitution as a possible treatment option, and a feasibility study on this subject is under preparation (see APA 2010). The discussion of legal, political and technical aspects of the plan to establish a drug treatment point in Graz, the capital of Styria, has continued (see GÖG/ÖBIG 2009b and Chapter 7.2). At federal level, the Ministry of Health asked the Superior Public Health Council to review this plan from a scientific point of view. The pertinent discussions have not yet been concluded. At present, the City Government of Graz does not press this matter. The Green Party contributed to the discussion of consumption rooms by organising an expert hearing on standards for the treatment of drug patients (Graz, 1 February 2010).

A new publication presents an analysis of the development and (political) control of Vienna's drug services (Eisenbach–Stangl et al. 2009; see also Chapter 5.2), underlining that in Vienna, drug policy has traditionally been oriented towards the social integration of drug users and drug addicts. Vienna's Drug Coordination Office has always closely cooperated with the Government of the City of Vienna. Decisions on drug and treatment strategies, which are aimed at consensus, have focused on drug policy aspects, and only in recent years have economic factors also been taken into account to a greater extent.

The Ludwig Boltzmann Institute for Addiction research, an institution of international renown affiliated to the Anton Proksch Institute, was closed by the end of 2009, after 36 years of activity. On 20 and 21 November 2009, a conference was held in Vienna as a concluding event. Its focus was placed on the methods of addiction research: controversy over facts, trends and ephemera. As of 2010, drug-related research has been continued by the new Department of Documentation and Research of Addiction Prevention at Anton Proksch Institute.

1.3 Economic analysis

The financial regulations in the field of drugs did not see changes in the reporting period. For an overview of the present situation please consult SQ32. The selected issues chapter of this report (see Chapter 12) provides further details on funding drug-related treatment. Regarding budgets, no conclusive statements may be derived as most budgets do not specify drug-related items.

2 Drug Use in the General Population and Specific Target Groups

In 2004 and 2008 two representative studies focusing on alcohol, tobacco and drugs, financed by the Federal Ministry of Health, were carried out. These studies are the most important data sources available regarding drug use in the population. The drug parts of the questionnaires correspond to the guidelines of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The data on school populations have been obtained from the ESPAD surveys (conducted as of 2003). In Vienna, the time series of surveys concerning drug use go back to the year 1993. In addition, regional surveys and studies have repeatedly been carried out for specific settings. Regarding drug use in certain youth scenes, data gathered by the secondary prevention projects *MDA basecamp* and *ChEck iT!* provide useful information.

As to prevalence of drug use, a distinction is made between lifetime prevalence (drug use at some point in life), 12-months prevalence (drug use in the past year) and 30-day prevalence (drug use in the past month). Statements on current drug use can only be derived from 12-month or 30-day prevalence rates.

In Austria, experience of illicit drug use primarily concerns cannabis, with prevalence rates of approximately 30% to 40% among young adults. According to the majority of representative studies, experience of ecstasy, cocaine and amphetamines is found among approximately 2% to 4% of the population, and experience of opioids is between around 1% and a maximum of 2% (see Tables A1 and A2 in Annex A). In recent years, the range of substances taken in the context of experimental use has widened. In certain scenes and groups of young people, high prevalence rates for a variety of substances are found, including biogenic drugs as well as solvents and inhalants. As a rule, use of illicit substances is limited to a short period in life in most cases, however.

2.1 Drug use in the general population

No new data on drug use in the general population are available. The reporting period saw the publication of the final report on the second representative general population survey² on prevalence and patterns of use carried out in 2008 on behalf of the Federal Ministry of Health (Uhl et al. 2009). The most important results regarding prevalence of drug use (see Table A1 in Annex A) have already been given in the report of last year (see GÖG/ÖBIG 2009b). Below, a number of interesting details included in the final report have been summarised.

Experience of drug use depends on age, gender, place of living and education. In the younger age groups, lifetime prevalence rates are higher for almost all substances compared to older groups, with the highest shares found among young adults (20 to 24 years). For instance, lifetime prevalence rates for cannabis show a rise from 21% (15 to 19 years) to 26% (20 to 24 years), then they go down continually to around 16% (25 to 29 years as well as 30 to 39 years) and finally 4% (60 to 69 years).

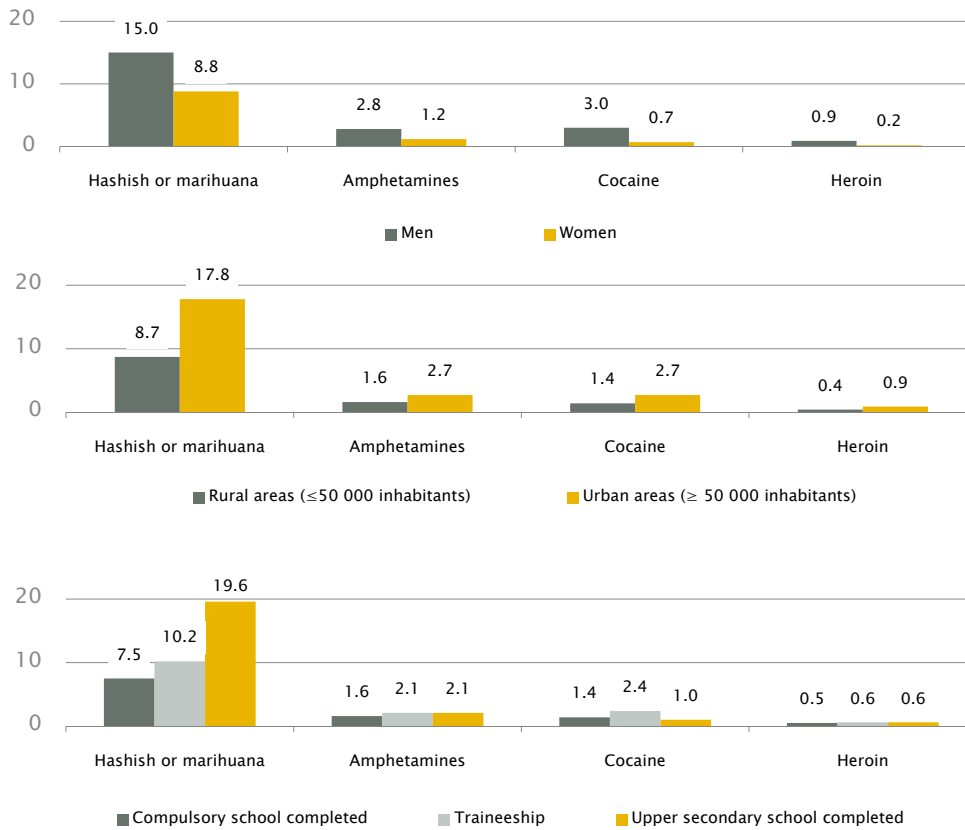
Men indicate lifetime experience of illicit substances more often than women. Inhabitants of urban areas (more than 50 000 inhabitants) show higher prevalence rates than people living in rural areas. In the case of most substances, the prevalence rates also rise parallel to levels of education: people who have completed compulsory school only, indicate experience of drugs, especially cannabis, less often than people who have completed traineeships or upper secondary school (see Figure 2.1).

2

In the context of this survey, a total of 4 196 people over 14 were interviewed with regard to their experience of use of legal as well as illicit psychoactive substances. 50% of respondents were in the age group from 15 to 24 (oversampling of young people/young adults). In the analyses regarding overall population, this oversampling was balanced by means of weighting. For details on the methodology of the survey please consult the report of last year (GÖG/ÖBIG 2009b) or the aforementioned final report (Uhl et al. 2009).

Figure 2.1

Lifetime experience of illicit drug use among the general population according to gender, place of residence and educational level (percentages)



Source: Uhl et al. 2009; representation by GÖG/ÖBIG

With regard to long-term trends, the study confirms an equalisation of gender differences and an acceleration effect: the share of women in the group of people with experience of cannabis is higher in younger age groups than among older groups, which indicates that gender differences in patterns of cannabis use are decreasing. A comparison of different age cohorts also reveals that the age of first use of cannabis is lower in the younger age groups compared to the older age groups. This is referred to as an acceleration effect, because a younger age of first use reflects the fact that (physical) maturity takes place earlier in young people today than in the past, and as a consequence, they start to behave like adults also at an increasingly younger age.

The quitting rate³ is considerably higher for all illicit substances than for alcohol (10%) and nicotine (38%) and is around 80% also regarding cannabis (exceptions show in the case of LSD and biogenic drugs: approx. 90%, as well as cocaine: approx. 60%). This confirms that use of illicit substances is a temporary phenomenon in the case of most people and typically limited to adolescence and young adulthood.

In the survey, people who had used cannabis in the past 12 months were also asked if they had problems related to cannabis use and to specify which problem indicator applied (difficulty to stop using the drug, worried because of drug use, cannot control drug use). For each indicator, at least four out of five respondents said that they 'hardly ever' had the problem in question.

It has already been mentioned in last year's report (GÖG/ÖBIG 2009b) that certain data of the survey do not seem to be plausible, because a comparison of the surveys conducted in 2004 and 2008 reveals such an extraordinary decline in lifetime prevalence rates that it is ruled out by logic. As other studies (see GÖG/ÖBIG 2008c) have confirmed a trend towards stronger objections and more repressive attitudes to drugs and drug policies, a likely assumption is that the willingness to admit illicit drug use in an interview has gone down (Uhl et al. 2009). A national REITOX Academy has been planned to take place in autumn 2010, where the issues of data reliability and possible solutions will be discussed. At any rate, the prevalence rates indicated in the survey definitely seem to be too low. While caution is advised when interpreting the available data, they seem to be plausible at least at a qualitative level (e.g., regarding differences according to age and gender).

2.2 Drug use in the school and youth populations

Regarding drug use among young people, no new data are available either, but to complement the prevalence rates given already in 2008 (GÖG/ÖBIG 2008c; see Table A2 in Annex A) a number of detailed results from the final report on the 2007 ESPAD study⁴ (see Strizek et al. 2008) are worth mentioning.

3

Share of former drug users among all people indicating past or present drug use.

4

In 2007 Austria took part in the ESPAD study (European School Survey Project on Alcohol and other Drugs) the second time after 2003 (see Uhl et al. 2005b). A total of 277 classes with 5 959 school students in the 9th and 10th grades were asked to complete questionnaires on experience of use. The Austrian ESPAD study was funded by the Federal Ministry of Health, Family and Youth.

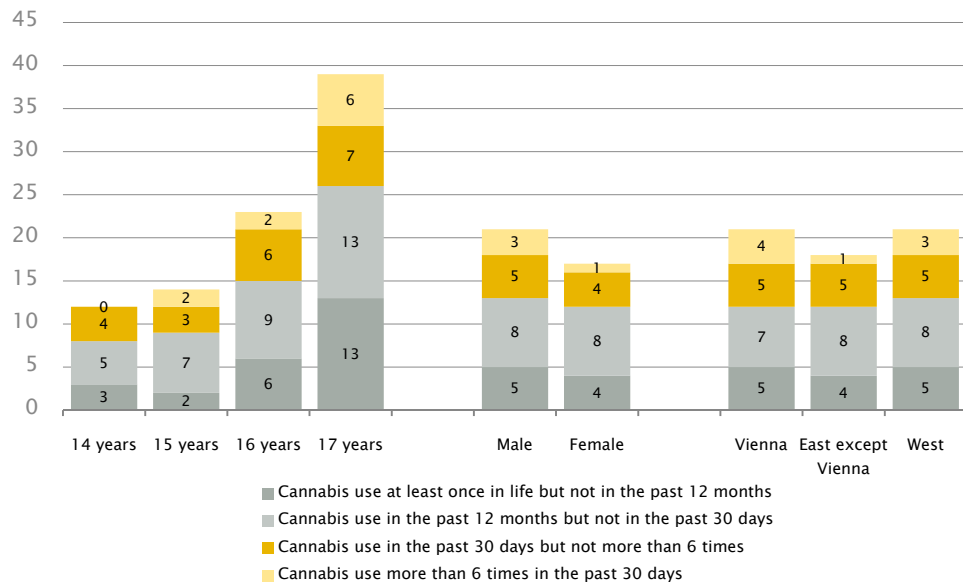
Differences according to gender and region also show among young people: the consumption rates are higher among boys/young men than among girls/young women — and boys considerably more often also indicated use of an inexistent drug named re Levin, which was included in the survey for control purposes. For almost all illicit substances, the prevalence rates are highest in western Austria followed by Vienna, and the lowest prevalence rates are found in eastern Austria except Vienna. The results regarding differences depending on type of school attended do not show specific trends.

Use of cannabis was analysed in more detail as also regular use (i.e., more than six times in the past 30 days) was included in the survey. A total of two percent of respondents indicated regular use, and among adolescents under 14, it was hardly ever found. Again, the prevalence rates were broken down by gender, age and region (see Figure 2.2), with similar shares of cannabis use showing for both Vienna and western Austria.

In addition to the written questionnaire, a validation study was carried out on the basis of 100 qualitative interviews with a random sample of young people who had completed the questionnaire (see Schmutterer et al. 2009). It showed that many of the terms used in the survey were vague and not precise enough, and that the young people did not understand all of them. The questionnaire was long, it included very complex questions, and in some cases the answers among which to choose did not fully meet the questions asked. Therefore the respondents' motivation, which was high in the beginning, tended to decline in the course of completing the survey: they grew less concentrated and thus their answers became less exact. It is recommended in the study to improve the questionnaire, which should also include a critical review of the terms used.

Figure 2.2

Experience of cannabis use among school students: lifetime use, 30-day prevalence, 12-month prevalence and regular use by age, gender and region (percentages)



Source: Strizek et al. 2008; representation by GÖG/ÖBIG

2.3 Drug use among targeted groups/settings at national and local levels

No new data on drug use among specific groups are available. *Check iT!* (see Chapter 10.3) carried out an online survey, the results of which have not yet been published, however.

3 Prevention

Following the EMCDDA classification of prevention, this chapter has been divided into universal prevention, selective prevention and indicated prevention⁵. However, in practice the terms of primary and secondary prevention⁶ continue to be used to some extent as this classification is regarded to be less stigmatising. In Austria, the corresponding programmes are primarily implemented at local and regional levels, in accordance with expert consensus. In this context, the provincial Addiction Prevention Units (see Figure 1.1), the Addiction Prevention Forums of Salzburg and Vienna as well as regional coordination and control bodies (Salzburg) play important roles. As a rule, prevention measures are oriented towards long-term effectiveness and sustainability, which is aimed at primarily by means of training programmes for multipliers. In line with Austria's comprehensive approach to addiction, many prevention measures are not aimed at specific substances but also encompass forms of addiction that are not related to substances. In recent years, specific interventions concerning legal substances (alcohol and nicotine) as well as forms of addiction that are not related to substances (e.g., compulsive gambling) have become increasingly important. However, this report focuses on unspecific measures or interventions specifically aiming at illicit substances.

In addition to a number of standard programmes carried out at nationwide level, in recent years also numerous regional activities have routinely been initiated and advanced (see Tables A30 to A33 in Annex A). Current prevention measures taken are

5

Universal prevention is aimed at large groups of the population (e.g., school communities, towns) that, independent of the individual situation, are equally likely to develop patterns of substance use. Selective prevention focuses on smaller groups that, due to biological, psychological, social or environmental risk factors – independent of the individual situation – are more likely to develop patterns of substance use than the general population (e.g., children of addicted parents). Indicated prevention addresses individual persons who already show early signs of substance use or problem patterns of behaviour that are associated with drug use but do not yet meet the criteria for a diagnosis of dependence and for whom the risk of developing addictive behaviour is thus particularly high. A requirement for indicated prevention is that medical experts have already diagnosed mental, conduct or behavioural disorders that are known to constitute risk factors regarding the development of addictive behaviour, e.g., attention deficit hyperactivity disorder (ADHD).

6

Primary prevention aims at avoiding the development of a disease, in this case, an addiction disease, already before drug use or drug problems have arisen. Secondary prevention addresses drug users who definitely have problems, which have not yet become manifest to their full extent, however.

described on the individual websites and in the annual reports and newsletters of the Addiction Prevention Units, the Ministry of Education (BMUKK), GÖG/FGÖ and other relevant actors, as well as in previous reports on the drug situation and in the Best practice portal of the EMCDDA (see Bibliography). Furthermore, new strategies and approaches have continually been developed in order to optimise the quality of prevention activities and to take into account to a greater extent the specific needs of individual target groups and different settings. Due to the great number of activities at regional level, only certain selected examples can be described in this report.

Other activities of the Addiction Prevention Units that are worth mentioning include network building and public relations work, (financial) support of prevention initiatives and organising further training events for experts.

3.1 Universal prevention

For an overview of Austria's universal prevention activities and the general framework of prevention please consult SQ25. **Schools** play important roles as settings of implementation. Here, prevention takes place on a statutory basis in the context of the educational principle of health promotion⁷. It is recommended that prevention measures at schools involve all stakeholders of the school community as well as regional addiction experts. On this basis, training courses on prevention and further training events are organised, teaching materials and projects are prepared and all stakeholders are offered practical assistance in planning and implementing prevention activities. These activities are primarily aimed at awareness raising and health promotion approaches in the entire system and increasing life skills among students. In the older age groups, often patterns of use are also discussed.

In the reporting period, the Federal Ministry of Education (BMUKK) developed a new strategy, which, motivated by the UN Decade of Education for Sustainable Development (2005–14), combines environmental education and health promotion (BMUKK 2010). There are several commonalities between the two well-established fields of ecologic development of schools and education for sustainability on the one hand and healthy schools as well as health promotion in schools on the other (for instance, the themes

7

Health promotion, in accordance with the Ottawa Charter of the WHO, is understood as the process of enabling people to increase control over, and to improve, their health, i.e., to reach a state of complete physical, mental and social well-being.

of diet and exercise or mobility) and they follow similar approaches, such as ensuring a good atmosphere at school and also integrating stakeholders outside schools⁸. By linking these two areas, projects across different school subjects may be initiated and promoted, and synergy, e.g., with regard to (further) training of teachers and heads of school may be developed.

In Styria, prevention measures in schools are promoted by providing support for planning and implementing school projects aimed at preventing addiction, run as part of VIVID's *PROBE* programme for project-based prevention (VIVID 2010). *PROBE* projects have a minimum duration of one week and consist of several modules (e.g., basic knowhow on addiction and prevention). One theme is prepared in a workshop by VIVID workers in cooperation with the students.

Theatre education continues to be an essential part of prevention activities in Lower Austria: the Addiction Prevention Unit and Team Sieberer rehearsed a new play for primary school students: *Herr Anders* (Mr Different), which was presented in February 2010 (Hörhan, personal communication). It treats the issues of excessive consumerism, the atmosphere at school, responses to conflicts, spare-time activities and friendship. As in previous plays, the performance is combined with an obligatory information event for parents and an optional educational conference for teachers.

The trend to combine the prevention of addiction and the prevention of violence has continued (see GÖG/ÖBIG 2008c). The Addiction Prevention Institute of Upper Austria drew up guidelines for the prevention of addiction and violence, and a platform for preventing violence was established as an additional link between experts in addiction prevention and the police (Institut Suchtprävention 2009). The child and youth advisory office (Kija) and the school psychologists' service are also represented in the platform. This makes it possible to coordinate the individual services for promoting life skills among school students. In the province of Burgenland, the project *Los — check dein Leben* (Come on — get a hold on your life) was started, which also combines the prevention of addiction and of violence. It has been run since autumn 2009 by the Addiction Prevention Unit, in cooperation with the police, Kija and the Provincial School Board (Hausleitner 2010). It comprises five modules of three teaching units each and is implemented in the course of one semester.

There are several sources indicating that the risk of developing patterns of addiction

8

For further information see www.dekadenschulnetzwerke.at (27 May 2010; website in German).

behaviour is elevated for children in lower secondary schools and polytechnic schools compared to students attending upper secondary school, therefore more programmes specifically targeting these young people have been prepared. In addition, there is demand for services that respond to specific demands of individual schools. For instance, the programme *Think about it* by the Dialog association, which was started in Vienna in 2009, addresses these types of schools (Dialog 2010b). Vocational schools have increasingly become interested in prevention activities as well. A new project specifically targeting such schools has been available, which combines the aspects of promotion of life skills, personal approaches to drugs and risk competence.

The prevention activities targeting **kindergartens** and **families** have been continued. They include further training programmes, provision of information materials and information events for parents. The first results of Salzburg's project *FamilienBande* (Family ties) confirm that the approach chosen has worked (see GÖG/ÖBIG 2009b): the theme of adolescence met with much interest on the parts of parents and helped motivate them to take a closer look at prevention (Rögl, personal communication.) SUPRO, in cooperation with the Catholic Adult Education Programme, started the *eltern.chat* (parents' chat) project (Stiftung Maria Ebene 2010). Similar to the project of Salzburg, it focuses on moderated talks in private contexts. A short introduction to frequent issues occurring in everyday family life is given to stimulate the discussion about one's own experience. The main goal is empowerment and finding strategies to overcome problems. ARGE Suchtvorbeugung (Working Group for Addiction Prevention) published a new booklet as part of a series, which focuses on providing information on cannabis for the target group of parents. It gives an overview of this issue and also provides specific legal information and tips for responding to young people who use cannabis (kontakt+co 2009).

ARGE Suchtvorbeugung, in particular the VIVID and SUPRO Addiction Prevention Units, developed *Präventino*, a three-year model project aimed at prevention activities in kindergartens (VIVID 2010). However, the necessary funding for implementation has not yet been secured.

In Styria, a new target group has been addressed: three workshops were held for the Childminders' Association (VIVID 2010), with the focus placed on knowhow regarding the effects of bonding on children's psychosocial development as well as evasiveness and addiction within the family.

The majority of prevention measures taken at the **workplace** aim at preventing trainees from developing patterns of addiction behaviour, in particular by means of awareness raising and guidance for action. However, there are also interventions aimed at preventing the development of addiction or finding ways to address adult workers at risk of becoming addicted. In this context, drinking, not illicit drug use, is a pre-dominant issue. In Styria a new booklet on prevention in the context of traineeship was

published, which addresses trainers: its title is *Auf Zack!* (In top form; VIVID 2010). In addition, a specific package for enterprises is available, which includes both a training event for trainers and a workshop for trainees. In the context of the PIB project for prevention in enterprises in the Tyrol, after a request by trainers, five scenarios (e.g., hung-over at work after excessive recreational drug use or suspected drug use) and guidelines for action were drawn up (kontakt+co 2009). As of the beginning of 2010, a compact course for trainees, another compact course for trainees and trainers, as well as a theatre education workshop may be booked.

In Salzburg, the prevention activities targeting **young people** focused on the workshop *AngeRAUSCHt* (Half geared-up), which started in 2009. The workshop is also one of the modules of the project *Zeast üben, donn losdüsen!* (Practice before driving off!; (Akzente Fachstelle Suchtprävention 2010). This project is combined with other modules such as a safer driving training, which makes it very attractive to young people. In Styria, meanwhile also the Provincial Boy Scouts and Girl Scouts Association as well as Styrian District Youth Managers have become involved in these activities (VIVID 2010).

The trend towards prevention activities at **community** level has continued. Apart from awareness raising among the general public, initiatives in this field also aim at defining and implementing concrete measures oriented towards the special situation of the region in question. In the city of Salzburg, the *PräventionsFrühstück* (Prevention Breakfast) initiative (see GÖG/ÖBIG 2009b) turned out to be very attractive so that other regions also showed interest and began to organise similar activities, e.g., AfterNetwork (Rögl, personal communication). The work of the regional steering groups has also shown first results: in two districts, introductory events on innocuous v. infernal cannabis were organised in cooperation with schools and presented by means of forum theatre methods. Then working groups on this theme were established, and in spring 2010 a one-day workshop for youth social work was held. After discussing ways of restructuring the regional prevention system, it was decided that long-term focuses and themes should be prepared at provincial level and then presented at regional level, combined with specific projects (Drogenkoordination des Landes Salzburg 2010). Regional steering groups will be in charge of organising the corresponding information events and assisting the projects at the implementation stage.

The Addiction Prevention Institute of Upper Austria will modify the *CTC* (Communities That Care) programme for implementation in Upper Austria (Institut Suchtprävention 2010). *CTC* was developed in the English-speaking world and uses an evidence-based system of prevention to help reduce problems of addiction, violence and aggression in communities. Parallel to this, the community-oriented prevention projects implemented in Upper Austria under the heading *Wir setzen Zeichen* (We're making a point) have been continued (see GÖG/ÖBIG 2009). The sustainable character of these projects is ensured as in 2010 and 2011 the issue of prevention will also be a focal

theme of the *Gesunde Gemeinden* (healthy communities)⁹ initiative in Upper Austria (Institut Suchtprävention 2009).

VIVID Graz (Styria) also agreed upon a cooperation with a community health promotion project: *StaGes* of the Centre of Social Medicine in the Liebenau quarter of Graz (VIVID 2010). This is an opportunity to use health-related public events to address target groups who face an elevated risk of addiction.

Other activities in the reporting period include the publication of new information leaflets for young people, with a design that takes into account differences between boys and girls so that they may be addressed more specifically (kontakt+co 2009). As of autumn 2009, the college of St. Pölten has run three study courses on addiction and prevention. They differ with regard to duration and type of graduation and permit both practical and academic approaches to this matter. Other further training events in the reporting period that deserve mention include the conference *Brennpunkt: Virtuelle Welten und Suchtprävention* (In the limelight: virtual worlds and preventing addiction) organised by *ARGE Suchtvorbeugung*, which took place in Vienna in autumn 2009. May 2010 saw the conference *Kommunale Suchtprävention* (Preventing addiction in communities), held in Linz (Upper Austria), and in autumn 2009, Vorarlberg was the venue of the trinational conference *Umgang mit Vielfalt — Ist die Prävention überfordert?* (Responding to diversity: too much of a challenge for prevention?).

3.2 Selective prevention in at-risk groups and settings

SQ26 gives an overview of selective prevention measures and the framework in which they take place. Austria generally plans to expand its activities in the field of selective prevention. A number of ideas and strategies have already been presented but will not be implemented immediately (for lack of funding, among other reasons). **Young people participating in programmes of the Public Employment Service** are among the new target groups. These young people often face socio-cultural disadvantages combined with low levels of education, which elevates their risk of future substance abuse or addiction compared to young people of the same age who still go to school (Gollner, personal communication). As a first step, information events on addiction and prevention as well as courses on motivational interviewing are organised in the Tyrol for

9

For further information see <http://gesundeleben.at/lebensraum/gemeinde/gesunde-gemeinde> (23 June 2010; website in German).

the target group of staff and trainers of the Public Employment Service. Other activities that directly address young people have also been planned.

At European level, the *ENCARE* project was phased out in July 2010. However, in recent years the Addiction Prevention Units have intensified their activities targeting **children in families with addiction problems** and integrated this issue in their services: support for this target group will thus be available also in future. In autumn 2009, Lower Austria organised an expert meeting on this theme (ENCARE 2009). In Styria, early childhood intervention teams have become a new target group of the *ENCARE* series of training courses (VIVID 2010). A specific focus was placed on the question of how to address parents when addiction problems are suspected. In Tyrol, outreach individual support is provided as part of the INTERREG project¹⁰ *Kinderleicht — Zukunft. Von Anfang an* (Child's play: having a future, right from the start) (ENCARE 2010). Children of addicted parents get advice and support in a way that takes their age into account, in order to make it easier for them to understand and respond to the situation in their families¹¹. A set of further training measures for multipliers as well as group services for children in at-risk families have also been planned. In Salzburg a regional network is being built (Akzente Fachstelle Suchtprävention 2010). Clearly defined tasks and step-by-step procedures as well as integrating all stakeholders are regarded as most essential for maintaining a sustainable network. At the first stage, further training courses for multipliers from treatment and educational institutions will be organised. In addition, guidelines for the cooperation between youth welfare departments and addiction treatment and support centres will be drawn up (Drogenkoordination des Landes Salzburg 2010). Since 2009, the Drugs Advice Centre of the Province of Styria has run a children's group for this target group, where support is provided in a playful way (Drogenberatung des Landes Steiermark 2010). Apart from spare-time activities, there is also room for intensive talks about the situation in the family. The time spent in the group helps the children realise that they are not alone in their difficult situation.

Prevention activities aimed at specific groups primarily take place in **recreational settings**, with the aim of communicating a critical approach to psychoactive substances (risk competence) as well as alternatives to substance use. In this context, the club and

10

INTERREG is a Community initiative of the European Regional Development Fund (ERDF) to stimulate interregional cooperation in the European Union.

11

<http://www.caritas-tirol.at/hilfe-einrichtungen/familien-und-kinder/kinder-aus-risikofamilien/> (9 August 2010; website in German)

party scenes are relevant settings. Under the name *taktisch klug* (clever tactics) KOJE now provides its own event services in Vorarlberg: organisers of party events are assisted at the preparation stage and attendees are offered services on the spot (Neubacher, personal communication). Addiction support teams well as youth social workers of all districts of the province cooperate to provide the party services so that also long-term support may be ensured. The website¹² of *taktisch klug* provides information on available services and lists safer use rules as well as objective facts on substances used, and also warnings issued by *ChEck iT!* and *Saferparty*.

Further training events for youth social workers that deserve mention include the 2010 annual youth expert meeting of the Addiction Prevention Institute of Upper Austria, which focused on the issue of responsible drug use (Institut Suchtprävention 2010). A number of projects were presented, part of which addressed drug-using young people. Since autumn 2009, *Movin* seminars, where motivational interviewing is taught, have also been held in the province of Vorarlberg (SUPRO 2010). In Salzburg a separate third *Movin* seminar was organised for an especially interested audience (Rögl, personal communication).

It is a well-known fact that **immigrants** may face an increased risk of addiction, as described, for instance, by Penka (2004). Nevertheless, it is important in the sense of selective prevention to target especially those groups of immigrants who are particularly vulnerable because of their current situation and specific social factors, and who cannot adequately be addressed in the context of universal prevention. In 2009 initial steps in this direction were taken in Vienna, with the *SUPMIG* working group as an important player (see GÖG/ÖBIG 2009b): the issue of immigration was integrated in an event for multipliers and further discussed there (Dialog 2010b). Parallel to this, an information event was organised in order to establish contacts to immigrant communities, with Turkish-speaking parents and multipliers as specific target groups. According to an interim report on Vorarlberg's *Anababa* project, this approach has succeeded in reaching and activating parents of Turkish origin (Prenn, personal communication). In the workshops it is possible to address delicate themes, discuss questions of responsibility and accountability, reduce prejudice against prevention approaches and encourage people to turn to providers of addiction services whenever necessary. The workshops have been assessed very favourably and participants have recommended them to others. In 2009, Upper Austria's *Prägend* cooperation project of prevention services and the police held its annual autumn

12

More information see www.taktischklug.at (14 June 2010; website in German)

meeting, which focused on the issues of immigration, school and prevention (Institut Suchtprävention 2009).

3.3 Indicated prevention

Indicated prevention in the sense of the EMCDDA definition (see Chapter 3) has hardly been implemented in Austria so far. The majority of measures addressing particular target groups are based on social factors in the sense of selective prevention. Most of the measures that are adopted in response to patterns of behaviour of individual persons are not based on an additional medical diagnosis (see EMCDDA definition) but only on addictive or at-risk behaviour and behavioural disorders associated with addiction. In a national REITOX Academy on selective and indicated prevention, which took place at GÖG in December 2009, the basic facts and definitions of selective and indicated prevention were discussed with *ARGE Suchtprävention* (Working Group for Addiction Prevention) and other experts. It was concluded that methods of early detection and early interventions that are taken because of drug use (while symptoms of dependence are not yet apparent) may be regarded as part of indicated prevention.

In Vorarlberg the programme *VIVA* (see GÖG/ÖBIG 2009b) was evaluated and it showed that its implementation according to the criteria set by the University of Fribourg (Switzerland) was very difficult (SUPRO 2010). Furthermore, the costs of the tests at the beginning and upon conclusion of the programme were deemed to be too high. Therefore SUPRO developed its own programme for early detection and early intervention: *CHOICE*, which was tested in 2009 and, like *VIVA*, aims at promoting the ability to become aware of and regulate one's feelings, which may be achieved if appropriate methods are applied. The overall objective is to encourage young people to act and make decisions for themselves and to enhance their self-confidence.

In Carinthia, a new pilot project was started: *Grenzwert* (Limit value), which was developed by the Provincial Addiction Prevention Unit and the *Neustart* association, in cooperation with the Departments of Child and Youth Neurology and Child and Youth Psychiatry of the Provincial Hospital of Klagenfurt. It addresses young people between 12 and 17 who are admitted to hospital because of at-risk alcohol use. The project aims at helping the young people concerned become aware of their drinking patterns and cut down on drinking (Drobesch, personal communication). The services provided include immediate support for parents, experience-based education and also further

support if needed. The project is implemented in six individual counselling sessions within two to three months and three group sessions of three hours each¹³.

3.4 National and local media campaigns

In Austria, in agreement with experts in this field, no media campaigns on illicit substances are launched. The only exception is public relations work for a number of community-oriented projects or awareness-raising campaigns on legal substances, such as the recent non-smoking campaign initiated by the Federal Ministry of Health. Styria saw a media campaign promoting a smoke-free childhood (VIVID 2010).

13

<http://www.suchtvorbeugung.ktn.gv.at/Default.aspx?Slid=23&LAid=1> (23 September 2010; website in German)

4 Problem Drug Use

The EMCDDA's current definition of problem drug use is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'¹⁴. However, recent discussions at EU level aim at expanding this definition (e.g., to include problem use of cannabis as well). Austria's definition of problem drug use largely corresponds to the one of the EMCDDA, but underlines that it is primarily patterns of use and not substances as such that are risky or safe. Problem drug use means that drug use is accompanied by physical, psychological or social problems. If exclusively legal problems have ensued, the term problem drug use does not apply (see e.g., GÖG/ÖBIG 2008d).

As of 1993, the capture–recapture (CRC) method has been used for prevalence estimates in Austria (see Uhl und Seidler 2001). The data on which the estimates are based come from reports to the police related to opioids (see Chapter 9.1), the substitution registry (see Chapter 5.4) and drug–related deaths (see Chapter 6.3). In addition the DOKLI nationwide documentation system of clients of Austrian drug services provides information that is very helpful for an interpretation of the results obtained (see Chapter 5.3).

Poly–drug use with opioids, which are often injected, has traditionally played a significant role in Austria. A development of recent years that deserves special attention is the fact that young opioid users prefer snorting as their mode of administration and in many cases they switch to injecting use only at a later stage of their drug using career (Busch and Eggerth, under preparation). Apart from the group of people using opioids as their primary drugs, the treatment centres have registered another large group: people with cannabis as their primary drug. Many of these drug users have been referred to compulsory treatment, however (see GÖG/ÖBIG 2009b).

According to recent estimates, a prevalence rate of 25 000 up to a maximum of 37 000 problem opioid users, mostly in the context of multiple drug use, seems realistic for Austria (see ST7). This means that between four and seven out of 1 000 Austrians aged between 15 and 64 show problem patterns of opioid use.

However, prevalence estimates of problem drug use are difficult to give as methodological problems arise due to the complexity of the subject, and the figures obtained are conclusive to a limited extent only. Thus any results given are rough

14
www.emcdda.europa.eu/themes/key-indicators/pdu (15 July 2010)

approximations and have to be interpreted with caution. The prevalence rate of alcohol dependence, compared to illicit drugs, is estimated to be 5% of the population over 15 in Austria. This means that a total of 350 000 people in Austria are to be regarded as alcoholics (Uhl et al. 2009).

4.1 Prevalence and incidence estimates of PDU

In Austria scientific estimates of the prevalence of problem drug use are only available for opioids and for poly-drug use with opioids. GÖG/ÖBIG has updated the estimates which so far have been available up to 2007 (GÖG/ÖBIG 2010b): now the years 2008 and 2009 are covered as well (GÖG/ÖBIG, under preparation). For the capture–re–capture method, on which the prevalence estimate is based, data on opioid substitution treatment and reports to the police relating to opioids were used. However, the problem of ghost cases is a significant deficit regarding the quality of substitution data¹⁵.

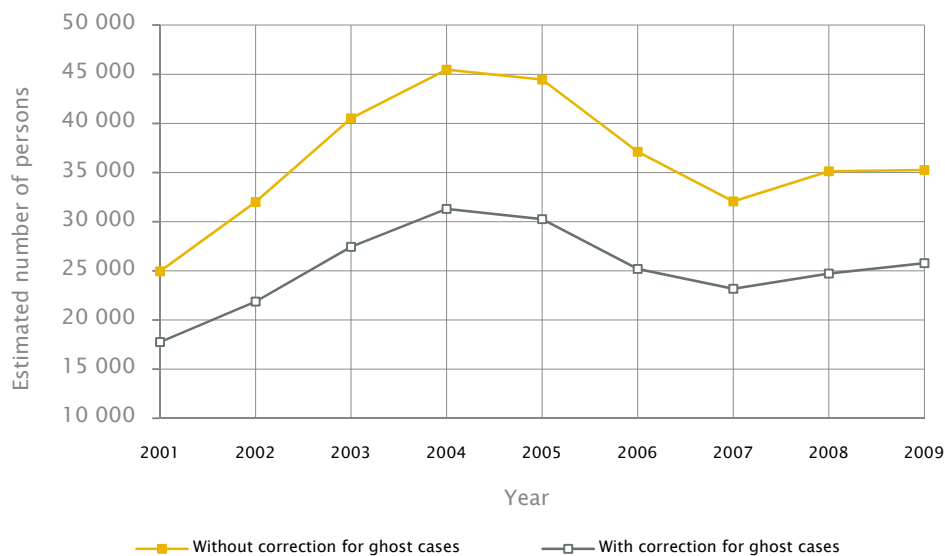
In order to correct the resulting bias, i.e., the tendency to overestimate prevalence rates, data from the year 2004 were used to derive a correction formula (GÖG/ÖBIG 2010b). Figure 4.1 shows the time series of prevalence estimates with and without a correction for ghost cases. When interpreting these figures one has to bear in mind that the correction factor calculated for the year 2004, due to correction routines in the substitution registry (see Chapter 5.4), may assume a number of ghost cases that is too high, which in turn leads to underestimates of prevalence rates. For this reason, the estimated current prevalence of problem drug use including opioid use in 2009 can only be given as a fairly rough approximation: between 25 000 and 37 000 people (prevalence estimate corrected for ghost cases in 2009: 25 777; 95% confidence interval: 24 867–26 687; prevalence estimate without correction for ghost cases in 2009: 35 252; 95% confidence interval: 33 976–36 529). If these figures are combined with other data sources, it is safe to assume that the prevalence rates of PDU, after a rise in 2004, have gone down again and have remained at similar levels in recent years (for details see GÖG/ÖBIG 2008c and GÖG/ÖBIG 2010b). For 2007, the results of the two–sample CRC estimates could be verified to a large extent by means of a three–sample CRC estimate which included drug–related deaths (GÖG/ÖBIG, under preparation).

15

If the end of treatment is not documented, the corresponding clients appear in the statistics as people currently undergoing treatment also in the years after the actual end of treatment (= ghost cases).

Figure 4.1

2-sample CRC estimates with and without correction for ghost cases, 2001–2009



Source: calculation and representation by GÖG/ÖBIG

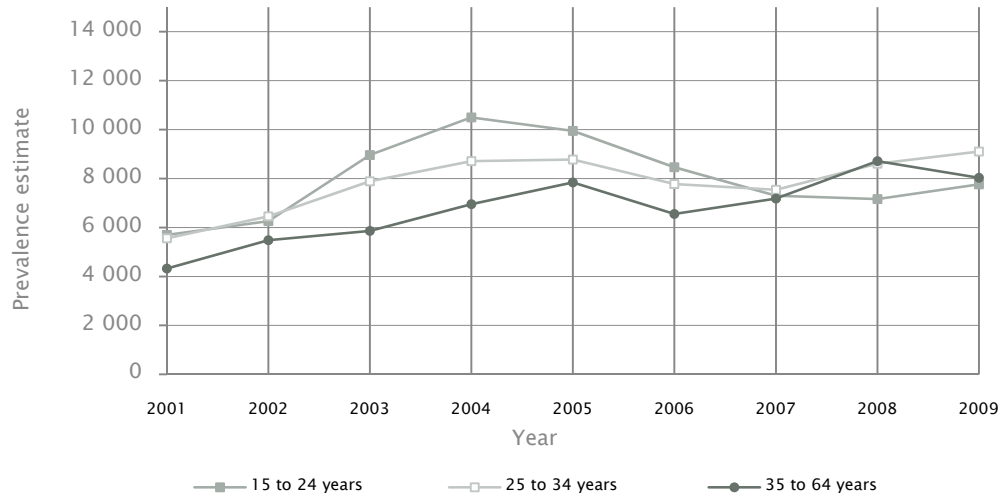
The time series of age-stratified prevalence estimates (see Figure 4.2) shows that both increases and declines in prevalence rates are first found in the group aged 15 to 24. This may be an indicator of the conclusiveness of data on the epidemiological development as one may safely assume that an increase or decline in PDU initiation first shows in the youngest age group.

Regarding gender, the prevalence estimates reveal a 4:1 ratio of men and women also for 2009.

If the prevalence estimates of 2009 are related to other data from drug monitoring the following figures may be derived:

- » In 2009 between 27% and 52% of problem drug users (including opioid use) were undergoing opioid substitution treatment (assuming that in 2009 a total number of 10 000 to 13 000 people were receiving OST; see Chapter 5.4)
- » Between 0.5% and 0.7% of problem drug users (including use of opioids) died of overdoses in 2009 (186 drug-related deaths with opioids or unknown substances).
- » In 2009 between 11% and 17% of problem drug users (including opioid use) were reported to the police because of violations of the SMG (4 180 people).

Figure 4.2
 2-sample CRC estimates with correction for ghost cases,
 2001 to 2009 (age stratified)



Source: calculation and representation by GÖG/ÖBIG

Apart from the prevalence of problem drug use including opioid use, for reasons of epidemiology the prevalence of injecting drug use is also of interest. In past years it was assumed that the two prevalence rates were at similar levels (opioid use = opioid injection), but recent analyses of patterns of use, based on the BADO and DOKLI documentation systems of drug treatment, have presented a different picture (see Chapter 5.3 and Busch and Eggerth, under preparation): only around half of the people using opioids as their primary drugs said that injection was their preferred mode of administration. If these statements are extrapolated to the entire group of PDUs who also use opioids, the number of people who primarily inject drugs seems to be between 12 500 and 18 500 in Austria. This is regarded as the upper limit, however, as injecting drug users are more likely to turn to drug treatment centres (because their drug problems are especially severe).

Again, it should be noted that because of methodological restrictions, the results of the CRC method are but rough approximations. For a more detailed discussion of methodology see, for instance, Uhl/Seidler 2000, ÖBIG 2003, GÖG/ÖBIG 2006 and GÖG/ÖBIG 2010b.

4.2 Data on PDUs from non-treatment sources

Salzburg provided analyses of patterns of use based on examinations of persons according to Section 12 of the SMG¹⁶ (Drogenkoordination des Landes Salzburg 2010). As in previous years, use of cannabis predominates in this group of persons (92% out of 483 people examined). Between 11% and 14% of examinations were related to use of cocaine, ecstasy, speed or opioids, and 4% to hallucinogenic drugs. 68% of examinations were carried out because of use of one substance, 19% resulted from use of two substances, and 11%, from use of three or more substances.

In the party drug scene, a trend away from ecstasy and amphetamines and towards 'research chemicals' has shown (see Chapter 10.3). By the end of May, the Poison Control Centre had already registered seven enquiries by hospitals relating to mephedrone intoxications (Hruby, personal communication). Until the end of August 2010, mephedrone was one of the most frequently used research chemicals. In August 2010, this substance was officially included in the list of narcotic substances and has since then been an illicit drug (see Chapters 1.1, 10.1 and 10.3).

4.3 Intensive, frequent, long-term and other problematic forms of use

Apart from the data already mentioned in Chapters 4.1 and 4.2, no further information on intensive, frequent, long-term and other forms of problem drug use is available. The results of the population survey of 2008 on intensive use of cannabis are given in Chapter 2.1.

16

Persons who, because of a reasonable suspicion of drug abuse and who, after a report to the police, or information by a head of school, a military authority or driving licence authority, were medically examined with regard to the need for undergoing a health-related measure.

5 Drug-related Treatment: Treatment Demand and Treatment Availability

Austria has an almost nationwide network of centres that provide drug-related advice, support and treatment services. A total of almost 200 specialised units provide inpatient and outpatient treatment or advice related to addiction and illicit substances (investigations by GÖG/ÖBIG). Drug advice, support and treatment services are provided both by specialised centres and as part of general health-care services (e.g., psychiatric hospitals, psychosocial services, established physicians). Inpatient treatment is open to people from all over Austria and also from abroad. In quantitative terms, opioid substitution treatment (OST) has become the most important form of treatment in Austria, and efforts to improve it have continuously been made.

Austria attributes great importance to the diversification of available treatment options. As a result, in the past decade the inpatient sector saw a development from long-term to short-term treatment and generally to more flexibility with regard to possible kinds of treatment, for instance in the form of modular systems. Opioid substitution treatment may be obtained in inpatient settings, and withdrawal is also possible in outpatient departments. The majority of advisory and treatment services is not oriented towards specific substances, but a distinction between legal and illicit drugs continues to be made. In addition, specialised services (e.g., for cocaine users or cannabis users) are delivered wherever necessary. In order to respond to individual demands and needs of addiction patients in the best possible way, a range of different substances is available for opioid substitution treatment. As the general aim is to maintain a comprehensive treatment and support network, most service providers also organise a variety of preparatory and aftercare measures as well as recreational and reintegration services (see Chapter 8.2) and also interventions for specific target groups (e.g. young people or persons with psychiatric comorbidity). For an overview of available drug treatment and advisory services please consult ST24, SQ27 as well as Maps 5.1 and 5.2. For detailed descriptions of available services please consult the websites as well as the annual reports and newsletters of the individual centres, ÖBIG's previous reports and the Best practice portal of the EMCDDA (see Bibliography).

The services provided in the fields of addiction advice and treatment have also tended to be expanded to include legal drugs as well as forms of addiction not related to substances, and programmes to this effect have been started (e.g., nicotine-free programmes and support for gambling addicts), which cannot be discussed in this report.

Since 2006, data on clients of drug service providers have been obtained from the DOKLI nationwide documentation system, which covers the majority of relevant centres that deliver support services in Austria (see ST3 and ST TDI). The data gathered include

all questions defined by the EMCDDA, and in addition, data on infectious diseases (also according to EMCDDA guidelines) and ICD-10 codes are collected on a voluntary basis. The substitution registry, which has been maintained at the Federal Ministry of Health since 1989 (see ST3 and ST TDI), is a further data source worth mentioning. Regarding personal data of clients, only gender, age and province of residence are registered.

5.1 Strategy/policy

Drug treatment strategies and policies are defined in the drug or addiction strategies of the individual provinces and in the corresponding laws. In December 2009 two **decrees** were issued (BGBl II 2009/485 and 2009/487), which again amended the legal framework for substitution treatment and further training for doctors providing OST. This was a response to the need for optimisation that showed when the effects of the amendments of the legal framework effective as of 2007 were evaluated (see GÖG/ÖBIG 2009b). One of the relevant aspects was the question of maintaining the necessary treatment and supply structures. The new regulations have been described in Chapter 1.1. The provisions regarding substances that should preferably be prescribed have not changed, and as to further training for doctors providing OST, now the Medical Association of Austria has to submit to the Ministry of Health an annual report on the state of development and organisation of said training (Section 4, Paras. 1 and 5). The lists of doctors providing substitution treatments are no longer public, and it has been specified who is entitled to access to these lists (Section 5, Para. 3). If the requirements for entry in the list are not, or no longer, met, or if doctors do not meet their professional obligations or violate these obligations, the district authorities, after hearing the Austrian Medical Association, may delete the corresponding entries or specify conditions for keeping these doctors on the list (Section 7, Paras. 1 and 3). The transitional period was extended until 31 December 2010, and further training has to be organised in a way that permits doctors to complete the basic training module by this deadline (Section 9, Para. 8). Public health officers are also obliged to attend the basic training module and have to meet the annual further training prerequisite.

From the point of view of many experts, the amendments have definitely helped improve the situation regarding substitution treatment of opioid users, although a number of provisions are still criticised (see GÖG/ÖBIG 2008c and 2009b as well as Chapter 11.3). By the end of 2010 it will show whether the easing of requirements regarding further training for doctors providing OST has actually had positive effects on the **supply situation**. In several provinces, the number of doctors entitled to opioid substitution treatment has meanwhile gone down further: for instance, Upper Austria saw a decline from 200 in 2007 to 80 in 2010 (Ömer 2010). According to Schwarzenbrunner (personal communication), after expiry of the transition period this figure is expected to decrease by another 50%. In Lower Austria, after a decline in mid-

2010, now 50 doctors are entitled to administer OST but a number of them do not admit new patients (Hörhan, personal communication). Because of an uneven distribution of doctors who are delivering substitution treatment in Lower Austria, there are districts where OST is no longer available. This indeed is a problem because if patients have to travel long distances for the regular appointments that they have to meet in order to continue treatment, they are more likely to drop out from OST. In Vienna, where the number of OST doctors has not decreased (see GÖG/ÖBIG 2009b), almost 380 doctors are entitled to provide substitution treatment, and 320 of them are established doctors who run their own practices (David, personal communication). In Vienna, more than 70% of patients entitled to receive OST are estimated actually to enter treatment, compared to less than 50% in the rest of Austrian provinces (David, personal communication).

Remuneration agreements between the medical associations and the provincial health insurance funds, which could contribute to an improvement of the situation (see GÖG/ÖBIG 2009c), have been concluded in a small number of provinces only (see Chapter 12). The reasons given for the reluctance to provide OST are lack of financial incentives, which caused the entire professional group of neurologists and psychiatrists to withdraw from OST (Wudy and Reisner, personal communication), as well as possible sanctions if treatment is not provided in accordance with the Decree (see Chapter 11.3) and eventually the further increase in paperwork that is required.

As another strategy, several provinces have planned or already started to **restructure** the system of substitution treatment (see GÖG/ÖBIG 2009b): for instance, in Burgenland, specialised clinics, treatment centres of the Psychosocial Services Association or psychiatric outpatient departments will be in charge of defining stabilisation doses of substitution medicines, while further treatment will be provided by general practitioners (Miksch, personal communication). Salzburg still reports difficulties regarding the implementation of the principle of substitution in drug treatment and advice centres: by the end of 2009, no qualified staff had yet been found for two regional centres and no agreement for the remuneration of medical services had been concluded with the competent health insurance funds (Drogenkoordination des Landes Salzburg 2010). In other words, apart from a small number of established psychiatrists, OST is only available in the Drug Outpatient Department of Christian Doppler Hospital or the Substitution Centre for Opiate Addicts (SUST).

According to Eisenbach–Stangl et al. (2009), in Vienna a trend towards reintegrating drug treatment and advice services in the general health–care system has shown. This goes hand in hand with the orientation towards individualised treatment that is encouraged also outside Vienna. Intravenous substitution treatment might be another new strategy worth considering, the feasibility of which has been tested in Vienna (see Chapter 1.2)

5.2 Treatment systems

For an overview of centres specialising in addiction services (except centres exclusively oriented towards alcohol addiction) please consult Maps 5.1 and 5.2. As Eisenbach–Stangl et al. (2009) point out with regard to Vienna, it is not easy to give a list of all centres because their organisational structures are often complex. For instance, Vienna provides services to drug users also outside Vienna. Moreover, drug addicts might be treated outside specialised institutions (e.g. in psychiatric departments of hospitals). The maps are an attempt to illustrate the situation regarding regional availability of drug service providers and treatment centres while avoiding unnecessary complexity. The maps show towns and cities where drug services are available.

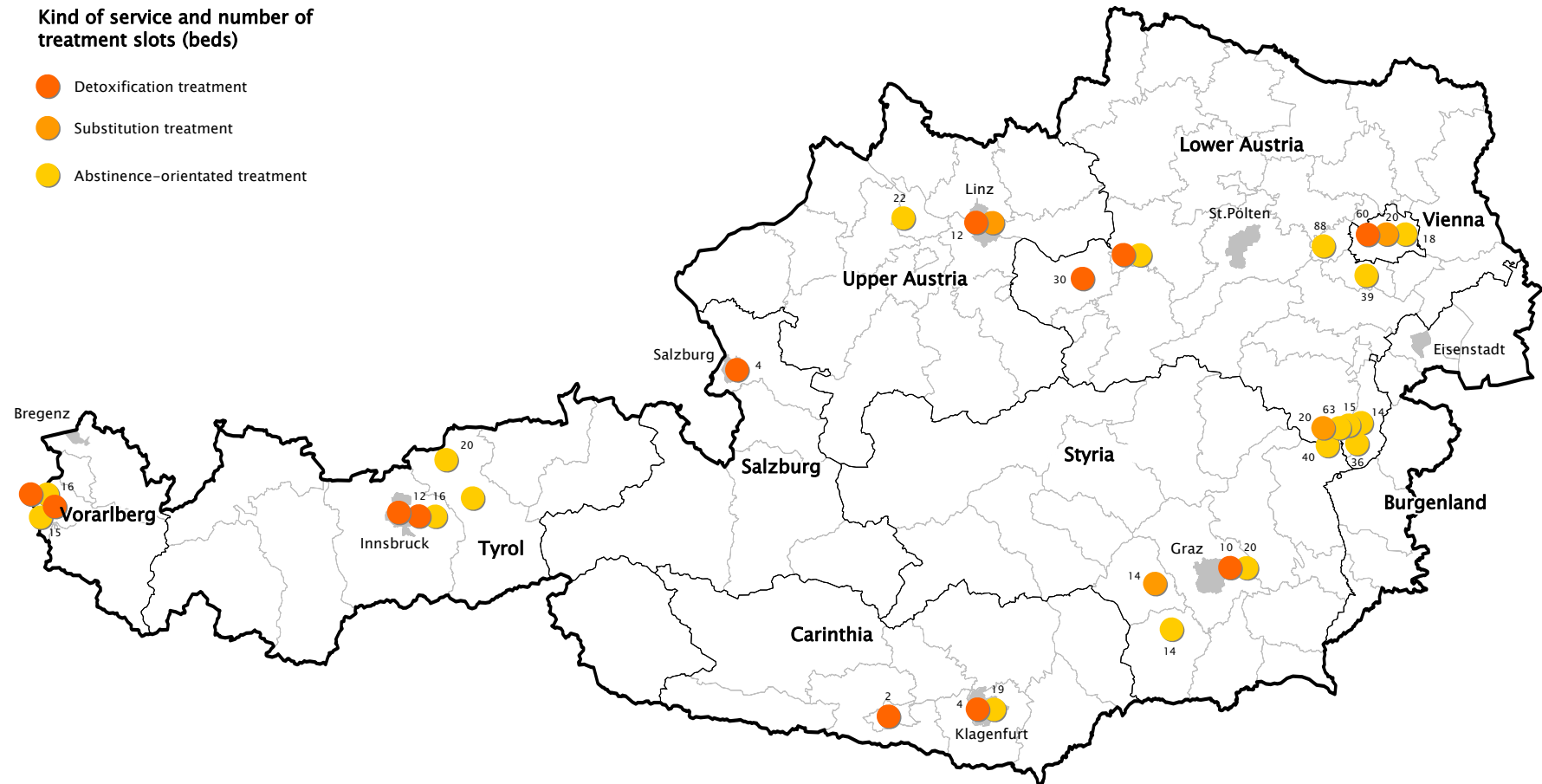
The capacities of drug services in Austria have continually been expanded but are still insufficient. This is reflected in waiting lists and in waiting times which, depending on treatment centre and type of treatment, may be up to several weeks or months. Here, pronounced regional differences show, however: for instance, the advice and treatment centres of the b.a.s. association in Styria report waiting times between two and three weeks for the first counselling talk (b.a.s. 2010), but one must take into account that in a number of centres the majority of clients have drinking problems. The drug advice and treatment centres of Maria Ebene Foundation (Vorarlberg) and the Drugs Advice Centre of the Province of Styria report that their caseload had reached a limit in 2009 (Stiftung Maria Ebene 2010, Drogenberatung des Landes Steiermark 2010). Apart from longer waiting times, this also means that less time can be spent with each client, which in turn reduces the services provided to what is absolutely necessary, and consequently reduces their quality. As a consequence, there are times when no new substitution patients can be admitted. The changes in the legal framework for OST (see GÖG/ÖBIG 2009b) have increased the caseload of outpatient departments, which, for instance, led to waiting times of two to six weeks at Wagner Jauregg neurological hospital of Linz, Upper Austria (Ömer 2010). Capacity problems arise not only because stabilising doses have to be determined for first-time patients but because patients have to turn to the outpatient clinics also for further treatment as OST is not provided elsewhere, and regular appointments thus have to be scheduled. The new withdrawal department at Amstetten/Mauer (see below) already has a waiting list of approximately 160 people, around 80% of whom are users of illicit substances (Spitzer, personal communication). According to Eisenbach–Stangl et al. (2009), in Vienna the waiting times for withdrawal treatment followed by further therapy are several weeks, and regarding inpatient long-term treatment, from no waiting time at all to up to six months. The b.a.s. association of Styria reports waiting times for a treatment slot between six and eight weeks (b.a.s. 2010). Carinthia also lacks resources in the area of addiction treatment (Prehslauer, personal information). At the University Hospital of Psychiatry and Psychotherapy II in Salzburg, the cooperation with the drug treatment and advice centres has been improved, and since then it has been possible to admit

patients for inpatient treatment almost immediately (Drogenkoordination des Landes Salzburg 2010). The problem of scarce resources, which increases waiting times or requires travelling long distances to get treatment, makes it impossible to meet the rising demand for quick professional and effective assistance that has been registered by several drug treatment and advisory centres. For instance, the Dialog association reports an enormous rise by 21.3% in the number of clients treated in 2009, paralleled by an increase in 10.2% of relatives of drug users who required Dialog's services (Dialog 2010b). Although it has been possible in recent years to increase services after taking professionalisation measures, it is regarded as impossible further to increase the provision of services with the present budget (Dialog 2010b). An area where it is difficult to plan capacities is services provided to people turning to a centre without an appointment, as fluctuations are considerable so that bottlenecks may occur in certain services, especially medical treatment. As a result, regulation measures especially regarding opioid substitution therapy will be planned.

In order to increase capacities, a number of new services have been established or planned in the reporting period: in April 2010, the new withdrawal department of the provincial hospital at Amstetten/Mauer in Lower Austria was opened, with large, bright and airy rooms that convey a relaxing, pleasant atmosphere. This has been possible because staff was integrated at the planning stage and the needs of clients were taken into account. The results seem to have positive effects on both groups. The withdrawal department pursues a new strategy: withdrawal treatment from any, both legal and illicit, psychoactive substance is available, which helps destigmatise the group of persons who are addicted to illicit drugs (Spitzer, personal communication). Patients addicted to opioids as well as benzodiazepines receive withdrawal treatment from both substances. Different to other hospitals, partial withdrawal is only possible upon written recommendation by the attending doctor. In this case, clients may take an active part in treatment decisions, i.e., the form of treatment and, within a defined limit, also the controlled use of additional medications during gradual discontinuation of benzodiazepines.

Map 5.1

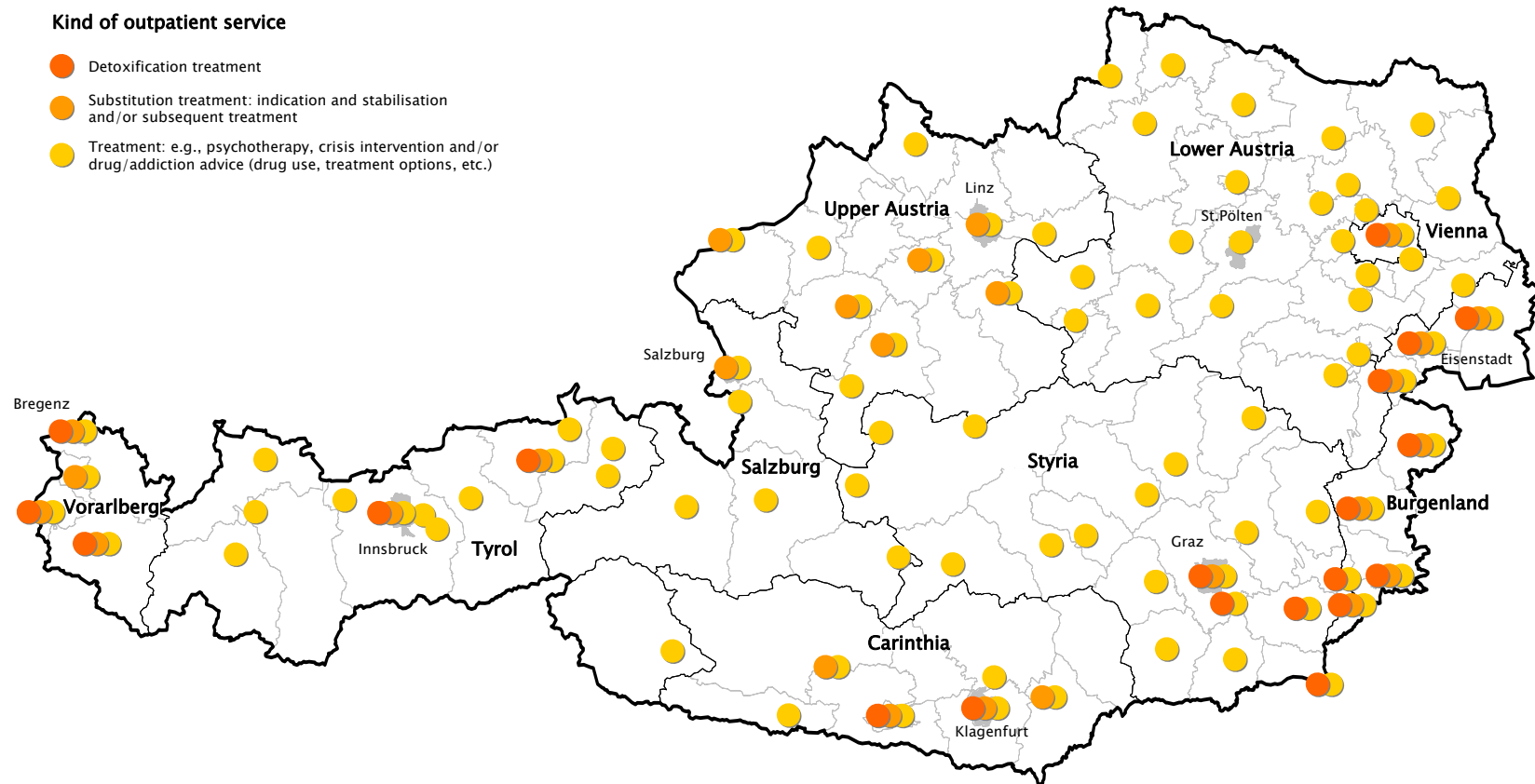
Specialised providers of inpatient treatment services for drug users and addiction patients, 2010



Source: GÖG/ÖBIG in cooperation with the Provincial Addiction and Drug Coordination Offices, representation by GÖG/ÖBIG

Map 5.2

Specialised providers of outpatient treatment services for drug users and addiction patients, 2010



Source: GÖG/ÖBIG in cooperation with the Provincial Addiction and Drug Coordination Offices, representation by GÖG/ÖBIG

By December 2009 Lower Austria had finished building a province-wide network of drugs advice and treatment centres. In Carinthia two new centres providing multi-professional services were opened at Spittal/Drau and Völkermarkt, in order to improve decentralised service provision especially regarding opioid substitution treatment (Prehslauer, personal communication). It will not be possible in the foreseeable future, however, to execute plans to rebuild the withdrawal department of Anton Proksch Institute (API) as funding has not been secured (Hörhan, personal communication).

Addressing **new target groups** continues to be an objective of a number of measures that have been planned. For instance, in the reporting period the Dialog association planned and implemented its *Brainstorm* group services for schizophrenic men (see Chapter 7.3) as well as a social work project in offices of general practitioners delivering substitution treatment (Dialog 2010b): social workers are present in doctors' offices to establish contacts to OST patients who do not receive any further psychosocial support. This seems to be the case for 75% of the patients undergoing substitution treatment whom the social workers addressed. Another new plan is the 'open timeline' service at the integrative addiction support centre at Wassermannngasse in Vienna. It targets clients who require low-threshold approaches (without scheduling of appointments) in order to receive regular support and treatment services. The open timeline service will be run parallel to the scheduled sessions.

Carinthia is about to establish an outpatient department for chronic cannabis users who also suffer from psychiatric diseases (Prehslauer, personal communication). Another new pilot project has been started by Grüner Kreis and the prison of Stein, in which prisoners undergoing substitution treatment may receive psychotherapy parallel to OST (see Chapter 9.5).

However, there are still groups of addicted patients who do not get the support they would need. According to Eisenbach-Stangl et al. (2009), this includes people without social insurance (especially regarding inpatient treatment) and people of foreign nationality. Spirig et al. (2010) also point to the group of older drug users (see GÖG/ÖBIG 2009b) for whom no adequate services exist, neither in the drug treatment system nor regarding social services. A possible reason for this deficit is that this target group is underestimated, that the competences and remits of service providers are not clearly defined and that they are reluctant to accept responsibility. The experts consulted recommend that the existing structures be used so that older drug users are not treated differently from others, which is in line with their own demands. This means that nursing and old-age care services should be opened to this group, and existing structures and approaches be modified accordingly. This would have to be combined with specific training for staff as well as public relations activities in order to reduce prejudice against addicted people, which in turn requires willingness and action on the part of policy makers, however, as funds are needed to establish the required

cooperation structures linking the service providers involved (drug treatment and advisory centres on the one hand and nursing and old-age services on the other). The greatest deficit of Austria's drug treatment services is the lack of specific services for young people, especially regarding inpatient treatment. Although, on principle, drug patients under 17 would have to be admitted to child and youth departments, hospitals are reluctant to do so or refuse patients with diagnoses of addiction (Spitzer, personal communication). Insufficient treatment structures for children and young people with psychiatric diseases are a problem not only as far as addiction treatment is concerned: deficits are generally found with regard to child and youth psychiatry (Sklenar 2010). Reports from the outpatient sector point to the fact that young clients increasingly often tend towards risky patterns of use, which is a major challenge for the providers of addiction support services.

As a response to evaluations or experience gathered in practical work, a number of measures have been taken that aim at modifying the support and treatment services of existing centres so that the **demands of their target groups** may be met more specifically. For instance, Dialog's services addressing young people (see GÖG/ÖBIG 2009b), which have met with great acceptance, have been evaluated. A specific issue of the year 2009 was the transfer from youth services to adult services of young people after their 21st birthday (Dialog 2010b). This is a great challenge because many clients experienced the break-up of relationships, which was often traumatising, and therefore it is immensely important to them to have a positive, stable relationship to their counsellors. As of 2010, Dialog's *Beyond the line* service specifically addressing cocaine users (see GÖG/ÖBIG 2009b) has become a part of its regular services. The evaluation has shown that *Beyond the line* has continuously been frequented by cocaine-using clients and has proved to be an adequate service for this target group.

In autumn 2009 the withdrawal and treatment department Walkabout (see GÖG/ÖBIG 2009b) celebrated its fifth anniversary. On this occasion a guideline and a report were published. In the course of its five years of existence, Walkabout's programme was adapted continually in order to meet the needs of clients with comorbid conditions or suffering from several addictions: they may undergo partial withdrawal, and Walkabout has sufficient qualified staff for treating people with psychiatric dual diagnoses. An individualised approach to treatment is pursued, based on transparency, clarity and a daily structure for orientation. It also includes a transition ritual for the change from withdrawal to the next stage of treatment, as well as services by social workers.

An evaluation of the Erlenhof treatment centre, based on a catamnestic study¹⁷ (Porstmann 2009) shows that long-term treatment definitely has positive effects and results in a general improvement of the patients' quality of life¹⁸. Significant improvements were found with regard to contacts to friends and within the family, spare-time activities as well as housing and job situation. To some extent, good results showed as far as financial situation, drug-free and crime-free life were concerned.

There are a number of services addressing pregnant addiction patients, which aim at goals such as improving the women's state of health, preventing adverse health effects on the foetus or newborn baby, or preventing the children from developing addiction behaviour themselves. Often, several goals are combined. The *DESK* project implemented in Lower Austria and Vienna (see GÖG/ÖBIG 2009b and Chapter 7.3) covers a wide range of activities. A major objective of *DESK*'s is awareness-raising among addicted people as well as addiction experts and youth welfare departments. For this purpose *DESK* published several booklets and organised further training events (Hörhan, personal communication). In order to encourage network-building, a working group in Lower Austria has prepared guidelines for action and a cooperation agreement for the institutions and organisations involved. In Tyrol, a pilot project for pregnant women undergoing opioid substitution treatment was launched (see Chapter 7.3), which since May 2010 has been run at the drug outpatient department of the University Hospital of Innsbruck (kontakt+co 2010). After the second examination required for granting the benefits included in the Mother-and-Child prenatal diagnostics booklet, a midwife is appointed who provides support to the woman in question during pregnancy and helps her prepare for birth and life with a new-born child (see Chapter 7.3). In Vienna, as of autumn 2009, addicted pregnant women have been contacted by social workers at the outpatient department for at-risk patients at Vienna General Hospital in order to provide support already during pregnancy (Sucht- und Drogenkoordination Wien 2010).

A wide range of activities take place for the purpose of **quality assurance** in addiction treatment: on the one hand, guidelines for action are provided and further training

17

For 58 people who completed treatment between 2004 and 2008, sociodemographic information gathered at the beginning of treatment permitted a comparison: it was planned to contact and interview these people for the catamnestic study (survey of the success of treatment after completion of treatment) early in 2009, which was not possible in all cases, however. Finally, 27 assessment questionnaire and 23 catamnestic questionnaires were available for analysis.

18

See also <http://www.emcdda.europa.eu/best-practice> (16 August 2010)

events are organised, and on the other, measures are taken in the individual centres themselves and also regarding organisational structures (see also Chapter 11). For instance, the supervision structures at the Lukaskfeld treatment department were revised in the reporting period (Stiftung Maria Ebene 2010): now team supervision, case supervision and supervision of object relations psychodynamic therapy are provided. Since autumn 2009, Grüner Kreis has participated in the Leonardo da Vinci project¹⁹ *Indeed*, which aims at improving the qualification of staff in charge of inpatient and outpatient drug treatment and advice, in particular regarding indebted addiction patients (Grüner Kreis 2010), in order to raise awareness of, and help find adequate responses to, the causal relationship between debts and difficulties to achieve economic and social reintegration.

Styria has pursued a new approach with a comprehensive quality assurance process for addiction treatment, started early in 2010 (Ederer, personal communication). In a meeting of drug experts, agreements for drug treatment have already been achieved, and now precise definitions of the individual addiction treatment services provided are drawn up. However, when this report went to press, no results were available yet. Upper Austria also plans to draw up framework guidelines for responses to addiction, which will include a list of services provided and quality standards to be met (Schwarzenbrunner, personal information). The pertinent work will not be started before 2011, however.

Other activities primarily aim at the links between inpatient and outpatient service providers and individual addiction support centres. For instance, in Carinthia, standards for interface management have been drawn up to reduce dropout from treatment and intoxications (Prehslauer, personal communication). In Vienna, a list of inpatient treatment services was compiled, a new multidimensional diagnostics tool was developed and client groups were defined based on demands to be met, who will then be allocated to the corresponding types of treatment (Sucht- und Drogenkoordination Wien, 2010). These instruments will permit a better analysis of treatment processes and help optimise changing from one service provider to another, and from inpatient to outpatient treatment. Another pilot project aims at making it a routine to have indications for inpatient treatment reviewed and confirmed by the Diagnoses Institute to obtain a second opinion.

19

The Leonardo da Vinci programme of the European Commission focuses on practical projects in the fields of vocational education and is part of the Commission's Lifelong Learning Programme.

Again, several **events** took place in the reporting period to promote exchange among experts: in May 2010, the Federal Ministry of Health organised a hearing on opioid substitution treatment, which included papers by international experts on new findings in relevant areas (e.g., substitution substances used, cost-benefit analyses) as well as a panel discussion on the future of substitution treatment in Austria. In June 2010 Styria held its second conference on responses to addiction, which focused on interdisciplinary approaches²⁰. For instance, it was underlined that intervention strategies have to be based on an individual assessment of the strengths and weaknesses of addicted persons, and all actors relevant in the lives of the patients have to be involved (Kurz 2010). In autumn 2009 the Austrian Working Group for Communicative Drug Work (ÖAKDA) held its 56th meeting²¹, which focused on immigration and addiction services. It was pointed out that addicted patients with a background of immigration hardly turn to the established drug treatment services but that drug experts are aware of this fact and attempts are made to change this situation. Another event worth mentioning is the 13th Substitution Forum organised by the Austrian Society of Pharmacologically Assisted Treatment of Addiction (ÖGABS) taking place at Mondsee (see Chapter 11.3). It is not possible here to list all addiction-related expert meetings, however. This year, the Dialog association has celebrated its 30th anniversary, and the corresponding events integrate both Dialog's clients (see Chapter 8.2) and cooperation partners. This has contributed to increasing awareness of the situation in life of addicted people and to more understanding for this social group (Dialog 2010a). For instance, texts and photos by clients have been presented²² and future perspectives have been discussed.

20
www.bluemonday.at (see Aktuelles; 4 August 2010; website in German)

21
<http://oevdf.at/> (ÖAKDA; 16 August 2010; German website with English summary)

22
See www.30dialoge.at (16 August 2010; website in German)

5.3 Characteristics of treated clients

The client year 2009 is the fourth year for which data of the DOKLI nationwide documentation system of clients of Austrian drug services are available²³.

The drug treatment centres in Austria that are covered by the DOKLI system communicated data on a total of 4 187 people who had started **long-term outpatient treatment** in 2009. For 1 887 of them this was their first drug treatment in life. 1 662 patients started long-term **inpatient treatment**, and for 217 clients this was their first long-term drug treatment. In addition to these persons undergoing drug treatment in a traditional sense, DOKLI also registered 663 clients requiring **support by low-threshold centres** and 6 233 people receiving drug treatment and advisory services in the form of **short-term contacts**. Generally speaking, the data gathered for 2009 correspond to those of previous years.

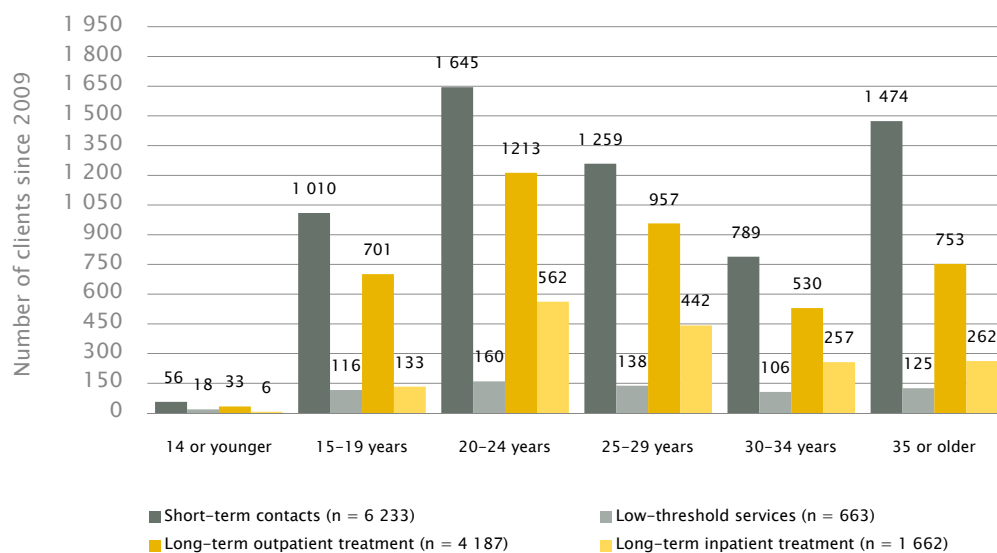
Approximately one out of five people undergoing treatment or receiving other services are younger than 20, with the exception of people treated in inpatient settings, where their share is 8%. The age group 20 to 29 years accounts for between 45% (low-threshold services) and 60% (long-term inpatient treatment) of clients, respectively (see Figure 5.1, Table A22 in Annex A as well as ST3 and ST TDI).

In all settings covered, the share of women is between 22% and 27% (more detailed analyses regarding gender differences are given below).

23

When interpreting the results, one has to bear in mind that, while double counts of clients of one and the same centre can be excluded, due to the aggregate character of the data, double counts of clients who turned to several centres in 2009 cannot be avoided. The share of such cases of multiple treatment can only be guessed at. The report of Vienna's BADO Basic Documentation gives a general idea of the magnitude of this aspect as in the case of BADO, double counts of clients who contacted several drug support centres during the reporting period can be detected by means of an identifier. In 2008 19% of clients registered in BADO were provided services by more than one centre (12%: two centres; 7%: more than two centres; see GÖG/ÖBIG 2010b, IFES 2009b). However, as drug support centres are more easily accessible in Vienna due to the higher geographical density compared to rural areas, the share of double counts might be slightly smaller in the rest of Austria.

Figure 5.1
Number of people entering drug treatment in 2009, by age and type of service



Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

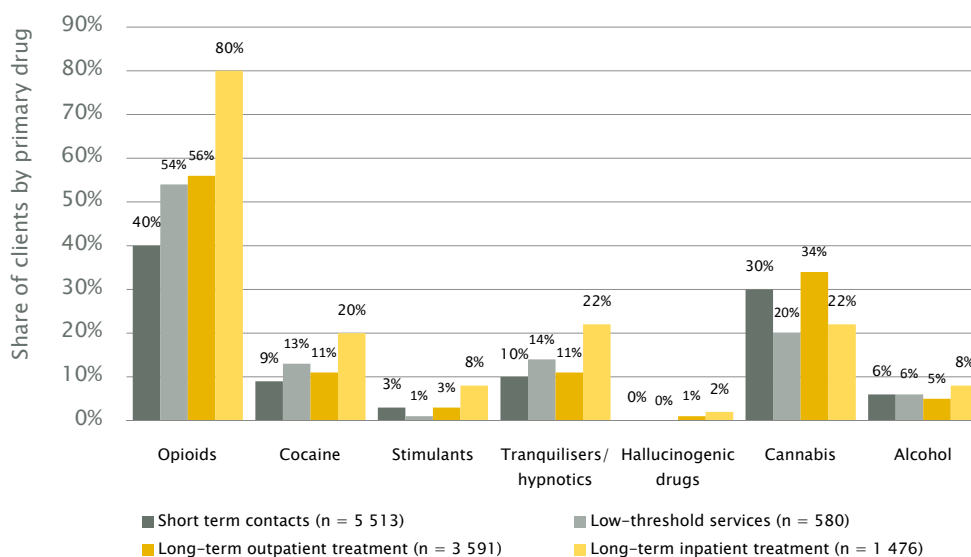
In the traditional treatment settings (long-term outpatient or inpatient treatment), opioids predominate as primary drugs²⁴. Cocaine continues to be irrelevant as far as primary drugs are concerned (see Figure 5.2 and Table A26 in Annex A). This shows that in Austria, different to a number of other countries of the European Union, opioids

24

For compiling the DOKLI case history, clients are first asked to name all drugs they have ever taken. Then the drugs mentioned are classified according to current patterns of use, as primary drugs, additional drugs, drugs only taken in the context of experimental use and drugs not relevant for treatment. The primary drug is the drug which causes the greatest problems from the personal point of view of the client. Here, problems – on the basis of ICD 10 – are understood as psychosocial and health-related problems and not solely legal problem situations. As a rule, the primary drug is the drug because of which the client has started the current treatment. If a client cannot decide which drug is the primary drug, several drugs may be named. Additional drugs are drugs which the client has used in addition to the primary drug in the past six months and which also constitute a problem for the client. Experimental drug use refers to intermittent use of the corresponding drug in the past six months without harmful use or manifest addiction problems. Drug use not relevant for treatment means that the drug in question has occasionally been taken over a period of more than half a year but no harmful use or manifest addiction problems show, or that the drug was used in the past but not during the six-month period preceding treatment (GÖG/ÖBIG 2010a).

play the most important role in the context of substance use that requires treatment (see, e.g., EMCDDA 2009). The share of cannabis named as a primary drug is between 17% and 32%, depending on the setting. In part, this has to be qualified, however, because a very high percentage of clients who only use cannabis have been referred to compulsory treatment: for instance, this applies to 61% of people undergoing long-term outpatient treatment (see also Chapter 4.1).

Figure 5.2
People entering drug-related treatment, by primary drug and type of service



Note: Multiple answers were permitted.

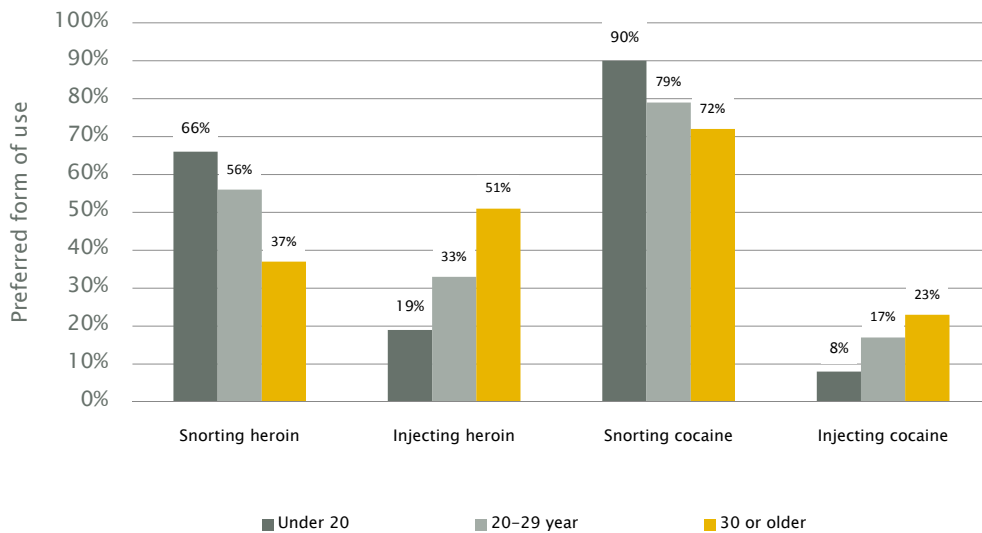
Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

Approximately half of the clients turning to the respective services (except short-term contacts, where this aspect is not documented) have already entered opioid substitution treatment (OST started in the course of the provision of drug-related services is not documented in this context), with the share of clients undergoing substitution treatment rising with age.

The DOKLI data of 2009 confirm former results regarding the great relevance of snorting also among users of heroin or other opioids, which is important with regard to harm reduction.

Figure 5.3

Preferred form of use of heroin (n = 2 237) and cocaine (n = 2 440) among people entering long-term outpatient treatment in 2009, by age



Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

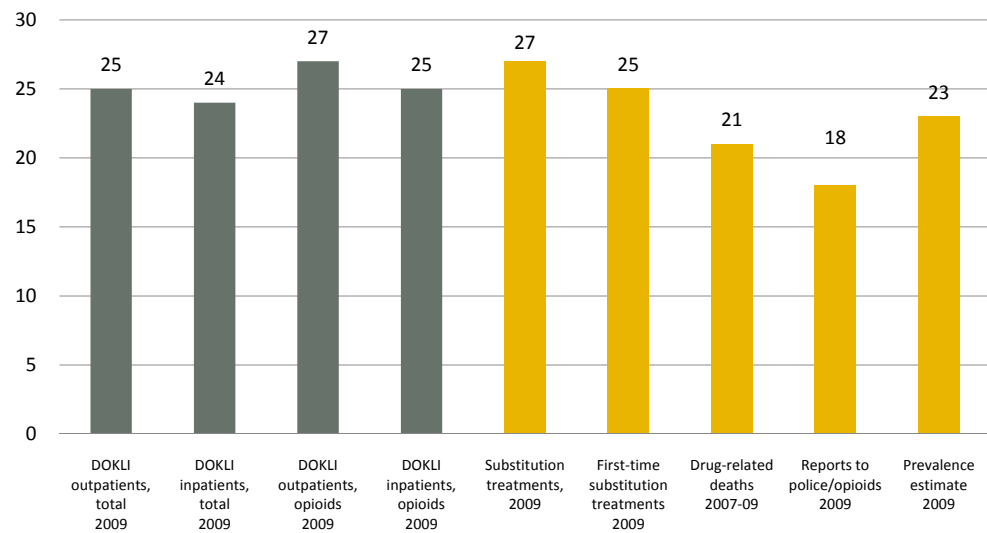
Persons undergoing long-term outpatient treatment most often name snorting (52%) as their preferred mode of administration of heroin, followed by injecting (37%). In inpatient settings, the corresponding shares are 32% and 60%, respectively. The number of people who indicate injecting as their most frequent way of drug use is rising with age of clients (see Figure 5.3). This is an interesting result, which was analysed in more detail in the selected issue of the 2008 DOKLI report (GÖG/ÖBIG 2008a and Busch und Eggerth, under preparation). It has shown that a considerable share of heroin users prefer snorting at the beginning of their drug careers and turn to injecting use only at a later stage, if at all. For possible prevention approaches that might result from these findings please consult GÖG/ÖBIG 2008a.

The selected issues chapter of this year's DOKLI report (GÖG/ÖBIG 2010a) deals with gender differences. First, it is discussed whether women are indeed underrepresented in the drug treatment and support system (e.g. for lack of adequate services), which is assumed in some publications. A comparison with other sources of data does not back this hypothesis, however, as the share of women mentioned there is at a similar level or lower than the share registered by DOKLI (see Figure 5.4). Still, if the above hypothesis were correct there would have to be a group of women not covered by the

existing treatment system who do not tend towards risky patterns of use (as they are not found among drug-related deaths) and have not been reported to the police either.

Figure 5.4

Share of women registered in the DOKLI system, undergoing OST, among people reported to the police because of opioid offences, in the 2009 prevalence estimate and among drug-related deaths 2007–09, respectively; percentages

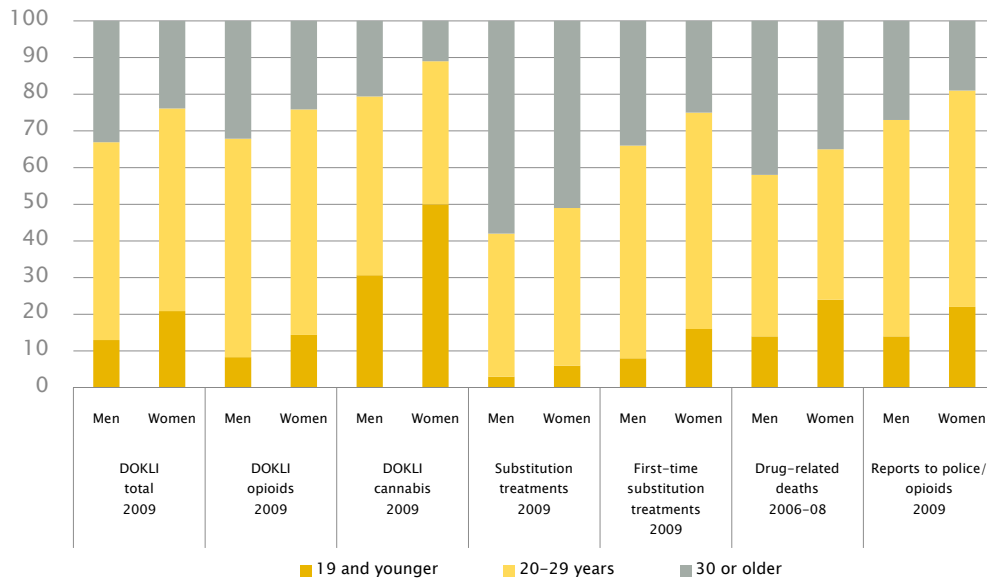


Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

Another result worth mentioning concerns the differences in age structure between men and women receiving drug-related treatment: women are overrepresented compared to men among young clients (20 or younger) and underrepresented in the group of older drug users (30 or older). This phenomenon also shows in other data sources in the field of drug monitoring (see Figure 5.5).

Figure 5.5

Age distribution of men and women registered in the DOKLI system, among people undergoing OST, among drug-related deaths and among people reported to the police because of opioid offences, respectively (percentages)



Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

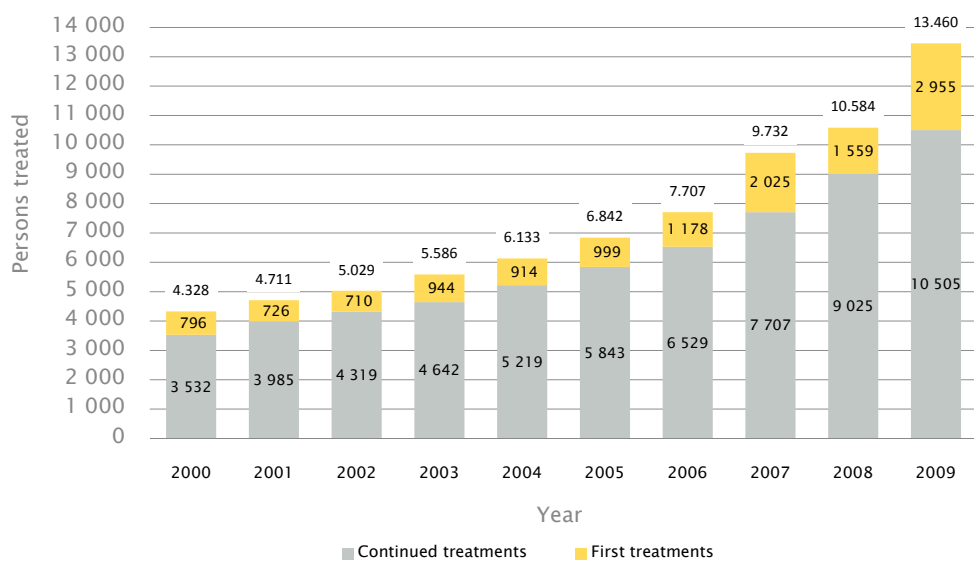
One obvious reason for the greater share of persons aged under 20 among women is that girls start to take drugs around one year earlier than boys. This discrepancy is also found with regard to the initiation of injecting use (see GÖG/ÖBIG 2010a; for possible causes please consult, e.g., GÖG/ÖBIG 2007a, Haas 2005). Another factor might be that the period between drug initiation and entering treatment is shorter in the case of girls. Still, an earlier start of therapy would primarily explain the greater share of clients under 20 among women but not the small share of clients over 29 among women: this might possibly be due to a greater insight of women into problems related to their drug use (see Haas 2005), or pregnancy as a motivation for turning away from drug use at a younger age. Incidentally, the analyses of directly drug-related deaths of people undergoing OST also reveal significantly smaller mortality rates among women (see Chapter 6.3), which indicates a better prognosis for women clients.

5.4 Trends of clients in treatment

As DOKLI has been available since 2006 only, no statements on trends can yet be given (the first analyses of trends have been planned for 2011). But time series going back over many years exist for opioid substitution treatment monitoring.

Figure 5.6

Development of annual reports of the number of people currently undergoing OST in Austria, by first treatment and continued treatment, 2000–2009



Note: **Continued treatment** means treatment started before the respective year or repeated treatment of persons already having undergone substitution treatment in the past. **First treatment** means treatment of persons who have never been in substitution treatment before. Any differences to the figures given in previous years (GÖG/ÖBIG 2009b) result from corrections on the part of the BMG.

Source: BMG, calculation and representation by GÖG/ÖBIG

The national monitoring of substitution treatment is performed by the Ministry of Health and based on reports by attending doctors²⁵. Although these reports are not always complete and frequently not provided in due time (see ÖBIG 2003, GÖG/ÖBIG

25

As of 2009, the district authorities, in their functions as health authorities, have been in charge of communicating data to the substitution registry.

2010b), they still give a general impression of both quantitative developments and characteristics of clients (see ST3, ST TDI and Figure 5.6).

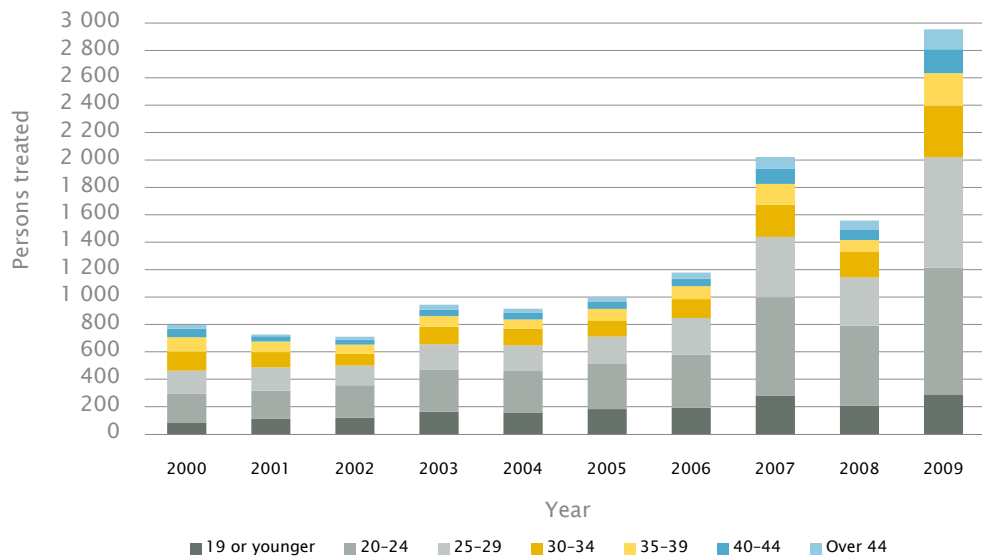
The problem of ghost cases ²⁶ (see Chapter 4.1) has been a significant deficit regarding data quality. In order to get this problem under control, the Ministry of Health started comprehensive correction routines in 2007, based on enquiries to attending doctors, and it may safely be assumed that the amendment to the Narcotic Drugs Decree (see GÖG/ÖBIG 2007b), which entered into force on 1 March 2007, has considerably improved reporting practices. Because of these corrections and a number of modifications, a number of differences compared to the figures given in previous years show. A considerable part of the rise in the number of treatments reported, and especially first treatments between 2006 and 2007, has probably been caused by the better coverage of cases. The massive increase in first treatments in 2009 (see Figure 5.7) might be due to the transfer of reporting competencies to the district authorities (subsequent reporting of persons already undergoing treatment for some time, who thus are incorrectly included in first treatment figures). It cannot be verified whether the number of people in treatment that is given now (13 480) indeed represents the actual situation. Still, assuming that all persons undergoing treatment have now been registered but that not all ghost cases have already been eliminated, the actual number of OST patients should be smaller.

Because of the methodological problems described above, it is not possible at present to provide ample epidemiological data. The growing acceptance of and readiness to undergo opioid substitution treatment is reflected in the annually rising number of persons reported as currently receiving OST (see Figure 5.6). As in previous years, the share of women is around one out of four. In view of the change in coverage, a further breakdown of data by age and province would not make sense. A list of reported substitution treatments by province is given in Table A21 in Annex A.

26

If the end of treatment is not reported, the corresponding clients appear in the statistics as people currently undergoing treatment also in the years after the actual end of treatment (= ghost cases; for details see GÖG/ÖBIG 2006 and GÖG/ÖBIG 2010b).

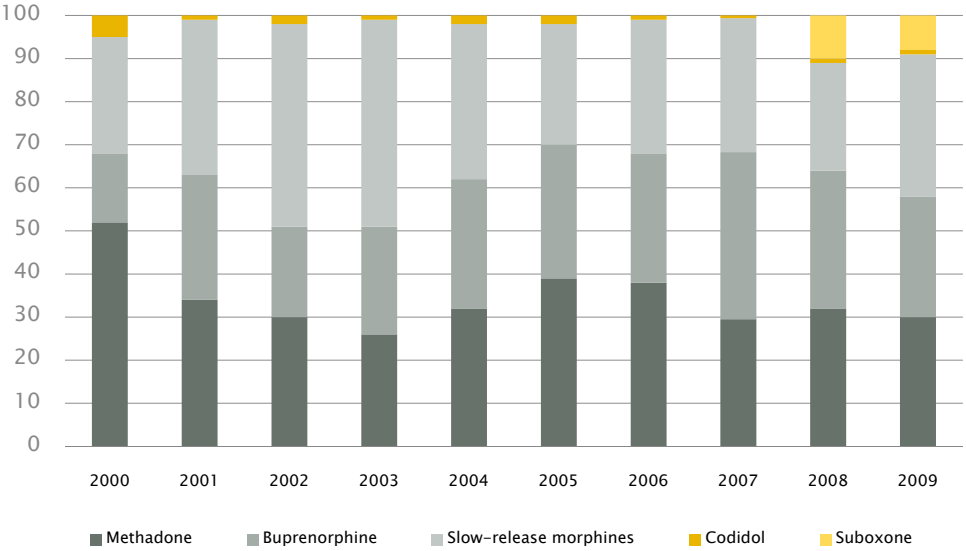
Figure 5.7
First substitution treatment in life, by age, 2000–2009



Source: BMG, calculation and representation by GÖG/ÖBIG

Caution is advised when analysing the substances prescribed for first treatment, as part of the treatments, due to the reasons mentioned above, might incorrectly have been entered as first treatments. The share of slow-release morphines has again slightly risen compared to previous years: to 33% (2008: 25%). The prescription rates of methadone, buprenorphine and Suboxone have gone down insignificantly (see Figure 5.8). As in past years, the analyses of the DOKLI data show a different picture. One has to bear in mind here that the respective data are comparable to a limited extent only (different groups of clients; see GÖG/ÖBIG 2007b). In the case of clients registered by DOKLI, slow-release morphines are prescribed most often (45% of long-term outpatient clients; 67% of clients receiving low-threshold services and 62% of persons undergoing long-term inpatient treatment), and the share of substitution patients who are administered methadone is between 17% and 27%, while buprenorphine is taken by only 5% to 21% of patients (GÖG/ÖBIG 2010a). Buprenorphine is typically prescribed to younger clients.

Figure 5.8
Trends regarding substitution substances used for first treatment, 2000-09,
percentages



Source: BMG, calculation and representation by GÖG/ÖBIG

Due to the aforementioned problems regarding data quality of the substitution registry it has not been regarded as sensible to update the estimate presented in last year's report of the total number of people undergoing drug related treatment based on DOKLI and OST data (the result for 2008 is given in GÖG/ÖBIG 2009b: 17 000 persons). It is safe to assume, however, that the respective figures will not have changed significantly within one year.

6 Health Correlates and Consequences

Infectious diseases are relevant in particular because of the risk of transmission due to injecting drug use. The available data in this context are based on non-representative samples from treatment or low-threshold centres. While the HIV prevalence rate still was around 20% in the early 1990s, it has remained at a low level since then (0% to 5%). The prevalence rate of hepatitis B was below 20% in the reporting year, and in the case of hepatitis C–Ab it has remained near 50%. Regarding hepatitis C, the prevalence rates relating to HCV antibody (HCV–Ab) and HCV–RNA tests have been documented separately by a few drug treatment centres. This is of interest as it is primarily positive testing for HCV based on PCR tests that indicates a chronic development of HCV.

Psychiatric comorbidity in the context of drug addiction continues to be a focal theme in Austria. Although no routine data have been collected in this field, many data and reports from treatment centres are available. These data indicate high prevalence rates of psychiatric comorbidity (dual diagnoses) among problem drug users.

In Austria, the Ministry of Health has collected data on drug-related deaths since 1989. In the case of directly drug-related deaths, a causal connection between death and drug use may safely be assumed, i.e., the patients in question died as a result of acute intoxication (overdoses). However, 2008 saw a considerable reduction in the number of cases in which post mortem examinations as well as toxicological tests were performed when overdoses of substances including illicit drugs were suspected, although such tests would be important for verification and analysis of any substances overdosed (GÖG/ÖBIG 2009b). In 2009, again 19 cases were registered in which an intoxication with narcotic drugs was mentioned in the confirmation-of-death certificate but no autopsy or post-mortem examination was requested by the courts or the public health police, respectively. In these cases, overdoses including narcotic drugs could not be verified, thus it is not sure whether they are in fact drug-related deaths or not. As the number of such cases has risen significantly in recent years, this both affects the conclusiveness of statistics and makes it impossible to relate the corresponding data to those of previous years. Generally speaking, the share of autopsies performed in Austria is above average compared to other European countries, but it has gone down continually for several years; in 2007 it was 19.4% in all cases of death (Leitner 2009). On the occasion of the annual meeting of the group of experts to discuss the key indicator of drug-related deaths, uniform guidelines for autopsies in cases of suspected drug-related deaths were drawn up in cooperation with the Society of Forensic Medicine Specialists in Austria, which will contribute to improving the conclusiveness of statistics regarding substances involved (e.g., clear distinction between heroin and morphine) as well as concomitant diseases (Beer et al. 2010).

In 2010 GÖG, in an EMCDDA working group on mortality cohorts, analysed directly drug-related deaths of people undergoing opioid substitution treatment (see Chapter 6.3).

6.1 Drug-related infectious diseases

The data on drug-related infectious diseases that are given in ST9 are based on national and subnational samples from low-threshold and inpatient treatment centres. The corresponding **prevalence rates** are summarised in Table 6.1. The data of the reporting year indicate hepatitis B (HVB) rates ranging from 2% to 19%. In most cases it can be excluded that positive findings result from previous vaccinations (see also footnote to Table 6.1). The drug treatment centres again report low HIV prevalence rates between 0% and 3% (2008: 0% to 2%). In recent years, a slightly higher HIV rate has already been found among drug-related deaths: in 2009, it was between 5% and 12%. The hepatitis C antibody (HCV-Ab) prevalence rates of 2009 were between 18% and 70%, i.e., again, great differences in prevalence rates show, depending on the data source (see GÖG/ÖBIG 2008c, GÖG/ÖBIG 2009b).

Regarding HCV-RNA, a chronic development of the disease shows in a high share of patients testing positive for HCV-Ab. Because of the great spread of HCV-RNA prevalence rates that are reported, i.e., between 52% (Marienambulanz) and 75% (Lukasfeld), these data cannot be used as a basis for deriving general statements on chronic developments of hepatitis C infections. Regarding HCV genotypes, neither national data nor information by individual centres is available for the reporting year.

Generally speaking, the prevalence rates reported are comparable only to a limited extent because of differences in data collection methods by the individual centres (routine examinations v. voluntary test services offered), and lack of representative data sources.

Table 6.1

Data on hepatitis B, hepatitis C–Ab, hepatitis C–RNA and HIV infection rates, in 2009

Data source	HBV rate	HCV–Ab rate	HIV rate
Lukasfeld treatment department	23% (14/60) ¹	33% (20/60)	3% (2/60)
Long-term treatment department at Anton Proksch Institute (API)	18% (15/82) ²	43% (35/82)	0% (0/82)
Low-threshold centre Ganslwirt	9% (5/55) ³	70% (51/74)	0% (0/79)
Caritas Marienambulanz outpatient department	15% (19/123) ⁴	70% (86/123)	1% (1/123)
DOKLI ⁵	14% (45/332)	55% (238/435)	2% (8/424)
Drug-related deaths (intoxications) 2009	n.a.	18% (34/187) ⁵ 45% (34/76)	5% (9/187) 12% (9/76)

1 This percentage relates to persons in whom antibodies to hepatitis B were found and whose medical history did not indicate hepatitis B vaccinations.

2 This percentage relates to persons in whom antibodies to hepatitis B were found and for whom it was established that they had not received vaccinations or been cured.

3 This percentage relates to persons in whom hepatitis B antibodies or antigens were found and who had not yet received hepatitis B vaccinations.

4 This percentage relates to persons in whom both HBVc and HBVs antibodies were found. People who tested positive only for antiHBVs were excluded because this results from HBV vaccinations.

5 Only 76 out of a total number of 187 expert opinions on directly drug-related deaths explicitly mentioned the presence or absence of HCV Ab or HIV infections. In the remaining cases it is not clear whether no tests for the relevant infections were carried out or whether the results were negative and thus not mentioned. The two percentages given therefore indicate maximum and minimum levels of HCV and HIV infection prevalence rates.

Sources: Duspara, Stolz–Gombocz, Haltmayer, Anderwald, Bauer, personal communications; GÖG/ÖBIG 2010a, GÖG/ÖBIG 2010c; see also ST9; representation by GÖG/ÖBIG

For Vienna, data on drug-related infectious diseases that have been obtained from cases histories are given in the section on current health problems of the BADO report (see Table A29 in the Annex; IFES 2009b). The information provided by clients for Vienna's BADO documentation indicates a HCV prevalence rate of 29% and a HBV prevalence rate of 3%, i.e., prevalence has remained at a level similar to previous years. HIV prevalence, also based on information by the clients themselves, has hardly changed as well: it is 4% now (IFES 2009b). An almost linear correlation between rises in hepatitis C infections and age of clients has shown: while the prevalence rate is 10% among clients under 21, it goes up to 40% among clients over 30. Because of the study design, it is not possible to distinguish between positive test results for HCV antibodies and a positive HCV RNA status.

No data from the official reporting statistics of infectious diseases relating to the general population have yet been available for 2009 (see GÖG/ÖBIG 2009b).

The reports from the long-term national AIDS statistics show that injecting use is the third-most risky situation (10 cases) after heterosexual contacts (n = 25) and homosexual contacts (n = 17). In 2009, seven cases were filed as 'other/unknown'. The statistics on AIDS deaths by risk situation and year show that less than one third out of a total of 19 deaths listed were related to injecting drug use (BMG 2010a; see Table A3 in Annex A).

Data on other drug-related infections are available only for tuberculosis (TB). No person out of 208 for whom tuberculosis entries exist in the corresponding DOKLI data set (see Chapter 5.3) had a positive TB diagnosis, two cases had already been registered before. These figures again confirm that TB is no relevant problem among clients receiving drug treatment services. The TB vaccination rate given is based on the data of 238 people. The latest data again point to a low TB vaccination coverage: it was 5% in both 2008 and 2009 (GÖG/ÖBIG 2009a; GÖG/ÖBIG 2010a).

The DOKLI data set on hepatitis A vaccinations includes 359 people, and regarding hepatitis B vaccinations, 493 people. The **vaccination coverage** of 28% for hepatitis A and 33% for hepatitis B is in fact small. However, among people under 20, higher vaccination rates have been registered than in the other age groups (see GÖG/ÖBIG 2010a). The above HBV vaccination coverage rates are similar to the rates communicated by the inpatient departments of Lukasfeld (27%) and API (34%) but not by the Marienambulanz low-threshold centre (10%; see ST9). The figures reported generally reflect previous vaccinations rather than the actual status of immunisation (GÖG/ÖBIG 2009a).

6.2 Other drug-related health correlates and consequences

In a diploma thesis, 58 clients living at the Erlenhof treatment centre were surveyed by means of a standardised questionnaire, which focused on their state of health and in particular their **psychological situation** (Porstmann 2009, see Chapter 5.2) Three out of four respondents indicated memory and concentration problems, and around half of clients said they suffered from severe depression. More than 50% indicated anxiety and feelings of tension, and approximately one out of three suffered from aggression they could not control. One third of respondents already had attempted suicide at least once: suicide attempts were found considerably more often among women than among men (Porstmann 2009).

The DOKLI data also provide information on psychiatric comorbidity (see Chapter 5.3). In 183 out of 347 people (53%) for whom at least one ICD-10 diagnosis not related to addiction was entered, a mental and behavioural disorder was found. The diagnoses

range from affective disorders (e.g., depression), personality and behavioural disorders to neurotic, stress and somatoform disorders (GÖG/ÖBIG 2010a).

According to the statistics of Vienna's BADO documentation system, 61% of people covered indicated that they were currently suffering from health problems²⁷. Apart from chronic hepatitis C (29%) the clients of Vienna's drug treatment centres most frequently named dental problems (19%), followed by gastrointestinal problems (12%), psychiatric problems (11%), and other diseases (11%). In the past five years, no significant changes have shown with regard to indications of the individual health-care problems listed (see Table 29 in Annex A). As a rule, women tend to indicate health-related problems to a somewhat greater degree than men (67% v. 58%). This difference is mostly found with regard to gastrointestinal problems and psychiatric diseases (IFES 2009b).

The question of mental health is primarily addressed by the providers of low-threshold services. The statistics of themes discussed in the context of support services at the Ganslwirt low-threshold centre underlines that mental health ranks second after housing problems, and before drug use and physical health (VWS 2010b).

Apart from psychiatric comorbidity and the health consequences of the infectious diseases discussed above, also **somatic diseases** and damage resulting from the chronic effects of toxins or the precarious life conditions of injecting drug users deserve mention.

Physical comorbidity (concomitant organic diseases) is analysed annually on the basis of test results (macroscopic and microscopic histological analyses of internal organs) obtained in the context of forensic expert opinions on directly drug-related deaths. As in previous years, these findings reveal pronounced organic damage among drug users. In the majority of indirectly drug-related deaths²⁸ (28 people), the cause of death was a disease such as myocarditis, cirrhosis or cancer; 10 persons died of AIDS,

27

These indications of health problems are exclusively based on information by the clients themselves and not on diagnostic interviews, medical findings or test results.

28

In the case of indirectly related deaths, the cause of death is not an acute intoxication with a narcotic drug. However, because of the patient's history of drug use, their death could be related to drug use. As a classification is only possible if a suspicion of an indirect drug relation is reported, the data cannot be assumed to be complete (see GÖG/ÖBIG 2007b).

two had fatal accidents and seven committed suicide (no lethal overdoses; see GÖG/ÖBIG (2010c).

Regarding comorbidity of pregnant drug users, only information on specific interventions is available (see Chapter 7.3). Statements on the prevalence of psychiatric or physical comorbidity cannot be made because the sample in question is not representative, among other reasons. The available data can only be regarded as a description of the frequency of incidents. Therefore interpretations in a political, legal, economic or social context cannot be given either.

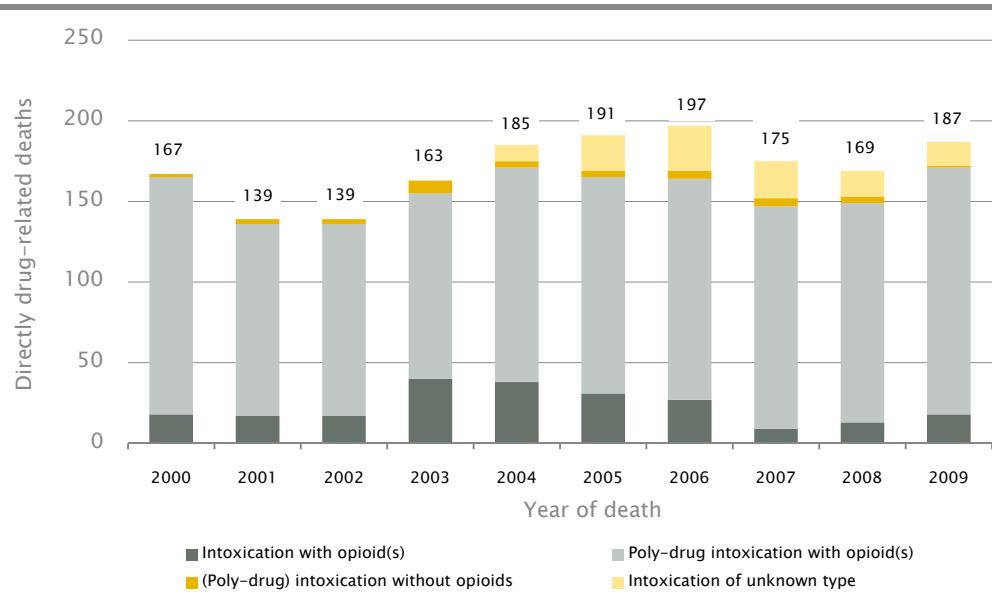
6.3 Drug-related deaths and mortality of drug users

Regarding drug-related deaths, a distinction is made between deaths directly caused by drug use and indirectly related deaths (for details on methodology see GÖG/ÖBIG 2010c). Based on autopsy findings, a total of 187 directly drug-related deaths could be verified. This figure has to be regarded as the lower limit, however. In fact, if one also includes suspicious cases that were reported and for which only confirmation-of-death certificates (based on an external examination of the body) are available, between 187 and 206 deaths might be directly drug-related. As already mentioned last year (see GÖG/ÖBIG 2009b), in a significant number of cases (19) no autopsy was performed, therefore it is not possible to derive any concrete trends.

In 13% of cases of drug-related death, the toxicological analyses revealed only illicit substances (one drug or a combination of several drugs). In addition, psychoactive substances were also found in 47% of cases, in 10% alcohol was detected as well, and in 30%, both substances, i.e., alcohol and psychoactive drugs, were found. As in previous years, poly-drug intoxications with opioids clearly predominate (99% of intoxications with known substances; see Figure 6.1). The opioids most often found are morphine and heroin, followed by other opioids and methadone (GÖG/ÖBIG 2010c). Cocaine and amphetamines were detected in only 22% and 15% of cases, respectively. The share of persons who had exclusively taken opioids is 11%, which is a slight rise compared to the year before (2006: 16%; 2007: 6%; 2008: 8%). Patterns of poly-drug use, where the effects of different substances may be potentiating and thus are difficult to control, continue to be widespread and constitute serious health hazards (see Chapter 4).

Figure 6.1

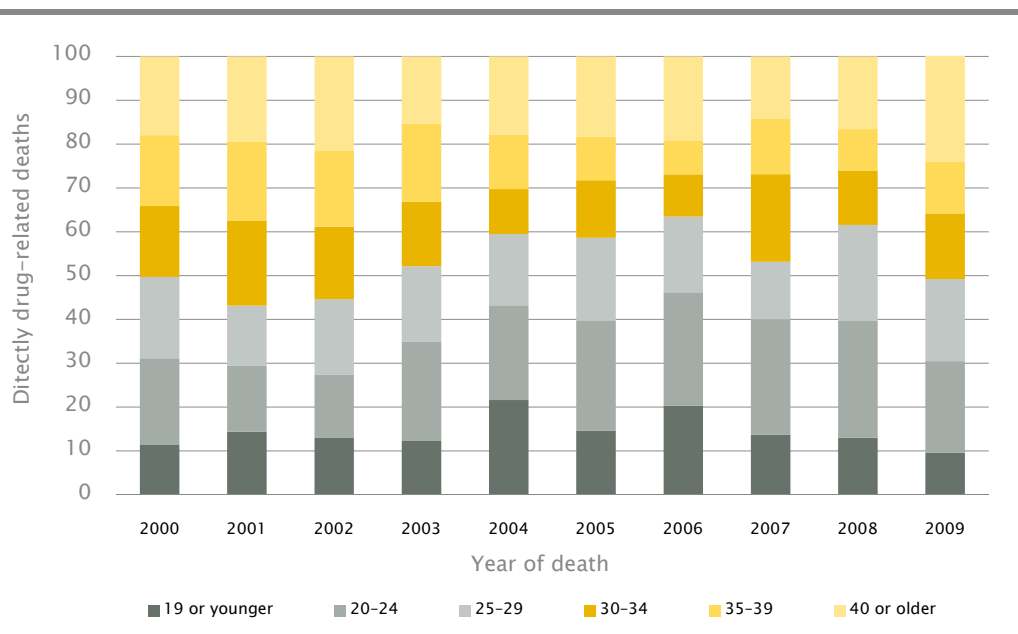
Share of directly drug-related deaths in Austria, by cause of death, 2000–2009



Source: GÖG/ÖBIG 2010c; representation by GÖG/ÖBIG

Figure 6.2

Age distribution of directly drug-related deaths in Austria, percentages; 2000–2009



Source: GÖG/ÖBIG 2010c; representation by GÖG/ÖBIG

The grouped median²⁹ of the age at death was 29.2 years in 2009: the age median of the reporting year thus is again at a level similar to previous years, (2006: 24.6; 2007: 28.3; 2008: 25.7). The share of persons under 20 (11%) was within the range of previous years (2006: 20%; 2007: 14%; 2008: 13%; see Figure 6.2). The share of women in directly drug-related deaths, i.e., 20%, is in line with the long-term average.

The Institute for Empirical Social Studies (IFES), on behalf of the Vienna Addiction and Drug Coordination Office, analysed those autopsy expert opinions drawn up between 2005 and 2007 in Vienna and Lower Austria in which a drug-related cause of death was proved or suspected (see Chapter 7.1). The evaluation of the expert opinions will serve as a basis for a uniform structure of, and definition of aspects to be covered in, future autopsy reports and test procedures. The results have not yet been published (Sucht- und Drogenkoordination Wien 2010).

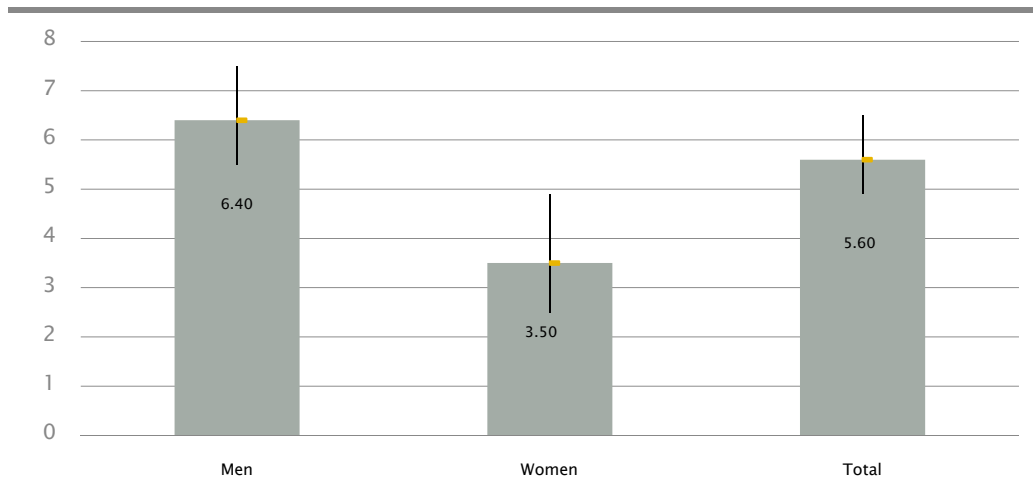
²⁹

Grouped median means that 50% of cases are above this figure and 50% are below this figure.

In the EMCDDA working group on cohort mortality, an analysis of directly drug-related mortality of people undergoing opioid substitution treatment was carried out in 2010.

Figure 6.3

Directly drug-related deaths per 1 000 person years of men, women and total number, of people entering OST for the first time in the period between 1 January 2000 and 31 December 2008



Note: The black lines refer to the width of the 95% confidence intervals.

Source: data analysis and representation by GÖG/ÖBIG

For this purpose, the data from the substitution registry and the statistics of drug-related deaths were linked after they had been pseudonymised³⁰. The analysis relates to those persons who between 1 January 2000 and 31 December 2008 entered opioid substitution treatment for the first time in life.

30

Pseudonymisation means that personal data such as name, date of birth, etc., are replaced by an identifier that cannot be traced back. In this way it is possible to see which data refer to one and the same person without permitting an identification of concrete persons.

This applies to a total number of 9 716 people. The sum of years in which these people have been registered in the observation period, results in a total of 35 497 person years³¹. The average age at entering the cohort (= beginning of first treatment) was 27.3 years, and the share of women was 26%. A total of 200 people out of the group of 9 716 patients died of an overdose in the period between 2000 and 2008. The mortality rate was 5.6 (95% confidence interval: 4.9 to 6.5) deaths per 1 000 person years (see ST 18). An interesting aspect is that the mortality rate regarding directly drug-related deaths is significantly lower among women than among men (see Figure 6.3 and Chapter 5.3).

One has to take into account, however, that this analysis exclusively relates to overdoses and thus to directly drug-related deaths. It does not permit conclusions as to total mortality of people in OST (e.g., death because of diseases associated with drug use, etc.; GÖG/ÖBIG, under preparation).

31

The term person year refers to the time during which a person is observed in the context of a cohort study. For instance, in the cohort in question, any person entering OST on 1 January 2000 contributes nine person years (except people who died before 31 December 2008). Any person entering OST on 1 January 2001 contributes eight person years, etc. For instance, if a person enters OST on 1 January 2002 and dies on 30 June 2002, they account for half a person year. In many mortality cohort analyses, the mortality rate is expressed as deaths per 1 000 person years.

7 Responses to Health Correlates and Consequences

In Austria the responses to health correlates and consequences include a wide range of interventions. The relevant measures focus on drug-related infectious diseases, in particular low-threshold services aimed at harm reduction. For instance, syringe exchange, hepatitis vaccinations and information on safer use/safer sex are typical services performed by low-threshold centres and outreach services (street social work). Treatment of health consequences is primarily provided by the general health-care system (e.g., emergency physicians, psychiatrists), and to an increasing extent also in the context of consulting hours of physicians/specialists in low-threshold centres. In the past year, also the themes of diagnosing and treating hepatitis C, as well as comorbidity, were of particular relevance. The available information and data primarily come from the annual reports of individual units and the Drug and Addiction Coordination Offices in the provinces.

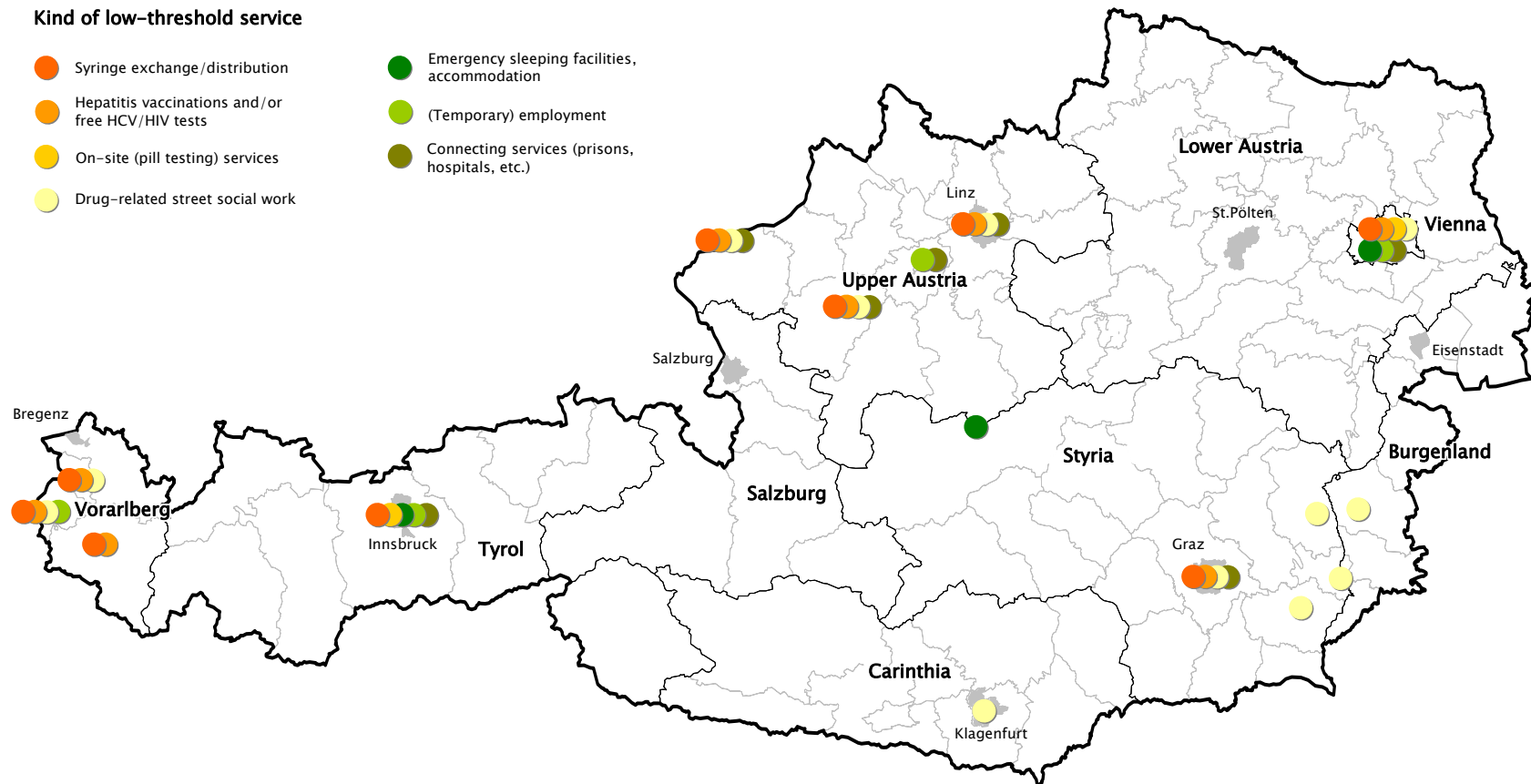
7.1 Prevention of drug-related emergencies and reduction of drug-related deaths

At federal level, interventions aimed at reducing drug-related deaths continue to be of great importance. In the reporting year, a special meeting of the Federal Drug Forum took place, where this issue was discussed. In addition, a steering group is to be convoked, which will focus on possible measures to reduce drug-related mortality, and a position paper on harm reduction measures in the context of drug support services will be drawn up (see Chapter 1.2).

Specific initiatives focusing on drug-related emergencies and deaths are mainly pursued by low-threshold drug services, by individual centres, and in some cases also at provincial level. Information and advisory services play an important role in this context. However, emergency services are also of vital importance, e.g., crisis intervention and observation (VWS 2010b; VWS 2010c). In the study on drug-related deaths conducted in Vienna, possible risk factors have been identified and will form the basis for defining risk profiles and developing specific prevention strategies as well as early detection measures in order to reduce drug-related deaths (see Chapter 6.3). For an overview of specialised harm reduction measures aimed at drug users in towns and cities of Austria, see Map 7.1.

Map 7.1

Specialised low-threshold providers of harm reduction services for drug users, 2010



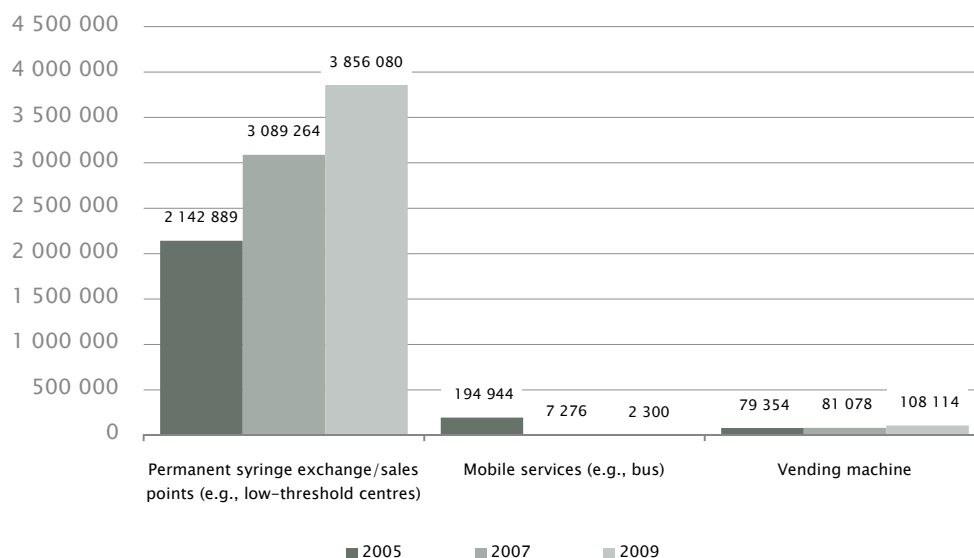
Source: GÖG/ÖBIG in cooperation with the provincial Drug and Addiction Coordination Offices, representation by GÖG/ÖBIG

7.2 Prevention and treatment of drug-related infectious diseases

Preventing infections continues to play an important role in low-threshold centres and outreach work: here the **exchange and sale of syringes** is especially important. In addition to the established programmes for the exchange and sale of syringes that are run at provincial level, it is also possible in Austria to buy syringes and needles in pharmacies and vending machines.

In Vienna the existing services provided by drug treatment and advice centres have been expanded and approaches have been modified (see Chapter 9.2). The streetwork contact point closed its syringe exchange service because of restructuration plans at Karlsplatz square. Instead, as of mid 2010 syringe exchange has been possible at the temporary office of TaBeNo-Süd and as part of the regular services provided by the Ganslwirt low threshold centre. In order to be able to meet the additional demand, Ganslwirt expanded its room capacities. By the end of 2011, both TaBeNo-Süd and Ganslwirt, i.e., both syringe exchange services in Vienna, will move to Ganslwirt's new location at Gumpendorfer Gürtel in Vienna's 6th district (Sucht- und Drogenkoordination Wien 2010). So far, the acceptance by drug users of the new place for syringe exchange has been very good. In July 2010, the number of syringes exchanged again reached its former level (Öllinger, personal communication).

Figure 7.1
Syringe exchange and syringe sales in Austria; 2005, 2007 and 2009



Source: Substanz 2009; representation by GÖG/ÖBIG

Figure 7.1 clearly indicates a further rise in the total number of syringes returned or sold compared to the two previous years surveyed. In 2009, 3 966 494 syringes or needles were dispensed to drug users in Austria in permanent syringe sales and exchange points, primarily located in low-threshold centres (see Table A28 in Annex A; ST10). A development worth mentioning is that in recent years the number of syringes distributed through mobile services (e.g., bus) has declined continuously. Here, the fact that mobile syringe exchange and sales services in Vienna were closed in 2007 is related to the considerable decline in numbers between 2005 and 2007 (see GÖG/ÖBIG 2008c). By now, vending machines exist in five provinces. In Upper Austria, the first vending machine of the province was procured for the town of Wels (see Table A28 in Annex A; ST10). In 2009 a total of 108 114 injection sets were sold through this channel. Since 2008, the number of vending machines in Austria has slightly increased (see Table A28 in Annex A, GÖG/ÖBIG 2008c).

Safer use and **safer sex** continue to be essential issues that are addressed in the context of outreach drug social work, usually on the occasion of syringe exchange. Streetwork registered a marked increase in the provision of information on safer use as well as advice and counselling talks compared to 2008, while crisis intervention and life-saving measures were required less often (VWS 2010c; VWS 2009). In the context of prevention of infectious diseases, information on safer use and safer sex (including

distribution of condoms) is provided at the temporary office of TaBeNo-Süd (Sucht- und Drogenkoordination Wien 2010).

Hepatitis vaccination projects are further essential interventions to prevent and treat drug-related infectious diseases. They are organised at regional level or as initiatives by individual centres. In most cases the vaccination services are combined with free HIV and viral hepatitis testing. For instance, in 2009 the Ganslwirt low-threshold centre (Vienna) registered 76 HAV/HBV vaccinations, and Kontaktladen (Graz) 47 vaccinations (VWS 2010b; Caritas Diözese Graz-Seckau 2010). In order to check the immunisation status, Ganslwirt's outpatient clinic also carries out annual anti-HBs titre tests. As a rule, the non-responder rate (rate of people who do not develop antibodies after a vaccination) is elevated among drug users because their immune response is not as good as other people's (see GÖG/ÖBIG 2006). Still, in 2009 Ganslwirt registered a non-responder rate of approximately 10% among drug users, which corresponds to the non-responder rate of the general population.

In Innsbruck a study on safer use and infectious diseases was drawn up. Its results will form the basis for harm reduction measures addressing defined target groups of clients of the nationwide network of Caritas drug support centres (Gratzel, personal communication). Carinthia is preparing recommendations for the implementation of harm reduction measures (see Chapter 1.2).

The Austrian Society of Gastroenterology and Hepatology (ÖGGH) as well as three Austrian universities revised the German guidelines on prevention, diagnosing and treatment of hepatitis C virus infections published in 2004. The guidelines aim at establishing standards for reducing the number of new infections and applying evidence-based forms of antiviral treatment (Sarrazin et. al 2010; see Chapter 11.1).

Treating infectious diseases in drug users has become increasingly important in the whole country. A prerequisite for successful treatment is that multiprofessional networks exist which link drug support centres and providers of other health-care services. For instance, in Vienna drug patients who suffer from hepatitis B or C may also obtain treatment in all gastrointestinal outpatient departments of the individual hospitals. Because of the significant rise in hepatitis C infection rates (HCV PCR positive cases) among clients, Kontaktladen in Graz has planned a hepatitis campaign (Caritas Diözese Graz-Seckau 2010).

The question of drug consumption rooms, discussed in the context of the plans to establish a drug treatment contact point in Graz, Styria, has been a highly controversial topic in previous years (see GÖG/ÖBIG 2008c and 2009b; Chapter 1.2). In February 2010 the Green Party organised a hearing with international experts to discuss the issue of drug consumption rooms. However, at present, local policy makers in Graz do

not actively promote the implementation of a pilot project (Zeder and Ederer, personal communication).

7.3 Responses to other health correlates among drug users

Services with regard to **psychiatric comorbidity** are still part of the activities of the providers of support services for drug users. The services delivered by the individual centres hardly differ from those reported in previous years (see GÖG/ÖBIG 2008c and 2009b).

Interventions and measures that aim at the **general state of health** of drug users are integrated in all treatment and advice services delivered by the drug support centres, with different focuses depending on the setting in question. In particular in the low-threshold field, the corresponding services also include dressing of wounds, health information, hygiene routines, etc. For instance, two doctors are present at the Komfudro centre (Tyrol) once a week for free medical advice and dressing of wounds (Kern, personal communication). At the outpatient clinic of the Ganslwirt centre, doctors now hold surgery also in the morning (Sucht- und Drogenkoordination Wien 2010).

In Vienna, the *Brainstorm* group services for schizophrenic men were established: psychiatrists and psychosocial staff provide support to drug users to help them manage their disease in everyday life, and the clients thus have an opportunity to share experience and coping strategies (Dialog 2010b).

Another new service in Vienna is the neunerHaus dentist's office in the 6th district, which provides free treatment also for drug users. Although this service primarily addresses homeless people, it is open for addicted patients as well (VWS 2010k).

Special health promotion services addressing women continue to be an integral part of the work of the low-threshold centres (see GÖG/ÖBIG 2009b). The corresponding services include advice and support regarding problems that specifically concern women (e.g. prostitution to finance drug use, experience of violence), which usually take place in a defined setting. In the temporary office of TaBeNo-Süd (Vienna), also a range of advisory services, e.g. gynaecological consultancy by the FEM non-profit association, are available (Sucht- und Drogenkoordination Wien 2010).

In the Tyrol a one-year pilot support project for *pregnant OST patients* was started (see Chapter 5.2). Apart from a general preparation for birth, the interventions on which the project focuses include the provision of health-care services as well as

information on the risks of additional drug use during pregnancy (Aufhammer, personal communication). In Lower Austria, the project *DESK (Drugs, Parents, Addiction, Children)* was started, which also addresses pregnant drug users (see Chapter 5.2). The services provided by *DESK* are primarily oriented towards psychosocial and medical counselling and treatment of pregnant addicts (Hörhan, personal communication).

The existing **further training** programmes have been continued in the reporting period. API again organised a training course in nursing for addicted patients³². The CONTACT hospital connection service in Vienna continued its series of further training courses in care for addicted inpatients, which address the target group of nursing staff of Vienna's hospitals and other providers of social services (see GÖG/ÖBIG 2009b).

32
www.api.or.at (12 July 2010)

8 Social Correlates and Social Reintegration

The main sources for this chapter are the nationwide documentation system of clients of Austrian drug treatment centres (DOKLI), annual reports of providers of support services for drug users and similar centres, as well as information issued by the Addiction and Drug Coordination Offices in the provinces. Additional information on this aspect is also provided in SQ28 as well as Map 8.1, which shows specialised social integration services provided by drug support centres in individual towns and cities of Austria.

As in previous years, the most pressing social problems of drug users are homelessness, unemployment and debts; this especially applies to severely addicted users in the street drug scene.

Interventions for social (re-)integration of (former) drug addicts are directed at both clients after drug-free treatment and people who are currently using drugs. In Austria, interventions of this kind have traditionally been of major importance, especially in the areas of housing, work and (further) education and training. To some extent they are part of the chain of treatment and integrated in the corresponding treatment modules. The various interventions, some of them low-threshold in kind, are available after treatment or as a part of accepting drug assistance. Addicted people may also take part in a range of other services that focus on unemployment, homelessness and spare-time activities. Building links between drug-specific organisations in order to provide better services to clients has become more and more important.

8.1 Social exclusion and drug use

The social situation of the drug users turning to treatment and advice centres in Austria definitely continues to be worse than that of the general population (as to housing, education, employment and income). However, it should by no means be concluded from this that drug problems mainly arise in the group of socially disadvantaged people. All it shows is that this group will more readily turn to the drug treatment system than people who (still) have their own social and financial resources (see Chapter 5.3).

Among the clients of 2009 registered in the Austrian DOKLI system (see Chapter 5.3), the share of people with jobs continues to be smallest in the group undergoing inpatient treatment: 9% (2008: 13%). Here, the percentage of persons who indicate that they are unemployed is also highest (2009: 47%). Especially among clients in long-term outpatient treatment, the share of women who have jobs is significantly smaller compared to men (women: 26%; men: 31%). The difference between these two groups has decreased slightly, however.

While smaller shares of women state that they are jobless, recipients of welfare assistance are found more often among women than among men (see Table A23 in Annex A). An average of 50% of clients of low-threshold centres whose data are covered by DOKLI said they had stable accommodation (2008: 48%). Among the group of people receiving long-term treatment, again between 84% (inpatients) and 92% (outpatients) indicated a stable housing situation (see Table A25 in Annex A).

Regarding educational level, almost 60% of clients of Austrian drug services aged 19 or older said that their highest degree was a compulsory school leaving certificate. Approximately one out of four said they had completed traineeship. Among the clients, more women than men have completed vocational intermediate secondary school, or general education/vocational education upper secondary schools (GÖG/ÖBIG 2010a).

Half of people turning to Vienna's BerufsBörse (WBB, Vienna Job Exchange) in 2009 had been jobless for more than 24 months, thus accounting for by far the largest share of clients. Almost two out of three clients said that illicit drug use was the main reason for requiring WBB's services, the rest indicated alcohol problems. 41% of clients needed psychosocial or addiction advisory services, and 9% were referred to a support or treatment centre. One out of five clients took part in training programmes, 7% were able to get jobs in the regular labour market, and 5% found subsidised employment (Wiener BerufsBörse 2010a).

8.2 Social reintegration

Services aimed at social (re)integration are delivered in the areas of employment and training, housing and spare-time activities (see also Map 8.1). Regarding **employment**, the corresponding measures are oriented towards low-threshold access to occupation on a per-day basis as well as for a longer period. No information on new services in the field of training has been available.

Since 2008 the Diagnoses Institute (ISD) has run a programme for the reintegration of persons with addiction problems. It includes an addiction-related diagnosing process in which social work as well as medical and psychological services are integrated, with the focus placed on fitness for work. If temporary inability to work is diagnosed, the client concerned may be referred to Standfest, a project run by Dialog, which aims at helping clients regain fitness for work. In 2009, Dialog's addiction and employment centre provided advice and support to a total of 771 clients, which is an increase by 45% compared to 2008 (Dialog 2010b; Sucht- und Drogenkoordination Wien 2010).

For clients who are assessed to be fit for work, the existing services have been expanded and now also include case management for people with addiction problems, which is implemented by BerufsBörse (WBB, Vienna Job Exchange). *Fix und fertig*, a socioeconomic enterprise run by VWS (Vienna Social Projects Association) as well as garbarage, run by Anton Proksch Institute, have been integrated in the new system in

order to increase efficiency and use of capacities of the enterprises and to ensure their orientation towards the specific demands of their target groups. The corresponding coordination tasks, i.e., matching of clients' skills and the requirements of enterprises, have been taken over by WBB (Dialog 2010b; Sucht- und Drogenkoordination Wien 2010).

The *fix und fertig* enterprise again reports that the number of applications per day has been considerably higher than the available jobs (by approx. 40%). A total of 5 766 jobs were offered in 2009, which means that 263 different people found employment on a per-day basis (VWS 2010f).

In Lower Austria, the Addiction Coordination Office and the Public Employment Service of Lower Austria continue to cooperate in a joint project aimed at stimulating the reintegration in the labour market of addicted patients. For instance, clients get letters of recommendation by the project staff, which help the staff at the local offices of the Public Employment Service find adequate training courses or jobs for the clients. It has been planned to start a 12-month pilot stage already in summer 2010, in three locations (Hörhan, personal communication).

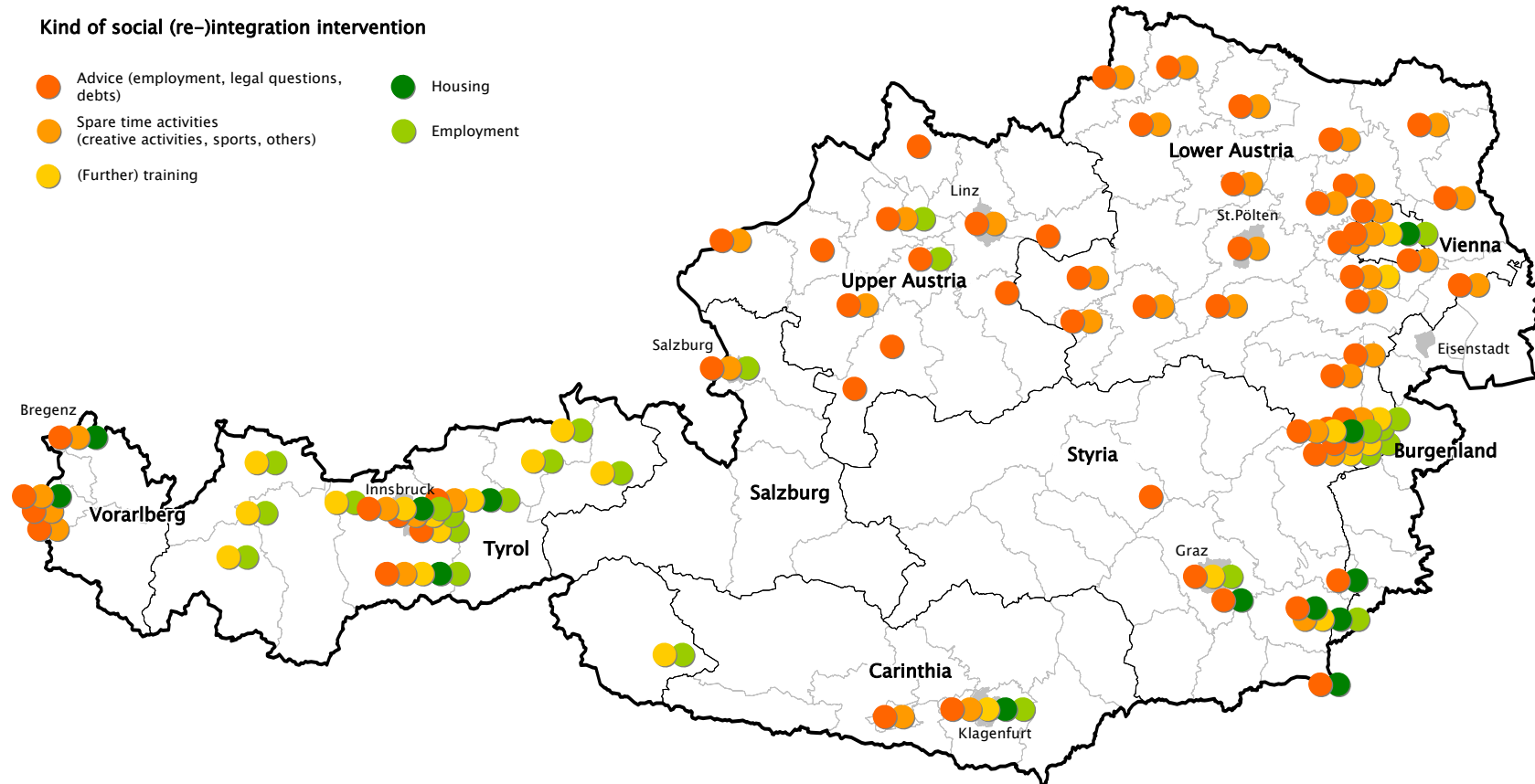
For rebuilding the Carina treatment facility in Vorarlberg, apart from professional building contractors, also patients were employed as workers. This served as a preparation for other jobs and later employment and helped clients find out if they have talent for and interest in work as craftspeople. An important aspect here was to give clients confidence in their own work skills and improve their self-esteem (Stiftung Maria Ebene 2010).

The job service unit of Caritas Vorarlberg provides employment in non-profit projects, two of which are low-threshold projects especially addressing young people. In 2009, more than 200 women and men who had been unemployed for more than one year thus found employment for a limited period. These projects also admit (former) drug users. While adult participants can only join the projects upon referral by the Public Employment Service, the projects for young people are open to all young people, independent of their previous period of unemployment (Caritas Vorarlberg 2010; see GÖG/ÖBIG 2009b).

The staff of Kontaktladen and streetwork in Graz (Styria) initiated working groups on the themes of housing and addiction on the one hand and employment and addiction on the other, in order to contribute to building support structures for people addicted to drugs. Two participants in the latter working group organised addiction competence training courses for staff of the Public Employment Service. Another result of the cooperation with the Public Employment Service was that more than 50 training places were created for clients of the drug treatment point (Caritas Diözese Graz-Seckau 2010).

Map 8.1

Specialised providers of inpatient and outpatient drug support services focusing on social (re)integration



Source: GÖG/ÖBIG in cooperation with the provincial Drug and Addiction Coordination Offices, representation by GÖG/ÖBIG

The services in the field of **housing** are of a similar structure to those in the area of employment: on the one hand, low-threshold emergency sleeping facilities are available on a per-night basis, and on the other, there are services that focus on finding long-term accommodation or flats for clients.

According to DOKLI (GÖG/ÖBIG 2010a) and as described in Chapter 8.1, one out of two clients of low-threshold centres lives in an unstable housing situation³³, which gives **housing** programmes special significance. In 2009, *Vienna's Konnex liaison* project of the *wieder wohnen housing company* started regular operation. It is a project initiated by the Addiction and Drug Coordination Office of Vienna (SDW) with the goal of supporting the staff of *wieder wohnen* with regard to responses to addicted people living in *wieder wohnen* flats. The services by SDW include advice and support by drug experts, who provide information on substances, modes of administration as well as available services provided by Vienna's network of drug services. In 2010, these services by SDW will be expanded to other houses of *wieder wohnen*, residential buildings of other social service organisations (e.g. Gruft and JUCA) and houses of the Workers' Samaritan Federation Austria (ASB).

The Vienna Addiction and Drug Coordination Office expanded its services, doubling the capacities of low-threshold centres, as a response to the recommendations given in the (not yet released) study on addicted patients in Vienna's public space, drawn up by the European Centre for Social Welfare Policy and Research, according to which approximately 300 people addicted to illicit substances who need daily structure services are living in Vienna (see GÖG/ÖBIG 2009b; Sucht und Drogenkoordination Wien 2010).

TaBeNo-Süd, a new temporary day-care centre providing basic, emergency and crisis intervention services for addicted people was established at Wiedner Gürtel in Vienna's 4th district. In the day-care centre, the clients may take part in creative work projects or do low-threshold work. TaBeNo-Süd also has an emergency sleeping facility, which until the end of 2011 will replace the one formerly run by Ganslwirt, and then it will be relocated to the new Ganslwirt centre at Gumpendorfer Gürtel in Vienna's 6th district. In addition, Ganslwirt's location at Esterházygasse was expanded (and has longer opening hours now), currently providing day structure for around 100 clients per day (Sucht und Drogenkoordination Wien 2010; see Chapter 7.2).

33

On the other hand, in the group of persons receiving long-term services 90% say that their housing situation is stable. However, when interpreting the statements about the housing situation, it should be noted that 'stable' does not necessarily mean that the housing situation involves no problems whatsoever (e.g., problems may exist if clients still live in their parents' household for want of an alternative on account of their drug problems).

The *Lighthouse* housing project of Menschen in Not (People in Need) combines housing for people suffering from HIV infections and AIDS with accepting drug assistance in Vienna. The people who live in the Lighthouse building are offered help whenever needed while leading as independent a life as possible. They take part in the necessary everyday work routines in the house, and thus make steps towards regaining a daily structure as well as self-determined living. Lighthouse has 62 clients who share five flats. Their income (retirement pensions, unemployment benefit, welfare assistance, etc.) is handed over to the counsellors at Lighthouse, who return it in small instalments paid out three times a week for private use by the clients. This system prevents clients from spending the entire amount at once (Lighthouse, undated).

Since the services for homeless people have been integrated in the addiction services unit of Caritas Vorarlberg, coordination has become much easier. It has been regarded as sensible to combine these two areas of activity as around 80% of clients are both homeless and addicted to drugs (GÖG/ÖBIG 2009b; Caritas Vorarlberg 2010).

The area of **spare-time** activities includes both low-threshold and one-off events as well as activities extending over a longer period, and some of them require signing in and signing off by participants. The activities offered range from sports to cultural events and group experience events such as partying.

Social integration is more than just having accommodation as well as financial and social security, therefore the assisted housing initiative *betreutes wohnen* drew up a spare-time programme that promotes social interaction, new experiences, self-esteem and self-confidence. In 2009, nine activities were offered (e.g., boules, billiards, barbecues, Christmas time celebrations), in which 29 clients took part. In addition, for the first time an event extending over several days was organised: six clients took part in a four-day vacation in an Alpine cabin in the mountains of Carinthia, where they were cooking, hiking, building camp fires, etc. (VWS 2010e).

Vienna *streetwork* focuses on adventure-based activities in order to intensify inter-relations with clients outside their traditional scenes while showing them options for interesting spare-time activities (e.g., horseback riding, sailing, bicycling, skating, bowling). 56 clients took part in 15 of these events in 2009 (VWS 2010c).

In a cooperation project of the Dialog association and MUMOK (Vienna Museum of Modern Art) two series of workshops were organised, which combined creative work and exhibitions of the Museum. The approach of the project *hergehört, aufgemalt und hingedruckt* (listen, paint, print) is to look at art exhibited in the museum as a starting point for one's own artistic expression — not only as a possible way of spending one's spare time but also as a means of learning more about art and art history and finding new friends. The closing events at MUMOK lounge provided an opportunity for presenting the objects of art created by the participants and for a further exchange (Dialog 2010b; see Chapter 5.2).

In 2009 the Drugs Advice Centre of the Province of Styria again organised rock climbing events for groups: six workshops took place, in which 12 clients participated. At first, the bouldering area was used for warm-up, because it did not require special knowhow nor a second person for safety. This was followed by outdoor climbing. Although the workshops had originally been planned for the target group of young people, the average age of the participants was 25 years, and both women and men attended the workshops (Drogenberatung des Landes Steiermark 2010).

The evaluation report³⁴ (Piovesan, undated) on the *LOG IN*³⁵ project has meanwhile been published. *LOG IN* was run from 2007 to 2009 and focused on health promotion and stabilisation of an improved state of health of addicted people receiving inpatient treatment (see GÖG/ÖBIG 2007b and 2008c). The objective of the project was to contribute to social network building and social reintegration by organising regular, activating and health-promoting spare-time events and a social programme in line with the needs of the participants. The rules for the programme included a prohibition to use illicit drugs and to drink alcohol, respect towards each other and informing the others if a participant was unable to attend.

The atmosphere in the individual groups was generally described as very good. The participants stated that the support and resources that were made available to them certainly outweighed any difficulties and tensions in the groups. As far as feelings of togetherness and belonging in the individual groups were concerned, the majority of people said they definitely saw themselves as part of the hard core of the group. This indicates that most of the participants identified with their groups and that taking part in the project meant more to them than just consuming what was offered. Through *LOG IN*, the participants became acquainted with an average of nine people, and 37% said they had found more than two good friends in the group. 30% found one good friend, and one out of four indicated they had not won any good friends. It also showed that the contacts established in the context of group activities were maintained outside the groups as well, which underlines the good results of the

34

The report is based on the project documentation, a questionnaire survey as well as qualitative interviews with participants and talks with cooperation partners. The gender composition remained constant throughout the entire project period: one third women and two thirds men. A total of 27 people completed the questionnaires. It was attempted to contact those participants in the project who had regularly attended the individual training units. The average age of test persons was 29 years; six of them were women, and 21 were men. Five of the women and 11 of the men had taken part in the volleyball group, eight men were in the football team, and two men and one woman participated in the theatre play group.

35

See also <http://www.emcdda.europa.eu/best-practice> (EDDRA; 16 August 2010)

empowerment that had been aimed at, and the sustainable character of the social network interventions (Piovesan, undated).

9 Drug-related Crime, Prevention of Drug-related Crime, and Prison

The data for this chapter come from the Federal Ministries of the Interior and of Justice, respectively, as well as from the court criminal statistics maintained by Statistics Austria. Other sources of information include the annual reports and evaluations of drug treatment and advice centres and the Addiction and Drug Co-ordination Offices in the provinces. Further input comes from ST11 and SQ31 as well as publications on prisons. The Narcotic Substances Act (SMG) plays an important role as a basis for measures taken by prosecution authorities. The SMG distinguishes between narcotic drugs, psychotropic substances and precursor substances, and specifies which substance comes under which category. A distinction is also made between misdemeanours (illicit handling of drugs: Section 27 of the SMG) and felonies (preparation for drug trafficking: Section 28 of the SMG; as well as drug trafficking: Section 28a). Our report of 2008 (GÖG/ÖBIG 2008c) includes a detailed presentation of the amendment to the Narcotic Substances Act which entered into force on 1 January 2008, and all the resulting changes.

As explained in previous years and also stressed by the responsible Ministry of the Interior (BMI 2010), the data concerning reports of offences permit only limited conclusions regarding the development of illicit drug use and misuse, because they primarily reflect the intensity and focus of police activity in this field.

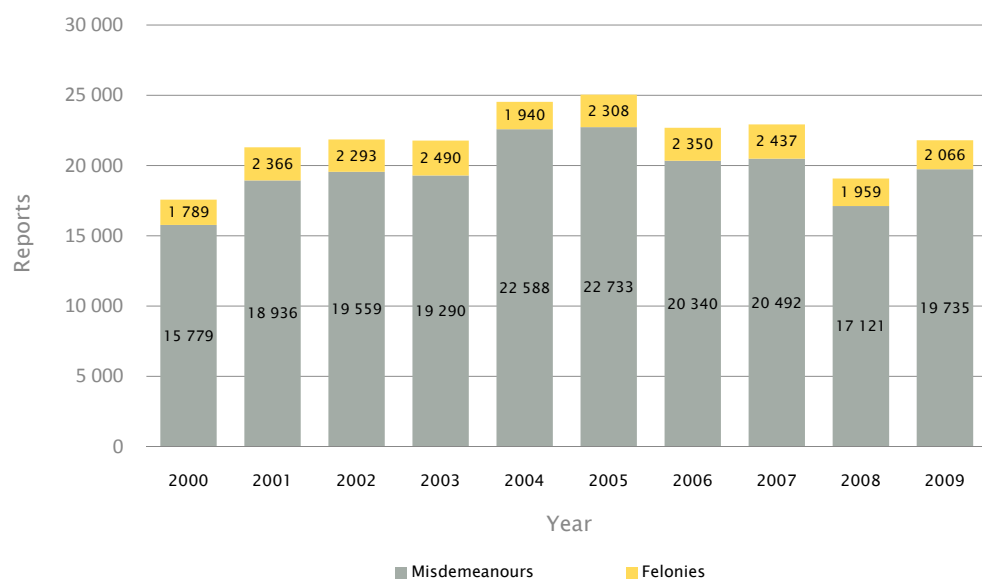
The number of reports to the police relating to violations of the SMG rose in 2009 compared to the year before, and is at a level similar to 2002 and 2003. Regarding SMG-related convictions because of misdemeanours (violation of Section 27 provisions) the decline showing since 2006 continued also in 2009, and convictions because of felonies (Section 28 of the SMG) have also gone down since 2006, roughly by 5% annually. In this context it should be noted that in the present report, the term felony is used for all violations of Section 28 and Section 28a of the SMG, whereas offences against Section 27 of the SMG are referred to as misdemeanours.

9.1 Drug-related crime

In 2009, the number of reported violations of the Narcotic Substances Act (SMG) was 22 729 (2008: 20 043; see also Table A9 in Annex A and ST11), which is an increase compared to the previous year. A total of 21 801 reports (2008: 19 080 reports) related to narcotic drugs and the rest to psychotropic substances. Regarding type of report (see Figure 9.1), in 2009, after a significant decline in the year before, another rise in the number of reports showed with regard to both misdemeanours (illicit

handling of drugs: Section 27 of the SMG) and felonies (preparation for drug trafficking: Section 28; or drug trafficking: Section 28a). In other words: compared to 2008 the number of reports relating to felonies has gone up by approximately 6%, and in the case of misdemeanours, by around 15%.

Figure 9.1
Development of reports relating to violation of the Narcotic Substances Act, by misdemeanours and felonies in Austria, 2000–2009



Note: The difference to the total number of reports results from reports that are not assignable.

Source: BMI/.BK, representation by GÖG/ÖBIG

In terms of substances involved (see Table A11 in Annex A, Figure 9.2 and ST11), a rise shows compared to 2008 in the case of all substances except ecstasy and psychotropic medicines³⁶. It should be taken into account, however, that this is the first report that distinguishes between medicines containing narcotic drugs or psychotropic medicines on the one hand and psychotropic substances or other narcotic drugs on the other (see Table A11 in Annex A and Figure 9.2). This permits a better overview of trends regarding the number of reports to the police relating to medicines

36

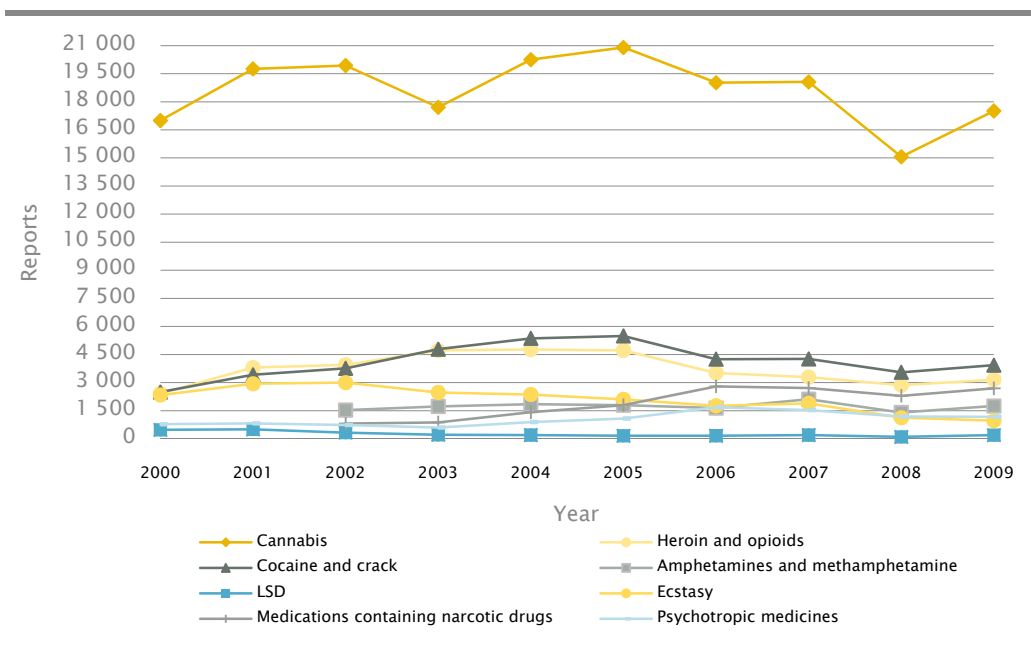
Psychotropic medicines are medicines that influence the psyche.

containing narcotic drugs, which showed a marked rise until 2006. Since then, with the exception of 2008, the corresponding figures have remained more or less constant.

At provincial level, compared to the previous year the number of reported offences shows the same trend as the nationwide situation; but different to last year, reports to the police have risen with regard to almost all substances. This increase is very pronounced especially in the Tyrol, for cannabis as well as heroin and opioids. In most provinces, small declines are found in reports relating to ecstasy (see Table A12 in Annex A).

In 2009, a total of 22 729 reports led to 2 775 arrests (2008: 2 490) in connection with narcotic drug investigations; however, regarding arrests no detailed information (type of offence, substances involved, etc.) can be given.

Figure 9.2
Development of reports relating to violation of the Narcotic Substances Act in Austria by type of substance, 2000–2009



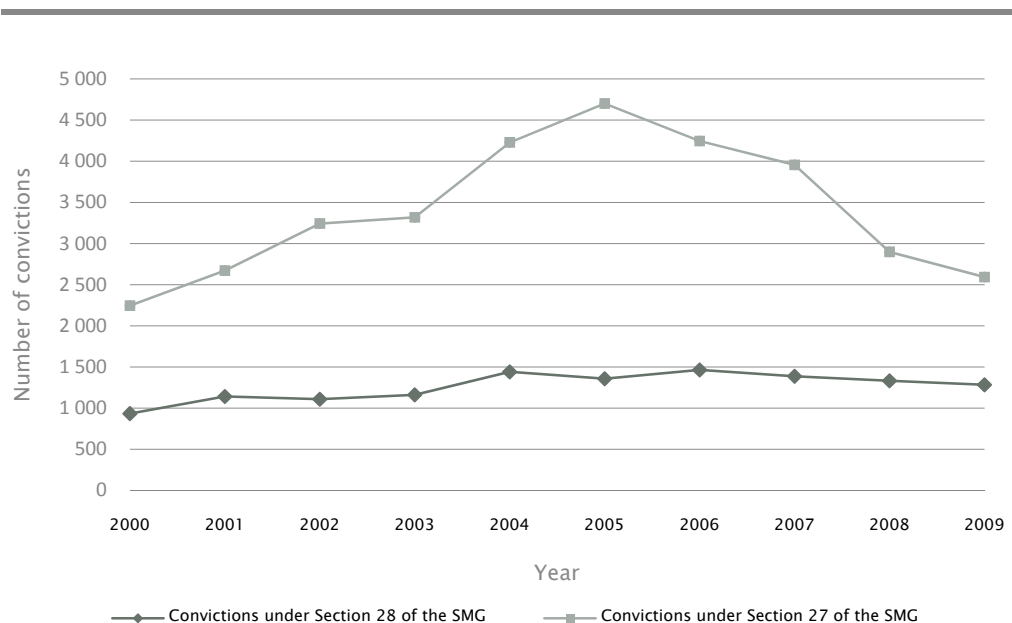
Source: BMI/.BK; representation by GÖG/ÖBIG

Figure 9.3 below as well as Table A13 in Annex A, with data provided by the court criminal statistics, illustrate the development of the number of convictions under Sections 27 and 28 of the Narcotic Substances Act over the past ten years. A comparison to previous years shows that the total number of convictions (n = 3 928) because of violations of the SMG has further declined in the reporting year. A decrease

also shows regarding prison sentences without probation (n = 1 094). The continued declining trend of the total number of SMG-related convictions is also reflected in a further reduction of the share of SMG convictions in the total number of convictions in 2009. While each of the offences has decreased in number, the share of misdemeanours (Section 27 of the SMG) continues to be much higher (2 593 cases) than that of felonies (Section 28 of the SMG: 1 283 cases). In 2009 the share of felonies in total convictions relating to the SMG again showed a rise (2009: 33%; 2008: 31%).

Table A15 in Annex A gives an overview of convictions according to age and basis of conviction. In the comparison to previous years, the figures for 2009 indicate a further downwards trend regarding both young people and adults. However, prison sentences with partial probation have gone up: with regard to both felonies and misdemeanours in the case of adults and only for misdemeanours in the case of young people.

Figure 9.3
Convictions according to Sections 27 and 28 of the SMG in Austria, 2000–2009



Until 2007: Section 28 of the SMG = trafficking in, possession, etc. of, large quantities of narcotic drugs (commercial trafficking);

Section 27 of the SMG = trafficking in, possession, etc. of, small quantities of narcotic drugs.

As of 2008: Section 27 of the SMG = illicit handling of narcotic drugs;

Section 28 of the SMG = preparation for trafficking in narcotic drugs;

Section 28a of the SMG = trafficking in narcotic drugs.

Note: These figures only refer to the leading offence, i.e., the offence with the highest range of punishment, therefore not all convictions under the SMG are covered.

Source: Statistics Austria (court criminal statistics); representation by GÖG/ÖBIG

74% of all convictions resulted in prison sentences (2008: 71%; 2007: 67%), with a share of prison sentences suspended on probation of 42% (2008: 45%; 2007: 47%), which is another slight downwards trend compared to the year before. The share of young people sentenced to imprisonment was 3.7% (2008: 3.1%); and for 2.4% (2008: 2.1%) the prison sentence was suspended on probation. In both cases a slight rise compared to previous years is found.

For further details on conviction statistics in Austria please consult Chapter 11 of the 2008 report (GÖG/ÖBIG 2008c). A comparison of the development of reported offences, convictions and implementation of alternatives to punishment as provided by law is included in Chapter 9.3 of the present report.

As yet, neither data nor surveys on offences committed in connection with drug acquisition and related offences are available.

9.2 Prevention of drug-related crime

In addition to a number of individual initiatives in the context of prevention at the level of provinces and by centres providing services for drug users, interventions for raising the general feeling of security and ease in the public sphere are gaining in importance.

Because in the beginning of June 2010 rebuilding works started at Karlsplatz underground passage, the services formerly provided there had to be restructured (Sucht- und Drogenkoordination Wien 2010; see also Chapter 8.2). At the contact office for standby services at Karlsplatz square, advice and information are provided, and in future the street social workers of the contact office will provide outreach social work all over Vienna wherever demanded (see Chapters 7.2 and 8.2; Grotte 2010).

The services provided by *HELP U* (at Karlsplatz square) and *SAM* (three teams) will be continued (see GÖG/ÖBIG 2008c, 2009b). *HELP U* has been contacted considerably less often and the interventions required have gone down significantly, from 74 792 contacts in 2008 to 51 615 in 2009, which is a decline by 31%, and interventions went down by 23% compared to 2008. This decrease in contacts and interventions may be seen as an indication of the success of this initiative (Schindler, personal communication). The majority of people who contacted *HELP U* were socially marginalised people (especially drug patients; VWS 2010g).

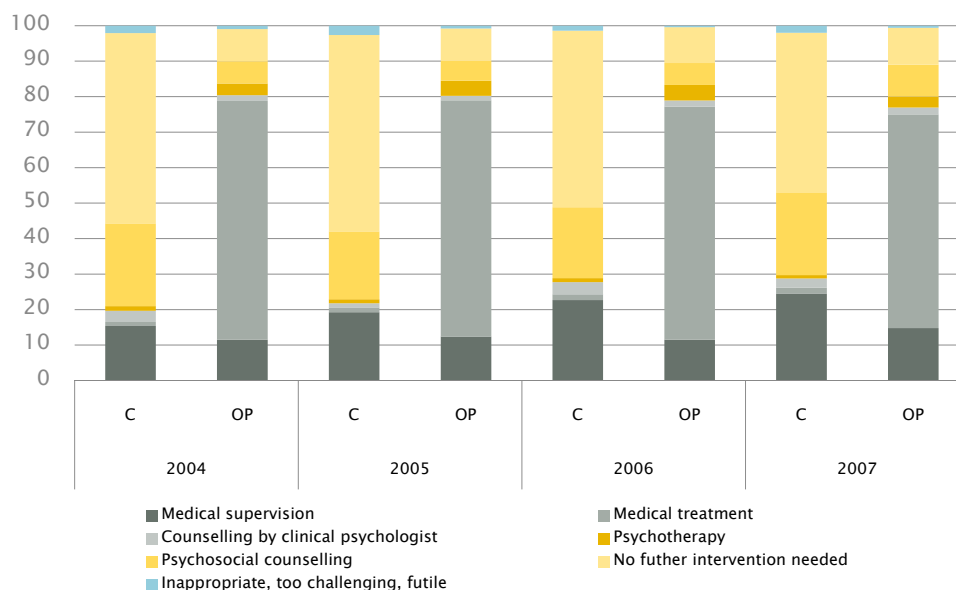
While *HELP U* services are limited to Karlsplatz square, *SAM* provides mobile social work in problem areas of the public space all over Vienna (see GÖG/ÖBIG 2008c). Here a strong increase in contacts to *SAM 2* (Praterstern, 2nd district) und *SAM 9* (Julius-Tandler-Platz and Spittelauer Platz squares, 9th district) shows from 2008 to 2009. Again, socially marginalised people predominate, accounting for 66% of contacts to *SAM 2* and 47% of contacts to *SAM 9*. *SAM flex* currently provides mobile services in various parts of Vienna, depending on demand, e.g., around Wien Mitte station,

Stadtpark, and Westbahnhof station. Figures for this type of service have been available only since mid 2008, thus no trends from 2008 to 2009 can be derived. Regarding contacts by type of group, again, as in the case of *SAM 2* and *SAM 9*, the largest group are socially marginalised people (43%), followed by passers-by, people living in the respective neighbourhood, children and young people, business owners and passengers of public means of transport (41%; VWS 2010h, 2010i, 2010j).

9.3 Interventions in the criminal justice system

In Austria the application of alternatives to punishment, especially suspension of sentence according to the principle of therapy instead of punishment, is regulated by law.

Figure 9.4
Results of examinations by district administration authorities according to Section 12 of the SMG, by primary drug, percentages, 2004–2007



Key: C = the report by the district administration authorities only mentions abuse of cannabis; OP = the report by the district administration authorities mentions abuse of at least one opioid, irrespective of any additional drugs mentioned. Persons examined may be referred to one or several obligatory health-related interventions (multiple answers possible). Data provided by Section IV of the Federal Ministry of Health.

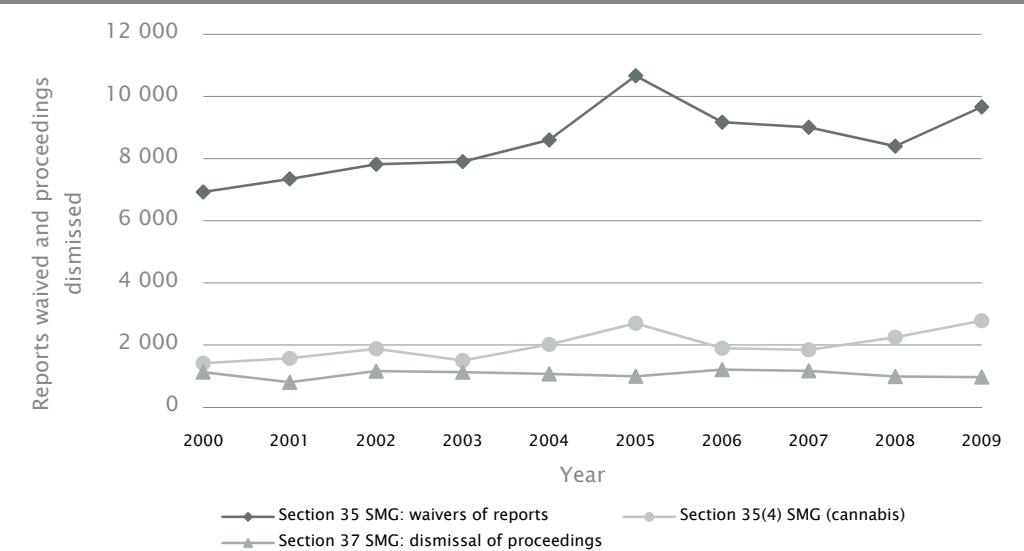
Source: GÖG/ÖBIG 2010b

Figure 9.4 above gives an overview of the consequences of examinations according to Section 12 of the SMG carried out by district administration authorities from 2004 to 2007, by primary drug, expressed as percentages (GÖG/ÖBIG 2010b). It shows the

results of examinations relating to exclusive use of cannabis as well as results of examinations in which use of at least one opioid is indicated. In the case of cannabis use, no need for health-related interventions is deemed necessary in most cases, while opioid users, as a rule, are referred to obligatory medical supervision. The majority of these examinations is carried out because of court orders but they may also be the consequence of reports by heads of school or military authorities.

Regarding implementation of the legal framework, information on the application of statutory alternatives to punishment is available (for more details see ÖBIG 2004). In addition to convictions (see Chapter 9.1), data regarding temporary (probationary) waivers of reports (Section 35 of the SMG) and proceedings dismissed (Section 37 of the SMG) are presented in Figure 9.5 and in Table A16 in Annex A.

Figure 9.5
Development of statutory alternatives to punishment applied in Austria
from 2000 to 2009



Until 2007: Section 35 SMG = temporary waiving of reports by the public prosecutors.
 Section 35 (4) SMG = temporary waiving of reports in the case of small quantities of cannabis for personal use.
 Section 37 SMG = temporary dismissal of proceedings by the courts.
 As of 2008: Section 35 SMG = temporary discontinuation of penal action by the public prosecutors.
 Section 35 (4) SMG = temporary waiving of reports in the case of small quantities of cannabis for personal use.
 Section 37 SMG = temporary dismissal of proceedings by the courts.
 Note: Data on Section 39 of the SMG (suspension of sentence — therapy instead of punishment) are not available at present.

Source: BMG, calculation and representation by GÖG/ÖBIG

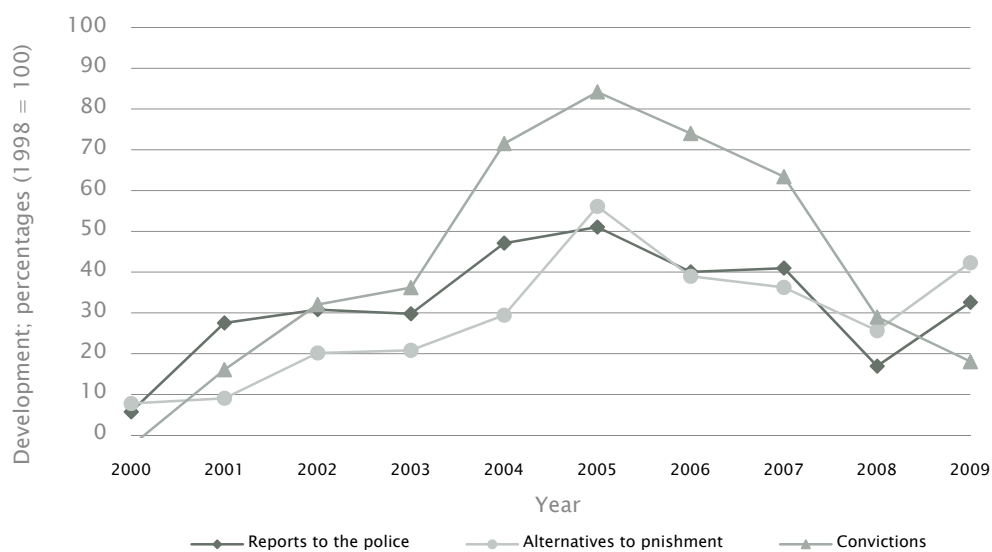
Figure 9.5 shows a decline in waivers of reports from 2005 to 2008, and as of 2006, also of dismissals of proceedings. Since 2008, however, the number of reports waived has increased considerably, also regarding cannabis-related reports. Further infor-

mation on final convictions because of violation of the SMG, by reason for conviction, gender and age group, is provided in Table A14 in Annex A.

There is still a lack of reliable data on suspension of sentences according to the therapy instead of punishment model (Section 39 of the SMG). Such figures would represent an important source of information on the actual implementation of this model.

A comparison of trends regarding reports of offences, convictions and application of alternatives to punishment shows interesting results. Based on an index taken as 100% in 1998, i.e., in the year when the SMG entered into force, Figure 9.6 reveals that in the period of analysis between 2000 and 2005 the shares of convictions went up most significantly. As of 2007 reports and convictions have declined to similar degrees, while the implementation of alternatives to punishment shows a slight rise, which becomes more pronounced as of 2008; this has been paralleled by a similar increase in reports as of 2008 and a decline in convictions.

Figure 9.6
Comparison of the index-related development of reported drug offences, convictions and application of statutory alternatives to punishment in Austria, 2000–2009



Note: Calculations are based on 1998, the year in which the Narcotic Drugs Act was replaced by the Narcotic Substances Act.

Sources: BMI/.BK, Statistics Austria, BMG; calculation and representation by GÖG/ÖBIG

9.4 Drug use and problem drug use in prisons

The existing information on drug use in prisons was presented in detail in the key issue chapter on drug use in prison in the 2001 report (ÖBIG 2001). Since then, no significant changes have taken place.

9.5 Responses to drug-related health issues in prisons

In Austria, interventions regarding drug-related health issues in prison primarily include opioid substitution treatment, prisons with drug-free zones and, to a lesser extent, harm reduction activities. In the latter context, however, no specific measures regarding infectious diseases have been taken so far (see Chapter 6.1).

The reporting year saw the update of a publication by the Federal Ministry of Justice (BMJ) that deals with treatment of addicted people during and after their stay in prison in Austria (BMJ 2009). A distinction is made between drug-free zones within prisons and prisons where drug treatment is available. Prisoners in drug-free zones agree not to use any illicit drugs nor alcohol or medicines (including substitution medication). Outside the drug-free departments and in the prisons where treatment is available, prisoners may undergo opioid substitution treatment or other forms of treatment related to addiction diseases. For instance, the prison of Graz Karlau plans to establish a group of Alcoholics Anonymous. This programme targets chronic alcoholics who refuse to take part in the treatment group for prisoners addicted to alcohol. The treatment services at Hirtenberg prison (Lower Austria) include group therapy for prisoners addicted to gambling (BMJ 2009).

The prison of Stein (Lower Austria) has a separate substitution unit for prisoners in substitution treatment. From January to July 2010, Stein prison implemented a pilot project in cooperation with Grüner Kreis association: prisoners undergoing opioid substitution treatment (OST) had the opportunity to take part in individual or group psychotherapy sessions every two weeks. 13 out of the total of 130 prisoners in substitution treatment attended the sessions (individual sessions: 4 prisoners; group psychotherapy: 9 prisoners). The prisoners could choose the type of therapy they preferred (Grüner Kreis 2010).

An overview of substitution treatment in all prisons of Austria is provided by statistics of the BMJ, according to which by 1 April 2010, a total of 864 inmates of Austrian prisons were in OST. This is a share of 10% of prisoners out of a total of 8 634 inmates (end of 2007: 8.6%; Moravec, personal communication).

The Dialog association continues to provide services directly in police detention centres: people detained because of administrative offences may receive advice and support by social workers, and all detainees may obtain medical treatment (by general

practitioners and psychiatrists). In 2009, a total of 1 533 detainees used these services, which is an increase by 10% compared to 2008 (Dialog 2010b).

9.6 Reintegration of drug users after release from prison

The majority of reintegration measures for drug users is also open to former prisoners. Specific information on the reintegration of (former) drug users after release from prison is available in a diploma thesis that investigates the voluntary probation assistance service for inmates granted prison leave³⁷ (Grubinger 2009).

Imprisonment under eased conditions as well as prison leave granted to inmates of the prison of Favoriten (Vienna) aims at making it possible for prisoners to prepare for the time after imprisonment under conditions near to real life. When inmates are transferred from regular wards to this type of imprisonment, the services delivered no longer focus on addiction and treating addiction but on managing everyday life. During this stage, social workers primarily provide advice and support, also in a confrontational way. Prisoners are encouraged to find perspectives for life after release and to prepare for this step. In addition, inmates granted eased conditions or prison leave are supported by the voluntary probation officers of the Neustart association who have attended an obligatory selection course organised by the Association of Probation Assistance (Grubinger 2009).

Among the prisoners surveyed, 10 out of 17 said that the services by the probation officers were helpful as this was an opportunity to talk about problems. Five of the respondents mentioned that the officers helped them find a flat; four indicated support regarding contacts to authorities, and three, regarding addiction problems. The themes addressed most often in the talks with the probation officers were housing, family matters, employment and addiction. Issues such as relapse, private problems, jobs and problems with authorities played a prominent role. The frequency of meetings (every two weeks) was regarded as exactly right by most of the inmates. A majority were very satisfied or mostly satisfied with the services delivered, and 11 of them said

37

The empirical section of the diploma thesis is based on a questionnaire survey, in which inmates (8 women and 9 men) indicated their views of the individual support services by the probation officers, and the team of probation officers (9 people) as well as the heads of the two prison–leave departments (men's and women's prisons) shared their experience.

it was quite conceivable for them to remain in contact with the probation officers for further services also after their release (Grubinger 2009).

Both the staff of the prison and the probation officers said that the present situation of sporadic contacts between these two groups should be changed and regular meetings should be scheduled between once and four times a year, in addition to phone calls, e.g., in situations of crisis. Another point that is regarded as essential is (more intensive) information to inmates on the general conditions as well as the purpose and goal of probation assistance already before delivering these services. Altogether, the provision of services by an organisation not affiliated to the prison is deemed to be of advantage in every respect because it is an opportunity for prisoners to address delicate problems within the prison and it helps inmates in the process of parting from prison (Grubinger 2009).

10 Drug Markets

The substance most frequently seized in Austria is cannabis, followed by cocaine and opioids (heroin, medicines containing opioids; see ST13). However, quantities seized are no valid indicators of the availability of a substance in Austria, as Austria often is not the final destination of these drugs but a transit country, and because these figures also reflect the intensity of police activities. Regarding potency and concentration of the substances available in Austria, experience of recent years has shown considerable variations. This applies to both substances used by the traditional street scene (opioids and cocaine) and also new synthetic drugs (ecstasy and amphetamines; see ST14 and ST15). The fact that actual ingredients and potency are often unknown constitutes a considerable risk factor for drug users.

Information about the availability of illicit drugs can be derived from some questions of the ESPAD surveys (Strizek et al. 2008; see Chapter 2.1). The data on seizures given in this chapter have been provided by the Federal Ministry of the Interior/Federal Criminal Agency (BMI/.BK), and the data on purity and prices, by the ChEck iT! project as well as BMI/.BK.

10.1 Availability and supply

In the report of last year (see GÖG/ÖBIG 2009b) information was given in advance regarding responses to a question asked in the ESPAD survey, namely how difficult respondents thought it would be to obtain certain legal and illicit substances if they wanted them. Now the final report is available (Strizek et al. 2008), and detailed results broken down by age, gender and region can be given.

While 80% of young people interviewed said it was fairly easy or very easy to obtain alcohol (wine/sparkling wine: 80%; hard liquor: 56%), the corresponding share for illicit drugs was slightly above one third (35%) only in the case of cannabis. Both ecstasy and amphetamines were considered to be available fairly easily or very easily by 20% of respondents. Regarding cannabis and ecstasy, the percentages the people interviewed who think that these substances are easy to obtain rise parallel to the age of respondents. In Vienna, a greater percentage thought that illicit substances were easy to get (see Table 10.1) However, these indications have to be qualified to some extent because of misunderstandings on the part of people interviewed (see notes to Table 10.1)

Table 10.1

Assessment of the difficulty to obtain certain psychoactive substances (shares of answers from 'very easy' to 'fairly easy')

Subgroup	Substance						
	Cannabis	Ecstasy	Ampheta- mines ¹	Tranquilisers/ sedatives	Cigarettes	Wine/ sparkling wine	Hard liquor
14 years	25%	16%	24%	13%	80%	70%	44%
15 years	31%	19%	23%	14%	81%	76%	50%
16 years	38%	21%	23%	13%	90%	87%	63%
17 years	51%	29%	31%	20%	89%	91%	69%
Girls	33%	21%	23%	14%	–	–	–
Boys	36%	20%	25%	14%	–	–	–
Vienna	42%	30%	29%	18%	–	–	–
East Austria w/o Vienna	33%	18%	22%	13%	–	–	–
West Austria	35%	20%	24%	14%	–	–	–
Total	35%	21%	24%	14%	85%	81%	56%

Note 1: The question was, 'How difficult do you think it is for you to obtain stimulants or amphetamines if you want them?' A validation study has shown, however, that the respondents thought that stimulants and amphetamines included energy drinks such as Red Bull.

Source: BMG, calculation and representation by GÖG/ÖBIG

When a rise in the use of 'research chemicals' such as mephedrone³⁸ showed, experts and the media attributed this to the easy availability of this substance in head shops³⁹ and online stores ("Die Presse", 20 November 2009; see Chapters 1.1 4.2 and 10.3). In the opinion of drug experts this was problematic in general, and especially at a time when a statutory prohibition was prepared, which might encourage panic buys. This proved true when an extraordinarily great number of customers was registered in a

38

Until late in August 2010, mephedrone was among the most frequently used research chemicals in Austria. In August 2010, mephedrone was included in the list of substances prohibited by statute and has been an illicit drug since then (see Chapters 1.1, 4.2 and 10.3).

39

Head shops are small shops selling paraphernalia related to the use of cannabis and other articles typical of the drug scene.

head shop in Graz (Styria) in August 2010 because of the impending prohibition of mephedrone (ORF coverage of 6 August 2010⁴⁰).

10.2 Seizures

Austria does not play a significant role as a country where illicit drugs are produced. While cocaine enters Austria primarily by air and by sea from South America, for heroin the route over the Balkans (Turkey, Bulgaria, Serbia, Croatia, Slovenia, Austria) is the dominant trafficking route. Cannabis products are imported from various countries and regions such as the Netherlands, the Balkan countries and Morocco; and to a small, but increasing extent, they are home-grown in Austria. Amphetamines and derivatives are mainly imported from the Netherlands (BMI 2009).

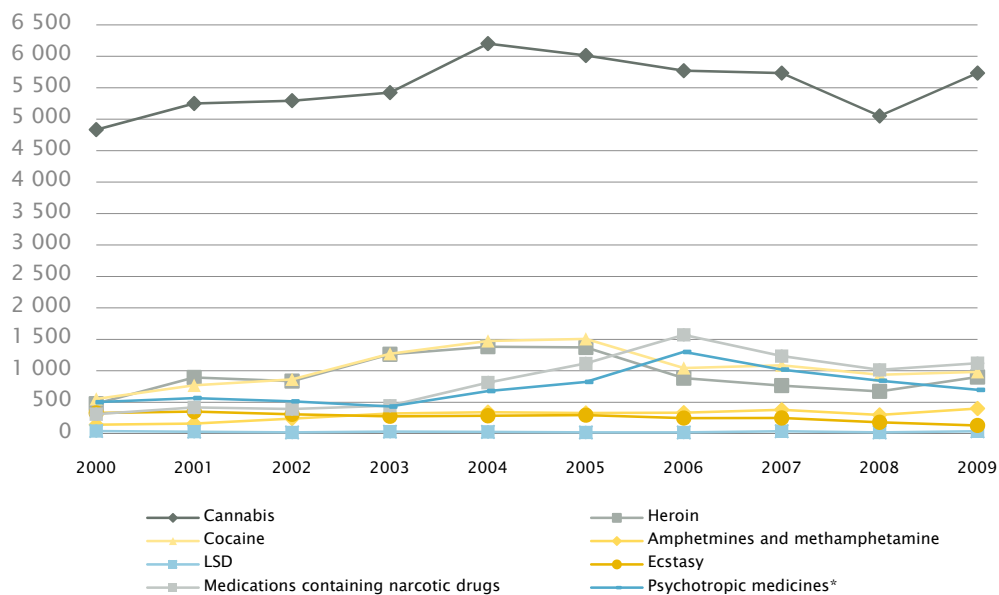
According to the Federal Ministry of the Interior (BMI), in 2009 the number of seizures increased for almost all drugs compared to the previous year (see Figure 10.1 and Table A17 in Annex A). The greatest rises, by one third each, are accounted for by heroin and amphetamines. After the decline in 2008, the level of 2007 has again been reached.

The quantities of drugs seized were slightly above the amounts of the year before and similar to 2007, or somewhat higher (see Table A18 in Annex A). One has to bear in mind, however, that individual seizures of large quantities which often are not intended for Austria (transit) distort the general picture.

40

<http://steiermark.orf.at/stories/460904/>: Mephedron: Suchtgift legal in Graz zu kaufen (7 August 2010; article in German)

Figure 10.1
 Number of seizures of narcotic drugs and psychotropic medicines in Austria,
 2000–2009



Note*: Psychotropic medicines are medicines that contain psychotropic substances.

Sources: BMI/.BK 2009, representation by GÖG/ÖBIG

10.3 Price/purity

In the context of the ChEck iT! project (see Chapter 2.3), which tests the purity and ingredients of substances bought as ecstasy or speed during events of the party and clubbing scenes, 105 samples bought as ecstasy (pills) and 113 samples purchased under the name of speed were analysed during a total of seven music events (goa, electronic) in the provinces of Burgenland, Lower Austria and Vienna in 2009 (VWS 2010d).

The percentage of pills bought as ecstasy that did not contain psychotropic substances other than MDMA⁴¹, MDE⁴² or MDA⁴³ was as small as 16%, which is a massive decline

41
 3,4-Methylenedioxy-N-methylamphetamine

(from 2005 to 2008, the corresponding shares were between 60% and 75%). As a result, users had to be warned in many cases (52%) about the tablets they had bought as ecstasy. For the first time in eight years, also para-methoxyamphetamine (PMA) was detected in three samples (see Table A19 in Annex A). PMA poses considerable health hazards: its effects are felt later than those of MDMA, which bears the risk that additional pills are taken in order to achieve the desired effect. The resulting accumulation of the substance may be lethal.

The trend to replace MDMA with legal piperazine derivatives such as mCPP increased strongly in 2009 (in 2008, 19% of samples contained piperazine, and in 2009, 51%). Compared to MDMA, the psychoactive effects of mCPP are weaker, but very often, unpleasant side-effects may occur: headaches, nausea, kidney pain, nervousness, heavy breathing, tiredness and a hangover lasting for several days. Furthermore, simultaneous use of MDMA may lead to convulsions. In 15 out of 55 pills that contained mCPP, also metoclopramide was found, an antiemetic which was probably added in order to suppress side effects of mCPP such as nausea. Metoclopramide may interact with many other substances and in part may accelerate their effects, while it slows down the users' reactions.

A general tendency shows to replace illicit substances usually referred to as ecstasy with legal chemical compounds that have similar effects (e.g., until August 2010, mephedrone⁴⁴). These products are marketed under fancy names such as Benzo Fly or Dragon Fly and described to buyers as research chemicals (see Chapters 1.1, 4.2 and 10.1). The effects of these substances have hardly been investigated, which is especially dangerous for users because it is almost impossible to predict the effects and risks of use (Die Presse, 20 November 2009). Research chemicals, primarily mephedrone, were found in 86 of the substances analysed by *ChEck iT!* until July 2010 (Nagy, personal communication).

Only 10% of the substances bought as speed and analysed by *ChEck iT!* contained amphetamine only, whereas 50% contained amphetamine and caffeine, and in 15% of

42
3,4-Methylenedioxy-N-ethylamphetamine

43
3,4-Methylenedioxyamphetamine

44
Until late in August 2010, mephedrone was among the most frequently used research chemicals in Austria. In August 2010, mephedrone was included in the list of substances prohibited by statute and has been an illicit drug since then (see Chapters 1.1, 4.2 and 10.1).

the samples, amphetamine was mixed with other pharmacologically active substances (see Table A20 in Annex A and ST15). 14% of these samples were classified as posing a serious threat to health (VWS 2010d).

Information by the Ministry of the Interior on the purity and prices of various drugs sold at street level is given in Table 10.2 (see also ST14 and ST16). As in previous years, a considerable variation of the potency of drugs sold at street level was noted.

Table 10.2
Purity and price (EUR per gram*/pill**) of various drugs sold in the streets in 2009

		Herbal cannabis*	Cannabis resin*	Brown heroin*	White heroin*	Cocaine*	Amphetamines*	Ecstasy **	LSD**
Purity	Minimum	0.08%	0.25%	0.2%	—	1%	0.3%	11%	—
	Maximum	39%	33%	53%	—	96%	43%	66%	—
	Typical	5%	10%	8%	—	24%	4%	45%	—
Price	Minimum	5	7	50	—	60	10	5	30
	Maximum	10	10	100	—	140	15	10	35
	Typical	7	8	70	—	70	12	7	30

Note: These data are based on information by undercover police agents. For the individual drugs, between 7 and 527 purity analyses were carried out.

Source: BMI/.BK, representation by GÖG/ÖBIG

Part B

Selected Issues

11 History, Methods and Implementation of National Treatment Guidelines

One of the priority areas of the EU Drug Action Plan 2009–12⁴⁵ is to get a better overview of guidelines for addiction treatment in Europe, their development and implementation as well as their roles with regard to assuring the quality of addiction treatment services. To contribute to this goal, this report includes a discussion of national guidelines for addiction treatment. In the course of a research project (Zurhold und Degkwitz 2009) studying the corresponding guidelines in Europe and also of a Reitox Academy on this theme organised by the EMCDDA in February 2010, it has shown, however, that Austria has no national guidelines that correspond to the definition by the EMCDDA⁴⁶ or what is understood to correspond to this definition at international level. National guidelines should be developed by independent experts in a standardised process in which all stakeholders, professions and clients have been integrated, and should be based on systematically collected research evidence. As a rule, review by third parties and public consultation are also part of the process of producing guidelines. The guidelines and standards that are available in Austria do not meet these criteria. Nevertheless they are relevant as a basis for the delivery of addiction treatment in Austria, therefore selected examples of such guidelines as well as their development and translation into action are described in the following chapter.

11.1 History and overall framework

The federal structure of Austria's administration is one of the reasons why no **national guidelines** for addiction treatment exist: many public health tasks and competence areas are provincial matters. Moreover, in Austria the discussion of the matter of

45

See http://europa.eu/legislation_summaries/justice_freedom_security/combating_drugs/jl0019_en.htm (16 August 2010)

46

The EMCDDA gives the following definition: guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate interventions for specific circumstances. Commonly guidelines include a set of recommendations or steps that can be followed when implementing an intervention. The content of guidelines is commonly based on the available research evidence.

national quality standards for medical treatment has started later than in other countries. The Federal Act on the Quality of Health-care Services (GQG; BGBl I 2004/179) effective as of 1 January 2005 provides the legal framework for the advancement of systematic quality research. The Act provides that quality standards for the delivery of health-care services be developed, in cooperation with the relevant stakeholders, in particular the health-care professionals involved as well as patients. Then the Federal Minister for Health may either issue Federal Quality Guidelines (BQLL) which recommend the use of the resulting quality standards or adopt a binding Decree stipulating their use as Federal Quality Directives (BQRL). The standards must permit nationwide implementation across sectors and professions, and must be in line with the general principles of health promotion and transparency as well as the state of the art of medicine and experience with regard to effectiveness and efficiency. In order to perform this task, in 2007 BIQG was established, an institute specialising in health-care quality, as a business unit of GÖG, a national research and planning institute for health care in Austria.

Since September 2007, BIQG has focused on providing a basis for producing quality standards. International experience and recommendations were used as input for preparing a metaguideline (GÖG under preparation), which defines the process of drawing up guidelines. According to the Metaguideline for Methods of Developing and Implementing Quality Guidelines, organisations may propose themes for Federal Quality Guidelines or Directives. These themes are weighted and ranked in a defined prioritisation process and eventually guidelines are drawn up on behalf of the Federal Ministry of Health or the Federal Health Agency (BGA). In addition, it is possible to file applications for recognition of papers as Federal Quality Directives (e.g., if a medical society or association has already produced a quality standard): in this case, it is verified in an accreditation procedure whether the formal criteria for Federal Quality Directives are met. At present, six themes are being reviewed. In order to draw up a Federal Quality Guideline or Directive on addiction treatment, it would be necessary to propose this theme for further examination.

Both BQLL and BQRL quality standards specify a certain path of action and decision-making with regard to treatment and care services and recommend proven, effective instruments and procedures, departure from which is admissible or may even be required in well-founded cases. Any deviations should adequately be documented, however. Either type of standard (BQLL and BQRL) is produced by multidisciplinary teams in a systematic procedure, with decisions based on consensus. Different to other member states of the EU, in Austria the focus is not solely placed on medical treatment, but other services are also included. Any existing medical, care or treatment standards are taken into consideration as source standards if their quality meets the defined criteria.

Apart from the process of guideline production, which still is in its early stages, also other actions have been undertaken in Austria to enhance or ensure the quality of medical treatment. In the specific case of substitution treatment for patients addicted to opioids, a **regulation** has existed for many years already, adopted for reasons of quality assurance and as a response to safety and health policy concerns. The first ordinance (an internal decree with instructions by the Minister for Health to the health authorities and public health officers responsible for the supervision of oral opioid substitution treatment) was issued in 1987. In accordance with the principle of last resort provided under the then Narcotic Drugs Act, it was not permitted to prescribe oral substitution medications for the sole reason of severe, treatment-resistant addiction to opiates: it had to be established in every individual case that any other form of treatment was extremely unlikely to bring about the desired results. Only after the adoption in 1998 of the Narcotic Substances Act was substitution treatment explicitly recognised by law as one of several possible forms of treatment. In 2007 the aforementioned ordinance was replaced by a decree which also lays down a binding framework for attending doctors (GÖG/ÖBIG 2007b as well as Chapters 1.1 and 5.1). A further decree was issued according to which the delivery of substitution treatment services requires the attending doctors' completion of further training in OST (GÖG/ÖBIG 2006 as well as Chapter 1.1 and 5.1).

In Austria, **consensus papers** drawn up in cooperation with, and initiated by, experts or professional associations have frequently been drawn up in order to promote uniform standards of treatment. These consensus papers are typically based on practical experience, while scientific evidence tends to be taken into account only indirectly and not in a systematic way. If scientific publications (e.g. Fischer/Kayer 2006, Busch et al. 2007) or guidelines (e.g., from Germany) are available when consensus papers are prepared, they will be considered for the paper, however. On the other hand, Austrian experts in turn have also been asked to contribute to guidelines drawn up in other countries or by international organisations (see Chapter 7.2). Many experts argue that it is reasonable to draw on practical experience as an essential source of knowhow for preparing consensus papers, as years of daily work indeed provide an invaluable basis of evidence which, in a complex process of careful decision-making, also take into account the individual situation of addicted patients (ÖGABS 2009). According to these experts, the drawback of relying on a scientific evidence base is that it primarily considers the results of clinical trials published in high ranking journals, and the conditions under which such studies are carried out often differ from actual practice. Moreover, in this context one has to bear in mind that the results or recommendations from other countries are influenced by the drug policies and also possible restrictions in those countries and caution has to be exercised when translating such findings to other countries. This particularly applies to substitution treatment delivered to people addicted to opioids, because in Austria a wider range of medications may be prescribed than in other countries.

Also, both at federal and provincial levels, **organisational guidelines** exist for providers of drug support and treatment services, which also aim at contributing to quality assurance in addiction treatment.

11.2 Existing guidelines: Narrative description of existing guidelines

Table 11.1 provides a list of the standards and guidelines that are relevant for addiction treatment in Austria. Our reports of past years (see GÖG/ÖBIG 2007b and 2008c) as well as Chapters 1.1 and 5.1 of this report provide additional details on the **regulations** concerning substitution treatment and the further training requirements as laid down in the Substitution Decree and the amendments of 2007 and 2009, respectively. Regarding the selection of **consensus papers**, please note that the list does not claim to be exhaustive. While taking care to include the most important and most recent papers, it has also been attempted to cover different themes and settings.

The consensus statement by the Austrian Society of Neuropsychopharmacology and Biological Psychiatry (ÖGPB 007) deals with several aspects of addiction treatment. It discusses epidemiology, genesis and clinical manifestations as well as substance-related secondary damage, i.e., health problems caused by alcohol, opioids, benzodiazepines or other psychoactive substances. This is followed by a description of the chain of treatment and forms of treatment, as well as — rather general — recommendations for approaches to specific target groups (e.g., children and young people).

Carinthia's guidelines for diagnosing and treating opioid addiction (Amt der Kärntner Landesregierung 2007a), which were initiated by the Drug Forum of Carinthia and drawn up by a working group on behalf of the Drug Forum, also discuss various aspects of addiction treatment. The guidelines aim at promoting an objective discussion of best practices in addiction treatment in Carinthia, improving the quality of treatment and establishing uniform treatment standards while taking into account public safety interests as well as individual needs of patients. They include detailed recommendations for diagnosing, indication, drug-free treatment as well as pharmacologically assisted treatment and also services provided by persons other than physicians (psychosocial counselling, psychotherapy, housing support, etc.) as well as specific advice regarding safety in substitution treatment.

Table 11.1
Austrian guidelines and standards for substitution treatment

Title and year [English translation of title]	Institution	Administrative level	Method of guideline production	Target group	Type of intervention	Substances covered
Suchtgiftverordnung. 2007 and 2009 [Narcotic Drugs Decree]	Federal Ministry of Health	Federal Government	Political decision-making process	All doctors delivering substitution treatment as well as public health officers supervising OST	Opioid substitution	Opioids
Weiterbildungsverordnung. 2007 and 2009 [Further Training Decree]	Federal Ministry of Health	Federal Government	Political decision-making process	All doctors providing substitution treatment as well as public health officers supervising OST	Opioid substitution	Opioids
Substanzbezogene Störungen und psychiatrische Erkrankungen — Konsensus-Statement — State of the Art. 2007 [Substance-related disorders and psychiatric diseases: Consensus statement — state of the art]	ÖGPB (Austrian Society of Neuropsychopharmacology and Biological Psychiatry)		Consensus found in personal and written exchange	All doctors (especially established doctors) delivering substitution treatment, as well as decision makers	Early intervention, withdrawal treatment, opioid substitution, psychotherapy, outpatient services	Opioids, alcohol, benzodiazepines, nicotine and other psychoactive substances
Diagnostik und Behandlung der Opioid-abhängigkeit. Ein Leitfaden. 2007 [Diagnosis and treatment of opioid dependence. A guideline]	Provincial Government of Carinthia, Department 12: Public Health; Subdivision of Drug Coordination/Social Medicine	Carinthia	Expert consensus	All doctors delivering substitution treatment	Diagnosis, indication, partial abstinence treatment, opioid substitution., psychosocial care services, psychotherapy, social reintegration	Opioids
Handbuch für Drogenkranke in Wien. 2004 [Manual for drug patients in Vienna]	Medical Association of Vienna	Vienna	Combination of evidence and practical experience	Established doctors, public health officers, pharmacists	Diagnosis, withdrawal treatment, opioid substitution	Opioids
Konsensus-Statement „Substitutions-gestützte Behandlung Opioidabhängiger“. 2009 [Consensus statement on pharmacologically assisted treatment of opioid addicts]	ÖGABS (Austrian Society of Pharmacologically Assisted Treatment of Addiction)		Consensus of experts from several professions in a process similar to the Delphi method	All doctors (especially established general practitioners) who deliver addiction treatment, as well as decision makers	Opioid substitution	Opioids

Continued next page

Table 11.1, continued

Title and year [English translation of title]	Institution	Administrative level	Method of guideline production	Target group	Type of intervention	Substances covered
Konsensus zur Behandlung der chronischen Hepatitis C bei DrogenkonsumentInnen in Österreich aus suchtmmedizinischer Sicht. 2001 [Consensus on the treatment of chronic hepatitis C in drug users in Austria, from the point of view of addiction medicine]	Addiction experts from several addiction treatment and support centres in Vienna		Expert consensus	All doctors treating patients dependent on opioids who suffer from chronic hepatitis C (addiction specialists, gastroenterologists)	Treatment of chronic hepatitis C	Opioids
Leitfaden für den Gefängnisarzt. 2006 [Guidelines for doctors treating prisoners]	Federal Ministry of Justice	Federal Government	Analysis of existing international conventions and strategies	All doctors delivering treatment in prisons	Addiction treatment including opioid substitution	Opioids, alcohol, cocaine, amphetamines, benzodiazepines
Substitutions-Richtlinien für Justizanstalten. 2005 [Substitution guidelines for prisons]	Federal Ministry of Justice	Federal Government	Expert consensus	All doctors delivering treatment in prisons	Opioid substitution	Opioids
Richtlinien für Ansuchen um Kundmachung im BGBl. gemäß § 15 SMG durch Einrichtungen und Vereinigungen mit Betreuungsangebot für Personen im Hinblick auf Suchtgiftmissbrauch. 2004 [Guidelines for application for announcement in the Federal Collection of Statutes, according to Section 15 of the Narcotic Substances Act, of institutions and centres providing services with regard to abuse of narcotic drugs]	Federal Ministry of Health	Federal Government	Expert consensus	Drug treatment and support centres	Advice, treatment and support services, withdrawal, post-withdrawal treatment, counselling, social reintegration	Not specified
Förderrichtlinien der Sucht- und Drogenkoordination Wien. 2008 [Funding guidelines by the Vienna Addiction and Drug Coordination Office]	Vienna Addiction and Drug Coordination Office	Vienna	Not specified	Drug treatment and support centres in Vienna	Advice, treatment and support, withdrawal, post-withdrawal treatment, counselling, social reintegration	Not specified

Source: data collection and representation by GÖG/ÖBIG

The manual for drug patients in Vienna published by the Medical Association of Vienna (Ärzttekammer für Wien 2004) primarily focuses on substitution treatment but also discusses other forms of intervention. It provides recommendations for the treatment of addicted patients and describes different approaches to and philosophies of treatment. Furthermore, the themes of indication and the practical delivery of OST are treated. It also points out the importance of individualised treatment regimens within a wide range of available options as well as the need for multidisciplinary orientation.

The consensus paper by the Austrian Society of Pharmacologically Assisted Treatment of Addiction (ÖGABS 2009) exclusively deals with substitution treatment. It defines objectives and the development as well as the political and social framework of opioid substitution treatment in Austria. Its main part consists of specific, detailed recommendations for integrating OST in the system of addiction treatment as well as practical implementation. It also stresses the need for approaches that take into account individual needs and demands of the patients.

One consensus paper specifically addresses the theme of treating addiction patients with chronic hepatitis C (Haltmayer et al. 2001). It is based on a multidimensional five-axis model and defines detailed criteria for advice, diagnosis and indication. It was drawn up by experts on the basis of literature sources as well as practical experience.

With regard to prison settings, the guidelines for doctors treating prisoners (Pont und Wool 2006) and the substitution guidelines for prisons (BMJ 2005) deserve mention. The former discuss approaches to drug abuse and addiction in prisons and underline the importance of opioid substitution as well as early diagnosing of addiction diseases as a contribution to harm reduction. However, they hardly provide concrete recommendations or instructions for translation into practice. By contrast, the substitution guidelines for prisons, apart from discussing objectives and different strategies, also include specific details of implementation.

Organisational guidelines aimed at quality assurance of addiction services have been adopted at both federal and provincial levels. The guidelines for application for announcement in the Federal Collection of Statutes, according to Section 15 of the Narcotic Substances Act, of institutions and centres providing services with regard to abuse of narcotic drugs (BMGF 2004) also contribute to assuring the quality of services in the respective addiction advice and treatment centres. For instance, the centres must have treatment or intervention strategies that define both the theoretical background and the goals and target groups of the services delivered. A profile of services has to be drawn up, and certain minimum services have to be provided. In addition, the centres have to meet defined structural and staff requirements, and annual reports have to be submitted. The funding guidelines issued by the Vienna Addiction and Drug Coordination Office stipulate similar conditions (SDW 2008).

Plans for new **guidelines and standards**, or guidelines and standards under preparation, primarily focus on describing services in the form of catalogues on the one hand and the related quality and continuity standards on the other, in particular regarding links between inpatient and outpatient services and across different service providers (see Chapter 5.2).

11.3 Implementation process

Implementation of the aforementioned standards by the attending doctors and addiction treatment and support services is voluntary because, with the exception of decrees and organisational guidelines, they are mere recommendations. Therefore the authorities in charge (i.e., public health officers, Ministry of Health, Vienna Addiction and Drug Coordination Office) only supervise adherence to the provisions of the obligatory organisational guidelines and decrees. In Carinthia, a guide has been published to assist public health officers, which lists competences regarding individual provisions of the Narcotic Drugs Decree as well as ways of ensuring whether doctors delivering OST meet the corresponding regulations (Amt der Kärntner Landesregierung 2007b). The activities undertaken to safeguard consistency in the execution of the Decree primarily focus on information and communication of knowhow by means of further training schemes. For this purpose, quality circles have been established, among other further training events.

The Act on Doctors (BGBl I 1998/169, latest amendment published in BGBl I 2009/144) obliges doctors to treat diligently and without distinction any person, either healthy or ill, who turns to them for medical advice or treatment. In addition, doctors shall regularly take part in recognised further training programmes organised by the Provincial or Austrian Medical Associations or in recognised further training programmes of other countries and, according to the state of the art of medicine and practical experience, while meeting any applicable regulations and professional quality standards, restore the wellbeing of the sick and protect the healthy (Act on Doctors, Section 49, Para. 1). The detailed regulations for substitution treatment, as provided by the Decree of 2007 issued on the basis of Section 10, Para. 1 No. 5 of the Narcotic Substances Act, were regarded as too restrictive by the doctors, arguing that this limited their competences defined by the Act on Doctors. The modifications laid down in the amendment to the Decree on Narcotic Drugs adopted late in 2009 as a result of experience with the existing Decree (see GÖG/ÖBIG 2008c and 2009b as well as Chapter 5.1) have increased the doctors' acceptance. What continues to be controversial is the fact that treatment-related decisions which are not in line with the Decree may still have legal consequences for the attending doctor in question. The issue of criminal law aspects of substitution treatment thus was a focal theme at this year's Substitution Forum at Mondsee organised by the Austrian Society of

Pharmacologically Assisted Treatment of Addiction (ÖGABS). At the Forum the view was expressed that the current situation was quite intricate indeed: substitution treatment is closely linked to criminal and civil law, but appropriate analysis and deliberation of OST are lacking (no studies, expert articles or supreme court decisions)⁴⁷.

Several strategies have been pursued in order to advance the implementation of standards that are not obligatory but provide orientation. For instance, the recommendations by ÖGABS have been communicated on the occasion of professional events such as the Substitution Forum or further training programmes such as the quality circles organised by the Medical Associations. In addition they were sent to all Provincial Addiction and Drug Coordinators, public health officers and other experts and bodies, and they have been published on several websites (e.g., of ÖGABS and the Medical Association of Lower Austria). The other standards mentioned in this chapter are distributed in a similar way. In order to achieve practical application to the greatest possible extent it is important to cooperate with experts from several professions when standards are drawn up, as this is essential for finding a consensus that is backed and eventually communicated by the experts themselves.

.

47

www.drogensubstitution.at/drogenpolitik/gesetze-richtlinien.htm (2 June 2010; website in German)

12 Cost of Drug-related Treatment

This chapter discusses the funding that is available for drug-related treatment in Austria. Drug treatment is any activity that directly targets individuals who have problems with their drug use and which aims to improve the psychological, medical or social state of those who seek help for their drug problems. This activity often takes place at specialised facilities for drug users, but may also occur in the context of general services offering medical and/or psychological help to people with drug problems (EMCDDA 2000). For the field of drug treatment in Austria, no (recent) cost studies or economic analyses are available — with the exception of an overview from 1997 of expenditure and services of drug treatment centres (Bruckner und Zederbauer 2000) and a diploma thesis of 2005 providing an economic assessment of drug treatment in Upper Austria (Starzer 2008). In 2002 ÖBIG, in a selected issue chapter of the report on the drug situation, provided a detailed study on the costs of drug-related measures, with figures relating to the years 1999 and 2001 (ÖBIG 2002). GÖG/ÖBIG 2007b gives updates of several results relating to 2005. Because budgets usually do not specify drug-related expenditure in separate items (see Chapter 1.3 and GÖG/ÖBIG 2007b) and it has not been possible to repeat the study of 2002, only a very restricted update of the figures given in 2002 can be provided here, complemented by a number of new aspects.

12.1 Funding sources

Funding for drug-related treatment primarily comes from the federal, provincial and local governments as well as social security institutions. Because of the federal structure of Austria's health and social care system, the provinces play important roles in this context. With regard to inpatient and outpatient treatment, one has to distinguish between treatment in hospitals, treatment in drug treatment and support centres that are no hospitals, and treatment by established doctors (ÖBIG 2002, BMG 2010).

Treatment in hospitals is financed by several sources. Based on an agreement between the Federal and Provincial Governments, provincial funds exist that provide resources to all hospitals in the province in question which are entitled to money from the respective fund. The Federal Government, the Provincial Government and the social security institutions allocate money to these provincial funds, and the persons insured provide copayment (except groups exempt from copayment; ÖBIG 2002, BMGFJ 2009).

Non-hospital providers of outpatient drug services are mostly funded through annual subsidies. In recent years, a few provinces have tended to link funding to the provision

of a defined range of services. Provincial funding for services provided by non-hospital inpatient drug treatment centres is often based on refunding of daily costs for individual services delivered to patients on the basis of case-by-case approval, with resources coming from the budgets of disability, social welfare or youth welfare bodies. Under Section 16 of the SMG the Federal Ministry of Health grants annual subsidies to part of the inpatient and outpatient treatment centres announced according to Section 15 of the Narcotic Substances Act (SMG)⁴⁸.

Resources by social security institutions are available to clients with health insurance who are delivered services by a provider that has concluded an agreement with the health insurance fund in question, if the type of treatment provided is among the list of reimbursable services of the health insurance fund. As a rule, in the case of services delivered by established doctors it is not specified whether they are related to drug treatment — with the exception of special services provided primarily in the context of opioid substitution treatment. Such special services have been defined in the provinces of Carinthia, Salzburg, the Tyrol, Upper Austria, Vorarlberg and Vienna.

An exceptional case in this field is cost of health-related measures adopted under the Narcotic Substances Act (in particular if related to the principle of therapy instead of punishment) which is not covered by health insurance funds: under the SMG, the Federal Government shall subsidiarily be liable for taking over the corresponding costs (Section 41, Para. 1 of the SMG), if certain prerequisites are met. But as some of the provincial welfare assistance laws also include subsidiary cost coverage provisions, a negative conflict of competences between the federal and provincial governments has existed for many years. The Ministry of Justice, which assumes such costs at the federal level, has concluded agreements with treatment centres for addicted offenders (according to Section 41, Para. 3 of the SMG), and in 2000 a decree was issued which defines the criteria on which decisions regarding eligibility for, and amounts of, subsidiary cost coverage by the Federal Government have to be based (703.015/58-II 2/2000). At present, lump sum agreements under Section 41, Para. 3 of the SMG exist, which form the basis for individual agreements, concluded with seven treatment

48

According to the Decree by the Federal Ministry of Finance on general guidelines for granting funding from Federal resources (BGBl II 2004/51), financial support is only admissible for services that are in the interest of more than one province. However, under a special provision of the SMG, the Federal Ministry of Health may provide money for the establishment and operation of inpatient and outpatient drug treatment and support centres as far as federal funds are available according to the Act on Federal Financing as amended, if other territorial authorities (e.g., Provinces) also contribute to said funding. In the case of treatment and support centres run by a territorial authority (e.g., a Province) this type of funding is only granted if other territorial authorities contribute sums at least to the same amount as the federal funding provided.

centres so far (Schweizer Haus Hadersdorf, Zukunftsschmiede Voggeneder, Grüner Kreis, PASS, DIALOG, BASIS and Psychosocial Services of Burgenland). Under the lump sum agreements, the treatment centres in question are obliged towards the Federal Government to provide, for fees not exceeding the maximum fees defined, inpatient and outpatient treatment and counselling services, including medical supervision of the patients' state of health, medical treatment including withdrawal and opioid substitution treatment, as well as treatment and counselling by clinical psychologists or psychotherapists. The lump sums agreed upon are index-linked and annually adjusted for inflation on the basis of the consumer price index, and the new lump sums are communicated by decree (latest adjustment in 2010: JMZ 703015L/1/II2/10). It would be in the interest of the Provinces if a greater number of treatment centres concluded cost-coverage agreements with the Ministry of Justice regarding health-related measures, in particular outpatient services (Hörhan, personal communication).

The majority of drug treatment centres receives public funding. A few non-profit associations raise a certain share of their income themselves by selling products and providing services (e.g., postal dispatch services or renovation work). In this field, profit-oriented enterprises have never played a significant role in Austria. The funds provided by public authorities, also by the Federal Government, go directly to the owners of the corresponding treatment centres and projects. The complex legal situation on which the system of funding of addiction-related services by public authorities is based has repeatedly given rise to controversy between federal and provincial governments, and many attempts have been made to resolve this matter. At present, a working group established by the Drug Forum is discussing this issue (see Chapter 1.2).

12.2 Cost of inpatient treatment

The cost of inpatient treatment in hospitals because of drug problems may be assessed on the basis of days of hospital stay by patients with drug-related primary diagnoses (F11, F12, F13, F14, F15, F16 and F19) multiplied by the average cost of one inpatient day (see Table 12.1). However, one has to bear in mind that there are cases in which accounting and cost coverage aspects may have an influence on the codes entered.

No detailed information can be given on cost of inpatient treatment in drug treatment centres that are no hospitals. However, in the case of centres covered by the DOKLI documentation, approximate figures for days of stay and funding sources involved can

be given (Vienna is not included, however)⁴⁹. In 2009 a total of 762 people were treated in non-hospital centres covered by DOKLI, with an estimated total of 102 930 days of stay. It shows that the majority of costs has been taken over by the provinces (61%), followed by the court authorities (38%).

Table 12.1
Estimated cost of inpatient hospital treatment of people with drug-related primary diagnoses, from 2001 to 2008

	2001	2002	2003	2004	2005	2006	2007	2008
Stays in hospital	4 795	4 981	4 984	5 258	5 252	5 611	5 781	5 873
Days of hospital stay	84 299	88 481	89 638	93 745	98 571	113 266	111 672	118 559
Estimated cost (EUR)*	18.4	19.9	20.7	22.2	24.1	28.4	28.7	31.2

Note*: Figures relate to million euros.

Source: BMG — DLD 2001–2009; calculation and representation by GÖG/ÖBIG

It was not possible to derive the average cost of one day of hospital stay. In 2009 the court authorities spent a total of EUR 7 032 611 for health-related interventions according to Section 41 of the SMG. This expenditure includes both inpatient and out-patient services, however (communication by the Federal Ministry of Justice).

12.3 Cost of outpatient treatment

It is not possible to break down the number of people receiving outpatient treatment in hospital in the same way as that of inpatients because no comparable documentation system exists for outpatient departments. However, the majority of specialised drug outpatient departments of hospitals communicate data to DOKLI and have therefore been included in the table below.

Table 12.2 shows that the largest share of outpatient treatments expenses are covered through the drug treatment centres on a basis other than per-case funding. The

49

For estimating days of inpatient stay, the number of people in treatment on 30 June 2009 (282 patients) was multiplied with 365. The percentage of actual funding sources, investigated at the end of treatment, relates to those 507 patients who were released from inpatient treatment in 2009 (multiple answers were permitted). The figures given do not include Vienna because data on funding sources are not transferred from Vienna's BADO documentation system to DOKLI, therefore it is not possible to distinguish between hospitals on the one hand and non-hospital treatment centres on the other (see GÖG/ÖBIG 2010a).

greatest percentage of the respective sums has in turn been provided by the provinces (ÖBIG 2002). More recent figures on provincial expenditure in this specific field are not available. In addition, treatment centres announced in the Federal Collection of Statutes according to Section 15 of the SMG may receive funding from the Federal Ministry of Health. In 2009 this amounted to a total of EUR 2 051 868 (communication by the Federal Ministry of Health). Part of this sum is also spent for inpatient drug treatment.

Table 12.2

Outpatients, estimated number of days of service delivery and funding sources, in treatment centres covered by DOKLI, in 2009

Coverage	People treated ¹	Source of funding (percentages) ²			
		Health insurance fund	Provinces	Court authorities	No per-case funding
Austria, nationwide	9 759	–	–	–	–
Austria excl. Vienna	6 556	10%	26%	3%	63%

Note 1: All people treated in 2009.

Note 2: Percentage of actual funding source, investigated at the end of treatment, relating to those patients whose outpatient treatment ended in 2009, not including Vienna (multiple answers were permitted). The figures relating to funding source do not include Vienna because data on funding sources are not transferred from Vienna's BADO documentation system to the nationwide DOKLI system (see GÖG/ÖBIG 2010a).

Source: GÖG/ÖBIG, DOKLI analysis of client year 2009; representation by GÖG/ÖBIG

No data on costs per day of outpatient treatment are available.

12.4 Cost of substitution treatment

Although there are problems regarding the data quality of the substitution registry (e.g., ghost cases; see Chapters 4.1 and 5.4 as well as GÖG/ÖBIG 2010b), it is still obvious that the number of people undergoing opioid substitution treatment has strongly risen over the years (see Chapter 5.4). For 2009, the number of 'OST-days'⁵⁰ is estimated to be between 2.4 and 4 million.

⁵⁰

The total of 10 837 people in substitution treatment on 30 June 2009 multiplied by 365. In order to take into account ghost cases, the lower limit of 60% of the number derived has been given (see GÖG/ÖBIG 2010b).

According to the Main Association of Austrian Social Security Institutions, the cost of substitution medicines taken over by the social security institutions was EUR 25 million in 2009. Only substances that are exclusively prescribed for substitution treatment have been considered here (Näglein, personal communication).

Because in most provinces OST is primarily provided by established doctors, visits to these physicians are relevant for costs. Only Vienna, Upper Austria and the Tyrol grant a separate OST remuneration in addition to the standard fees for consultations with doctors: in Vienna, EUR 26 per patient may be charged ten times a quarter at the most; in Upper Austria, it is EUR 65 for first-time and renewed stabilisation and EUR 20 five times a quarter for subsequent treatment; and doctors in the Tyrol may charge EUR 25 three times a quarter (Schwarzenbrunner, personal communication). In Salzburg, where 90% of substitution treatments are delivered by the SUST Substitution Centre for Opiate Addicts and the Drug Outpatient Department of Christian Doppler Hospital, the health insurance funds grant a lump sum of EUR 202 per quarter plus reimbursement of expenses of EUR 74 for substitution substances per patient and month, in the case of patients who have health insurance. If patients do not carry insurance, the corresponding costs are taken over by the Province (Schabus-Eder, personal communication). In Carinthia the social insurance institutions pay EUR 62 a year for diagnosing, first treatment and renewed stabilisation, plus EUR 19 five times a quarter at the most. Here, almost all substitution treatments are carried out by two established outpatient clinics not affiliated to hospitals. In Vorarlberg, established doctors who have additional consulting hours in drug treatment centres may obtain EUR 74 per quarter and patient (Schwarzenbrunner, personal communication; see also Chapter 5.1).

Regarding cost of substitution medicines for prisoners, figures for 2009 are available: approximately EUR 1.4 million was spent for substitution substances. The average cost per patient amounted to EUR 1 470 (Parliament enquiry No. 4288/J-NR/2010).

12.5 Conclusions

Because of the complex financing structure and budgets which are not broken down by drug-related spending in most cases, expenditure for drug-related treatment can only be given as a rough estimate. A detailed analysis of the corresponding cost would require much time and involve considerable cost, and no studies on this subject are available. The selected issues chapter of our 2002 Report to the EMCDDA (ÖBIG 2002) provides some information in this field: the overall cost of drug-related treatment was estimated to amount to EUR 40 770 400 in 1999 and EUR 50 736 800 in 2001. These figures include expenditure for inpatient and outpatient treatment centres, opioid substitution treatment, interventions according to the principle of therapy instead of punishment, treatment in prison, inpatient treatment in hospital as well as summarised other expenses by health insurance funds. As some of the available data indicate a considerable rise in treatment cost compared to the years studied for the 2002 report

(e.g., days of hospital stay because of drug-related ICD-10 primary diagnoses, expenditure for substitution medicines), it is safe to assume that overall cost has significantly gone up as well.

References

Bibliography

APA 2010. AIDS 2010. Wiener Drogenkoordination prüft intravenöse Substitution. APA-OTS press release, APA0021 5 CI 0478 of 28 June 2010. Vienna

Akzente Fachstelle Suchtprävention Salzburg (2010). Jahresbericht 2009. Akzente Salzburg — Fachstelle Suchtprävention. Salzburg

Amt der Kärntner Landesregierung (2007a). Diagnostik und Behandlung der Opioidabhängigkeit. Ein Leitfaden. Abteilung 12 — Sanitätswesen. Klagenfurt

Amt der Kärntner Landesregierung (2007b). SV — Substitutionsbehandlung. Arbeitsbehelf für Amtsärzte. Abteilung 12–Sanitätswesen. Klagenfurt

Ärztammer für Wien (2004). Handbuch für Drogenkranke in Wien. Vienna

b.a.s. 2010. info e-mail 2 of 29 April 2010. B.a.s. Steirische Gesellschaft für Suchtfragen. Graz

Beer, B.; Rabl, W.; Libiseller, K.; Giacomuzzi, S.; Riemer, Y.; Pavlic, M. (2010). Der Einfluss von retardiertem Morphin auf die Drogensituation in Österreich. Neuropsychiatrie, Band 24, Nr. 2/2010, 108–117

BMG 2010. Das Österreichische Gesundheitssystem. Bundesministerium für Gesundheit. Vienna

BMGF 2004. Richtlinien für Ansuchen um Kundmachung im Bundesgesetzblatt gemäß § 15 SMG durch Einrichtungen und Vereinigungen mit Betreuungsangebot für Personen im Hinblick auf Suchtgiftmissbrauch. Bundesministerium für Gesundheit und Frauen. Vienna

BMGFJ 2009. Leistungsorientierte Krankenanstaltenfinanzierung L K F System–beschreibung. Bundesministerium für Gesundheit Familie und Jugend. Vienna

BMI 2009. Jahresbericht über die Suchtmittelkriminalität in Österreich 2008. Bundesministerium für Inneres/Bundeskriminalamt. Vienna

BMI 2010. Jahresbericht über die Suchtmittelkriminalität in Österreich 2009. Bundesministerium für Inneres/Bundeskriminalamt. Vienna

BMG 2010a. Österreichische AIDS–Statistik. Periodischer Bericht; 7 July 2010. Bundesministerium für Gesundheit. Vienna

BMJ 2005. Substitutions-Richtlinien für Justizanstalten. Bundesministerium für Justiz. Vienna

BMJ 2009. Der Weg aus der Sucht — Drogenbetreuung während und nach der Haft in den Justizanstalten Österreichs. Bundesministerium für Justiz. 2009. Vienna

BMUKK 2010. Bildung für nachhaltige Entwicklung verbindet Gesundheitsförderung und Umweltbildung. Bundesministerium für Unterricht, Kunst und Kultur. Vienna

Bruckner, J.; Zederbauer, S. (2000). Vergleich und Analyse des Problems illegaler Drogen in Österreich unter ökonomischen Gesichtspunkten. Fonds Gesundes Österreich. Vienna

Busch, M.; Eggerth, A. (under preparation). Nasaler Heroinkonsum in Österreich.

Busch, M.; Haas, S.; Weigl, M.; Wirl, C.; Horvath, I.; Stürzlinger, H. (2007). Langzeit-substitutionsbehandlung Opioidabhängiger. Schriftenreihe Health Technology Assessment (HTA) in der Bundesrepublik Deutschland, Bd/Vol. 53. DIMDI (Ed.). Cologne

Caritas Diözese Graz-Seckau (2010). Jahresbericht 2009. Graz

Caritas Vorarlberg (2010). CaritasFenster Nr. 89, Jahresbericht 2009. Feldkirch

Dialog 2010a. 30 Jahre Dialog. Programm 2010. Verein Dialog. Vienna

Dialog 2010b. Jahresbericht 2009. Verein Dialog — Hilfs- und Beratungsstelle für Suchtgiftgefährdete und deren Angehörige. Vienna

Drogenberatung des Landes Steiermark (2010). Jahresbericht 2009. Graz

Drogenkoordination des Landes Salzburg (2010). Bericht zur Drogensituation im Land Salzburg. Jahresbericht 2009. Salzburg

Dür, W.; Griebler, R. (2007). Die Gesundheit der österreichischen SchülerInnen im Lebenszusammenhang. Ergebnisse des 7. HBSC-Surveys 2006. Schriftenreihe Originalarbeiten, Studien, Forschungsberichte. Bundesministerium für Gesundheit, Familie und Jugend. Vienna

Dür, W.; Mravlag, K. (2002). Gesundheit und Gesundheitsverhalten bei Kindern und Jugendlichen. Ergebnisse des 6. HBSC-Surveys 2001 und Trends von 1990 bis 2001. Reihe Originalarbeiten, Studien, Forschungsberichte. Bundesministerium für soziale Sicherheit und Generationen. Vienna

EMCDDA 2000. Treatment demand indicator Standard protocol 2.0. European Monitoring Centre for Drugs and Drug Addiction. Lisbon

EMCDDA 2009. Annual report on the state of the drugs problem in Europe. European Monitoring Centre for Drugs and Drug Addiction. Lisbon

Edelmann, M. (2010). Zivilrechtliche Aspekte der Substitutionsbehandlung aus der Sicht des Rechtsanwaltes. Paper presented at the 13th Substitution forum at Mondsee.

Eisenbach–Stangl, I.; David, A.; Dressel, M. (2009). „Viennese Blend“: Municipal drug services, their development and their governance. In: Drugs: Education, prevention, policy, December 2009; 16 (6), 537–549

ENCARE Österreich (2009). Newsletter 3/2009. Institut Suchtprävention, pro mente OÖ. Linz

ENCARE Österreich (2010). Newsletter 1/2010. Institut Suchtprävention, pro mente OÖ. Linz

Falbesoner, B.; Lehner, S. (2008). 2. Bericht zum Suchtmittelkonsum im Burgenland. Kurzfassung. Im Auftrag der Burgenländischen Landesregierung. Eisenstadt

Fischer, G.; Kayer, B. (2006). Substanzabhängigkeit vom Morphintyp — State of the Art: Erhaltungstherapie mit synthetischen Opioiden. Psychiatrie & Psychotherapie (2006) 2/2, 13–28

GÖG (under preparation). Metaleitlinienreport. Report zur Methode der Erstellung und Evaluation von Bundesqualitätsleitlinien. Gesundheit Österreich GmbH. Vienna

GÖG/ÖBIG 2006. Report on the Drug Situation 2006. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG 2007a. Einheitliche Dokumentation der Klientinnen und Klienten der Drogeneinrichtungen (DOKLI) — Klientenjahrgang 2006. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit, Familie und Jugend. Vienna

GÖG/ÖBIG 2007b. Report on the Drug Situation 2007. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG 2008a. Einheitliche Dokumentation der Klientinnen und Klienten der Drogeneinrichtungen (DOKLI) — Klientenjahrgang 2007. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit, Familie und Jugend. Vienna

GÖG/ÖBIG 2008c. Report on the Drug Situation 2008. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG 2008d. Einheitliche Dokumentation der Klientinnen und Klienten der Drogenhilfe (DOKLI) Basismanual. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG 2009a. Einheitliche Dokumentation der Klientinnen und Klienten der Drogeneinrichtungen (DOKLI) — Klientenjahrgang 2008. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit. Vienna

GÖG/ÖBIG 2009b. Report on the Drug Situation 2009. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG 2010a. Einheitliche Dokumentation der Klientinnen und Klienten der Drogeneinrichtungen (DOKLI) — Klientenjahrgang 2009. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit. Vienna

GÖG/ÖBIG 2010b. Drogen-Monitoring Auswertungsergebnisse 2004–2009. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit. Vienna

GÖG/ÖBIG 2010c. Suchtgiftbezogene Todesfälle 2009. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Vienna

GÖG/ÖBIG (under preparation). Drogen-Monitoring Auswertungsergebnisse 2010. Gesundheit Österreich GmbH / Geschäftsbereich ÖBIG. Im Auftrag des Bundesministeriums für Gesundheit. Vienna

Grotte, W. (2010). Sozialarbeiter-Aufstand. In: Wiener Zeitung of 17 June 2010. Vienna

Grubinger, S. J. (2009). Ehrenamtliche Bewährungshilfe am Freigang der Justizanstalt Wien-Favoriten. Diplomarbeit zur Erlangung des Grades eines Magisters (FH) für sozialwissenschaftliche Berufe an der Fachhochschule FH Campus Wien im Oktober 2009

Grüner Kreis (2010). Magazin. Sommer 2010, No. 74. Verein Grüner Kreis. Vienna

Haas, S. (2005). Problembewusste Frauen, risikofreudige Männer? Illegale Drogen und Geschlecht. In: Eisenbach–Stangl, I.; Lentner, S.; Mader, R. (Eds.): Männer Frauen Sucht. Wien, 133–144

Haltmayer, H.; Tanzmeister, E.; Zach, M.; David, A.; Resinger, E.; Skriboth, P.; Werner, W. (2001). Hepatitis C bei Suchtkrankheit. Vienna

Hausleitner, B. (2010). Zusammenfassung der Arbeitsschwerpunkte der Fachstelle für Suchtprävention Burgenland. Eisenstadt

Hinterhofer, H. (2010). Substitutionsbehandlung und Strafrecht. Paper presented at the 13th Substitution Forum at Mondsee

Hutsteiner, T.; Seebauer, S.; Auferbauer, M. (2005). Die Drogensituation an steirischen Berufsschulen und Lehrlingshäusern. Endbericht. X-Sample. Graz

IFES 2005. Suchtmittel–Monitoring 2005. Bevölkerungsbefragung Wien. Im Auftrag des Fonds Soziales Wien. Institut für empirische Sozialforschung. Vienna

IFES 2008. Suchtmittel–Monitoring 2007. Bevölkerungsbefragung Wien. Im Auftrag der Sucht– und Drogenkoordination Wien gemeinnützige GmbH. Institut für empirische Sozialforschung. Vienna

IFES 2009. Suchtmittel–Monitoring 2008. Bevölkerungsbefragung Wien. Im Auftrag der Sucht– und Drogenkoordination Wien gemeinnützige GmbH. Institut für empirische Sozialforschung. Vienna

IFES 2009b. BADO–Basisdokumentation. KlientInnenjahrgang 2008. Vienna

Institut Suchtprävention (2009). 4tyFour. Das Präventionsmagazin. No. 13, December 2009. Institut Suchtprävention, Pro Mente OÖ. Linz

Institut Suchtprävention (2010). Jahresbericht 2009. Institut Suchtprävention, Pro Mente OÖ. Linz

Klimont, Jeannette; Kytir, Josef; Leitner, B. (2007). Österreichische Gesundheitsbefragung 2006/2007. Hauptergebnisse und methodische Dokumentation. Bundesministerium für Gesundheit, Familie und Jugend. Vienna

kontakt+co (2009). Sucht+Prävention 2009/04. Kontakt+co Suchtprävention Jugendrotkreuz. Innsbruck

kontakt+co (2010). Sucht+Prävention 2010/03. Kontakt+co Suchtprävention Jugendrotkreuz. Innsbruck

Kurz, M. (2010). Regionale Suchthilfenetzwerke: Notwendigkeiten zukünftiger Zusammenarbeit in der Steiermark. Paper presented at the 2nd Addiction Support Conference at Bruck/Mur on 24 June 2010

Leitner, B. (2009). Todesursachenstatistik 2007: Schwerpunktthema Obduktionen. Statistische Nachrichten 1/2009

Lighthouse (undated). Informationsblatt über Lighthouse — Verein für Menschen in Not. Vienna

ÖBIG 2001. Report on the Drug Situation 2001. Österreichisches Bundesinstitut für Gesundheitswesen. Vienna

ÖBIG 2002. Report on the Drug Situation 2002. Österreichisches Bundesinstitut für Gesundheitswesen. Vienna

ÖBIG 2003. Weiterentwicklung des Monitoringsystems im Drogenbereich – Projektbericht 2001–2003. Österreichisches Bundesinstitut für Gesundheitswesen. Vienna

ÖBIG 2004. Report on the Drug Situation 2004. Österreichisches Bundesinstitut für Gesundheitswesen. Vienna

ÖGABS 2009. Konsensus-Statement „Substitutionsgestützte Behandlung Opioidabhängiger“. Suchtmedizin in Forschung und Praxis, Volume 11, No. 6 (2009), 281–297.

ÖGPB 2008. Substanzbezogene Störungen und psychiatrische Erkrankungen. Konsensus-Statement — State of the Art 2007. Clinicum neuropsychy, special edition November 2007. Vienna

Ömer, I. (2010). Ärztemangel für Substitutionspatienten. In: OÖ Ärzte. Ärztekammer für OÖ. No. 238/April 2010. Linz

Penka, S. (2004). Migration und Sucht. Notwendigkeit einer „Interkulturellen Suchthilfe“? Leipziger Universitätsverlag. Leipzig

Piovesan, A. (undated). Evaluationsbericht über das Projekt 1211. LOG IN — Gesundheitsförderung und Stabilisierung erreichter Gesundheit für stationär behandelte Suchtkranke. Verein zur Integration und Gesundheitsförderung von Risiko- und Randgruppen. Vienna

Pont, J.; Wool, R. (2006). Ein Leitfaden für den Gefängnisarzt — Richtlinien für Ärzte, die Gefangene betreuen. Bundesministerium für Justiz. Vienna

Porstmann, J. M. (2009). Abstinenzorientierte Drogentherapie am Beispiel der Therapiestation „Erlenhof“. Evaluationsstudie zur Langzeit-Drogentherapie. Diplomarbeit, eingereicht zur Erlangung des akademischen Grades Magistra der Sozial- und Wirtschaftswissenschaften am Institut für Soziologie an der Johannes Kepler-Universität. Linz

Die Presse (21 November 2009). Drogenkonsumraum in Graz weiter in Warteposition. By Klaud Höfler. Released 21 November 2009, 18:41.

Die Presse (20 November 2009). Drogen für die Alpträum-Party. By Andreas Wetz. Released 20 November 2009, 18:40.

Sarrazin, C.; Berg T.; Ross, R. S.; Schirmacher, P.; Wedemeyer, H.; Neumann, U.; Schmidt, H. H. J.; Spengler, U.; Wirth, S.; Kessler, H. H.; Peck-Radosavljevic, M.; Ferenci, P.; Vogel, W.; Moradpour, D.; Heim, M.; Cornberg, M.; Protzer, U.; Manns, M. P.; Fleig, W. E.; Dollinger, M. M.; Zeuzem, S. (2010). Update der S3-Leitlinie Prophylaxe, Diagnostik und Therapie der Hepatitis-C-Virus(HCV)-Infektion. AWMF-Register-Nr.: 021/012; http://www.oeggh.at/images/downloads/s3-hepatitis_c-konsensusleitlinie.pdf

Schmutterer, I.; Uhl, A.; Strizek, J.; Bachmayer, S.; Puhm, A.; Kobrna, U.; Grimm, G.; Springer, A. (2008). ESPAD Austria 2007: Europäische SchülerInnenstudie zu Alkohol und anderen Drogen. Band 2: Validierungsstudie. Bundesministerium für Gesundheit. Vienna

Schönfeldinger, R. P. (2002). Empirische Erhebung über den Konsum von legalen und illegalen Substanzen bei burgenländischen Jugendlichen. Abschlussbericht. PSD Burgenland. Eisenstadt

Seyer, S.; Lehner, R.; Gschwandtner, F.; Paulik, R. (2007). Bericht zum Drogenmonitoring 2006. Institut für Suchtprävention / Pro Mente OÖ. Linz

Sklenar, S. (2010). Kinder- und Jugendpsychiatrie. Österreichische Ärztezeitung, No. 5, 10 March 2010. Vienna

Spirig, H.; Gegenhuber, B.; Malfent, D. (2010). Neue Wege in der Begleitung älterer Drogenabhängiger. Interviews mit ExpertInnen. SDDCARE — Senior Drug Dependents and Care Structures. Teilbericht Austria. Schweizer Haus Hadersdorf. Vienna

Starzer, A. (2008). Öffentliche Ressourcenverteilung der Drogenpolitik in Oberösterreich — Eine Analyse der gesetzlichen Grundlagen, der Struktur und der Verteilung in Hinblick einer optimalen Ressourcenallokation für eine mittel- bis längerfristige Reduktion der Drogenproblematik. Diplomarbeit, eingereicht zur Erlangung des Grades Magister im Diplomstudium Sozialwirtschaft am Institut für Gesellschafts- und Sozialpolitik an der Johannes Kepler Universität Linz im Mai 2008. Linz

Stiftung Maria Ebene (2010). Jahresbericht 2009. Frastanz

Strizek, J.; Uhl, A.; Schmutterer, I.; Grimm, G.; Bohrn, K.; Fenk, R.; Kobrna, U.; Springer, A. (2008). ESPAD Austria 2007: Europäische SchülerInnenstudie zu Alkohol und anderen Drogen. Band/Volume 1: Forschungsbericht. Bundesministerium für Gesundheit. Vienna

Sucht- und Drogenkoordination Wien (2008). Förderrichtlinien. Sucht- und Drogenkoordination Wien. Vienna

Sucht- und Drogenkoordination Wien (2010). Input zur Drogensituation in Wien f. Österreichischen Drogenbericht. Vienna

SUPRO (2010). Jahresbericht 2009. SUPRO und VGKK.

Uhl, A.; Bachmayer, S.; Kobrna, U.; Puhm, A.; Springer, A.; Kopf, N.; Beiglböck, W.; Eisenbach-Stangl, I.; Preinsperger, W.; Musalek, M. (2009). Handbuch Alkohol — Österreich. Ludwig Boltzmann Institut für Suchtforschung, AlkoholKoordinations- und InformationsStelle (AKIS). Vienna

Uhl, A.; Bohrn, K.; Fenk, R.; Grimm, G.; Kobrna, U.; Springer, A.; Lantschik, E. (2005b). ESPAD Austria 2003: Europäische Schüler- und Schülerinnenstudie zu Alkohol und anderen Drogen. Bundesministerium für Gesundheit und Frauen. Vienna

Uhl, A.; Seidler, D. (2001). Prevalence Estimate of Problematic Opiate Consumption in Austria. Ludwig-Boltzmann-Institut für Suchtforschung. Vienna

Uhl, A.; Springer, A.; Kobrna, U.; Gnams, T.; Pfarrhofer, D. (2005a). Österreichweite Repräsentativerhebung zu Substanzgebrauch, Erhebung 2004. Bundesministerium für Gesundheit und Frauen. Vienna

Uhl, A.; Strizek, J.; Springer, A.; Kobrna, U.; Pfarrhofer, D. (2009). Österreichweite Repräsentativerhebung zu Substanzgebrauch, Erhebung 2008, Forschungsbericht. Bundesministerium für Gesundheit. Vienna

- VIVID 2010. Jahresbericht 2009. VIVID — Fachstelle für Suchtprävention. Graz
- VWS 2009. Bericht 2008. Verein Wiener Sozialprojekte. Vienna
- VWS 2010a. Infektionsprophylaxe. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010b. ganslwirt Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010c. streetwork Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010d. ChEckiTi! Tätigkeitsbericht 2010. Verein Wiener Sozialprojekte. Vienna
- VWS 2010e. *betreutes wohnen*. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010f. *fix und fertig*. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010g. HELP U. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010h. *SAM 2*. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010i. *SAM 9*. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010j. *SAM flex*. Tätigkeitsbericht 2009. Verein Wiener Sozialprojekte. Vienna
- VWS 2010k. GawiNews 32/10. Verein Wiener Sozialprojekte. Vienna
- Wiener BerufsBörse (2010a). Schreiberling 1 — Das Magazin der Wiener BerufsBörse. Vienna
- Wiener BerufsBörse (2010b). Schreiberling 2 — Das Magazin der Wiener BerufsBörse. Vienna
- Zurhold, H.; Degkwitz, P. (2009). Scientific review of national drug treatment guidelines. Final Report. Zentrum für interdisziplinäre Suchtforschung der Universität Hamburg. Hamburg

Referenced Federal Acts

BGBl I 1998/169 v. 10. 11. 1998. Bundesgesetz, mit dem ein Bundesgesetz über die Ausübung des ärztlichen Berufes und die Standesvertretung der Ärzte (Ärztegesetz 1998 — AerzteG 1998) erlassen und das Ausbildungsvorbehaltsgesetz geändert wird. Zuletzt geändert durch BGBl I 2009/144

BGBl I 2004/179 v. 30. 12. 2004. Gesundheitsreformgesetz 2005

BGBl II 2009/485 v. 23. 12. 2009. Verordnung der Bundesministerin für Gesundheit, Familie und Jugend, mit der die Suchtgiftverordnung geändert wird

BGBl II 2009/487 v. 23. 12. 2009. Verordnung des Bundesministers für Gesundheit, Familie und Jugend, mit der die Weiterbildungsverordnung orale Substitution geändert wird

BGBl II 2010/264 v. 20. 8. 2010. Verordnung des Bundesministers für Gesundheit, mit der die Suchtgiftverordnung geändert wird

Personal Communications (alphabetical order)

Name and page	Institution or function
Anderwald, Christine (p. 56)	Caritas Marienambulanz outpatient department, Graz
Aufhammer, Sandra (p. 70)	ENCARE Tyrol
Bauer, Dr. Bernhard (p. 56)	Caritas Marienambulanz outpatient department, Graz
David, Dr. Alexander (p. 34)	Addiction Representative of Vienna
Drobesch-Binter, Dr. Barbara (p. 25)	Provincial Addiction Prevention Unit of Carinthia
Duspara, Dr. Vinko (p. 56)	Lukasfeld treatment department of Maria Ebene foundation, Vorarlberg
Ederer, Klaus Peter (p. 42, 69)	Addiction Coordinator of Styria
Gollner, Gerhard (p. 22)	kontakt+co Addiction Prevention Unit of the Tyrol
Gratzel, Wolfgang (p. 68)	Caritas drug support centres in the Tyrol
Haltmayer, Dr. Hans (p. 56)	VWS (Vienna Social Projects Association), Ganslwirt low-threshold centre
Hörhan, Dr. Ursula (pp. 8, 19, 34, 39, 41, 70, 73, 110)	Addiction Coordinator of Lower Austria
Hruby, Dr. Karl (p. 31)	
Kern, Harald (p. 69)	Addiction Coordinator of the Tyrol
Miksch, Dr. Gerhard (p. 34)	Addiction Coordinator of Burgenland
Moravec, Dr. Wolfgang (p. 87)	Federal Ministry of Justice, Directorate of Sentence Execution
Neubacher, Thomas (p. 24)	Drug Coordinator of Vorarlberg
Nagy, Mag.a Constanze (p. 94)	
Näglein, Dr. Silke (p. 113)	
Öllinger, Mag. Robert (p. 66)	Managing Director of VWS (Vienna Social Projects Association)
Prehslauer, Dr. Brigitte (pp. 8, 35, 39, 42)	Drug Coordinator of Carinthia
Prenn, Andreas (p. 24)	SUPRO (Addiction Prevention Unit of Vorarlberg)
Reisner, Dr. Christoph (p. 34)	Medical Association of Lower Austria
Rögl, Nicole (pp. 20, 21, 24)	Akzente Salzburg (Addiction Prevention Unit of Salzburg)
Schwarzenbrunner, Thomas (pp. 33, 42, 113)	Addiction and Drug Coordinator of Upper Austria
Schindler, Hannes (p. 83)	VWS (Vienna Social Projects Association)
Spitzer, Dr. Bernhard (pp. 35, 36, 40)	Provincial Hospital Mostviertel Amstetten-Mauer, Department of Addiction Diseases
Stolz-Gombocz, Dr. Ingrid (p. 56)	Anton Proksch Institute, long-term treatment department for addicts with personality disorders, Mödling, Lower Austria
Wudy, Dr. Max (p. 34)	Medical Association of Lower Austria
Zeder, Dr. Ulf (p. 69)	Addiction Coordinator of Graz, Styria

Databases

Best Practice Portal: information on standards and guidelines as well as evaluation instruments (EIB) and examples of evaluated interventions (EDDRA = Exchange on Drug Demand Reduction Action)⁵¹

<http://www.emcdda.europa.eu/best-practice>

Austrian projects in the EDDRA database or EMCDDA Best Practice Portal, respectively (as at August 2010)

abrakadabra — (Re-)socialisation of drug addicts by integration in the labour market (Caritas der Diözese Innsbruck, Tyrol)

Addiction information in schools supported by experts

(kontakt+co — Suchtpräventionsstelle, Tyrol)

Addiction prevention within the apprenticeship of the Austrian Federal Railways

(Institut für Suchtprävention, Vienna)

Addiction prevention within the Styrian Soccer Association

(VIVID — Fachstelle für Suchtprävention, Styria)

Ambulance for addiction diseases at the University Hospital of Innsbruck, Department for Psychiatry (Universitätsklinik für Psychiatrie — Innsbruck, Tyrol)

Become Independent: education programme for prevention in schools

(SUPRO — Werkstatt für Suchtprophylaxe, Vorarlberg)

Being a parent can be beautifully difficult sometimes

(Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria)

51

In the course of establishing an internet portal on best practices, the EDDRA database of EMCDDA was revised in a move to improve the quality of entries and facilitate integrated use within the online portal. In this process the existing entries were selected according to certain criteria, reclassified and validated. Major improvements to the search function have been made; project descriptions are now available for download. During the revision a few Austrian projects were cancelled, which had been entered before 2001 and are no longer running.

Caritas Marienambulanz. Drug related street work, an outreach service in the field of medical care and treatment. (Caritas der Diözese Graz Seckau, Styria)

CONTACT: Liaison service for hospitals
(Sucht- und Drogenkoordination Wien, Vienna)

DAPHNE project: Addiction as chance of survival? For women with experience of violence.
(Verein Dialog und Verein Wiener Sozialprojekte, Vienna)

DP drugaddicts@work. Equal ESF community initiative programme for reintegrating people with problematic drug use into the labour market.
(Sucht- und Drogenkoordination Wien, Vienna)

Drug free zone Hirtenberg prison
(Justizanstalt Hirtenberg, Lower Austria)

Drug Out: Innsbruck prison's therapy unit
(Justizanstalt Innsbruck, Tyrol)

Drug treatment at the Drug Outpatient Clinic Klagenfurt
(Magistrat Klagenfurt, Carinthia)

Early detection and intervention with regard to problematic drug use and addiction
(kontakt+co – Suchtpräventionsstelle, Tyrol)

Employment Programme WALD (Forest)
(H.I.O.B. — Anlauf- und Beratungsstelle für Drogenabhängige, Vorarlberg)

Erlenhof: An inpatient treatment centre for addicts
(Pro mente Upper Austria)

Generation E: Workshop for creative parents work
(Institut für Suchtprävention, Fonds Soziales, Vienna)

Grüner Kreis: A treatment facility for adolescents
(Verein Grüner Kreis, Lower Austria)

“Guat beinand’!”: Addiction prevention in communities and city districts
(Akzente Salzburg — Suchtprävention, Salzburg)

FeierFest! — Leisure time and party culture for young people. Pilot project for the implementation of a new festival and party culture for young people in the EuRegio region Salzburg/Bavaria

(Akzente Salzburg — Suchtprävention, Salzburg)

Health Promotion and Addiction Prevention in the Workplace

(SUPRO — Werkstatt für Suchtprophylaxe, Vorarlberg)

High enough? — Practical kit for addiction prevention in the field of youth social work

(VIVID Fachstelle für Suchtprävention, Styria)

H.I.O.B.: Help, information, orientation and counselling for drug addicts

(H.I.O.B. — Anlauf- und Beratungsstelle für Drogenabhängige, Vorarlberg)

In motion: A multiplier project for addiction prevention at schools

(Institut Suchtprävention — eine Einrichtung von pro mente, Upper Austria)

Job assistance — subproject of the Vienna Job Exchange in the context of the Equal development partnership

(Wiener Berufsbörse, Vienna)

Living together in the 2nd district. Program for the prevention of addiction in schools, children and youth social work in urban areas.

(Institut für Suchtprävention, Vienna)

Local Capital for Social Purposes (a pilot action of the DG V of the EU) Programme:

“Socially Innovative 2000” (EU regional management Eastern Styria)

(Volkshilfe Steiermark, VIVID Fachstelle für Suchtprävention, Regionalbüro

Oststeiermark, Styria)

Log In: Measures for the integration and health promotion of former drug users

(Anton Proksch Institute, Lower Austria)

Long-term treatment, Anton Proksch-Institute, Mödling

(Anton Proksch Institute, Lower Austria)

Long-term treatment facility CARINA

(Stiftung Maria Ebene, Vorarlberg)

Long-term treatment of drug dependence Senobio, Schnifis, Vorarlberg

(Senobio, Vorarlberg)

Low threshold service Ganslwirt

(Verein Wiener Sozialprojekte, Vienna)

Lukasfeld: A short term therapy for young illegal drug addicts

(Stiftung Maria Ebene hospital, Vorarlberg)

Making kids strong through Sports

(SUPRO — Werkstatt für Suchtprophylaxe, Vorarlberg)

MDA basecamp — mobile drug work in recreational settings (Jugendzentrum Z6, Tyrol)

Medico–psycho–social Sanatorium „Schweizer Haus Hadersdorf“

(Evangelisches Haus Hadersdorf — WOBES, Vienna)

Needles or Pins: Vienna: A European Project to develop innovative projects for the social and labour integration of people with drug related problems.

(Beratungsstelle DIALOG, Vienna)

Needles or Pins: Occupational reintegration of (former) drug addicts.

(Beratungsstelle DIALOG, Vienna)

Peer education project

(Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria)

Pib – prevention in companies

(kontakt+co — Suchtpräventionsstelle, Tyrol)

Pilot projekt: Addiction prevention in Trofaiach

(b.a.s. (betrifft alkohol und sucht) — steirischer Verein für Suchtkrankenhilfe, Styria)

Probation assistance for prisoners at Vienna Favoriten prison provided by voluntary staff

(Verein für Bewährungshilfe und soziale Arbeit — Bewährungshilfe, Vienna)

Scientific project: ChEckiT!

(Verein Wiener Sozialprojekte, Vienna)

Social medicine counselling centre Ganslwirt

(Verein Wiener Sozialprojekte, Vienna)

Socio economical company: Fix und Fertig (“All ready”)

(Verein Wiener Sozialprojekte, Vienna)

Stationenmodell: Primary addiction prevention in schools
(Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria)

Step by Step: A programme for early detection and crisis intervention at schools
(VIVID — Fachstelle für Suchtprävention, Styria)

Streetwork mobile youth work: "Rumtrieb" Wiener Neustadt
(Verein für Jugend und Kultur Wr. Neustadt, Lower Austria)

Substitution treatment in the Outpatient Clinic for Addictions in Innsbruck
(Outpatient Clinic for Addictions Innsbruck, Tyrol)

Supervised housing
(Verein Wiener Sozialprojekte, Vienna)

Supromobil: Secondary prevention of the Foundation Maria Ebene
(Stiftung Maria Ebene, Vorarlberg)

The Umbrella Network Programme: Analysis of border issues with regard to HIV, AIDS and STD problems and the development of cooperative border crossing preventative measures.
(Institut für Sozialdienste, Vorarlberg)

Therapy for parents and children at Grüner Kreis
(Verein Grüner Kreis, Lower Austria)

Travelling exhibition with the aim of addiction prevention: "Have you got the hang of everything?"
(Fachstelle für Suchtprävention, Lower Austria)

Treatment and care of addicted offenders in Vienna Favoriten prison
(Justizanstalt Wien-Favoriten, Vienna)

Vaccination project Hepatitis B of the Social Medicine Counselling Centre Ganslwirt
(Verein Wiener Sozialprojekte, Vienna)

Vienna Job Exchange
(Wiener Berufsbörse, Vienna)

Viennese pilot project "Pregnancy and Addiction": Aftercare of the children.
Comprehensive care project for substance abusing mothers and their children
(Neuropsychiatrische Abteilung für Kinder und Jugendliche am KH Rosenhügel, Vienna)

Viennese pilot project “Pregnancy and Addiction”: Comprehensive care for substance dependent mothers and their children
(AKH, Vienna)

Viktorija’s birthday: Primary addiction prevention for primary school pupils.
(Fachstelle für Suchtprävention, Lower Austria)

Way Out: Early intervention for young drug-using first offenders.
(Kooperation der Landesstelle Suchtprävention und Neustart, Carinthia)

Youth and addiction counselling centre “Auftrieb”
(Verein für Jugend und Kultur Wr. Neustadt, Lower Austria)

Youth counselling centre „Waggon”
(TENDER — Verein für Jugendarbeit, Lower Austria)

Youth without borders?! Mladi brez meja?! — Addiction prevention in the district of Radkersburg
(bluemonday gesundheitsmanagement, Styria)

Websites

Please find below websites of relevant institutions and centres in the field of drugs and addiction in Austria.

For a comprehensive list of European and international websites on drugs and addiction please consult <http://www.goeg.at> (Areas / Prevention / Illicit drugs / Links).

Provincial Drug or Addiction Coordination Offices

Addiction Coordination Office of the Province of Burgenland

<http://www.psd-bgld.at/psychosoziale-dienste/suchtkoordination/index.html>

Drug Coordination Office of the Province of Carinthia

<http://www.gesundheit-kaernten.at/sucht/drogenkoordination-land-kaernten.html>

Addiction Coordination Office of the Province of Lower Austria

<http://www.suchtvorbeugung.at/suchtkoordination/>

Addiction and Drug Coordination Office of the Province of Upper Austria

http://www.land-oberoesterreich.gv.at/cps/rde/xchg/SID-3DCFCFC3-8C8F5206/ooe/hs.xsl/554_DEU_HTML.htm

Drug Coordination Office of the Province of Salzburg

http://www.salzburg.gv.at/themen/gs/soziales/leistungen_und_angebote/abhaengigkeit/abhaengigkeit_drogenkoordination.htm

Addiction Coordination Office of the Province of Styria

<http://www.verwaltung.steiermark.at/cms/beitrag/10896138/9752/>

Addiction Coordination Office of the Province of the Tyrol

<http://www.tirol.gv.at/themen/gesellschaft-und-soziales/soziales/projektmanagement/suchtkoordination/>

Addiction Coordination Office of the Province of Vorarlberg

http://www.vorarlberg.at/vorarlberg/gesellschaft_soziales/gesellschaft/suchtkoordination/start.htm

Addiction and Drug Coordination Office of Vienna (SDW)

<http://www.drogenhilfe.at>

Provincial Addiction Prevention Units

Burgenland: Fachstelle für Suchtprävention Burgenland

<http://www.psd-bgld.at/psychosoziale-dienste/suchtpraevention/>

Carinthia: Landesstelle für Suchtprävention Carinthia

<http://www.suchtvorbeugung.ktn.gv.at/>

Lower Austria: Fachstelle für Suchtvorbeugung, Koordination und Beratung, NÖ
<http://www.suchtvorbeugung.at>

Upper Austria: Institut Suchtprävention, OÖ
<http://www.praevention.at>

Salzburg: AKZENTE Suchtprävention — Fachstelle für Suchtvorbeugung Salzburg
<http://www.akzente.net/Fachstelle-Suchtpraevention.1250.0.html>

Styria: VIVID Fachstelle für Suchtprävention, Steiermark
<http://www.vivid.at>

Tyrol: kontakt+co Suchtprävention Jugendrotkreuz, Tirol
<http://www.kontaktco.at>

Vorarlberg: SUPRO — Werkstatt für Suchtprophylaxe, Vorarlberg
<http://www.supro.at>

Vienna: Institut für Suchtprävention, Vienna
<http://www.drogenhilfe.at>

Austrian Federal Ministries

Federal Ministry of Labour, Social Affairs and Consumer Protection
<http://www.bmask.gv.at>

Federal Ministry of Health
<http://www.bmg.gv.at>

Federal Ministry of the Interior
<http://www.bmi.gv.at>

Federal Ministry of Justice
<http://www.bmj.gv.at>

Federal Ministry of Education, Arts and Culture
<http://www.bmukk.gv.at>

Federal Ministry of Transport, Innovation and Technology
<http://www.bmvit.gv.at>

Federal Ministry of Economy, Family and Youth
<http://www.bmwfj.gv.at>

Federal Ministry of Science and Research
<http://www.bmwf.gv.at>

Monitoring and research

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction)
<http://www.emcdda.europa.eu>

GÖG/ÖBIG — Österreichischer Suchthilfekompass (Austrian Addiction Support Compass)

<http://suchthilfekompass.oebig.at>

GÖG/ÖBIG — Einheitliches Dokumentationssystem der Klienten und Klientinnen der Drogenhilfe (Uniform documentation and reporting system of clients of Austrian drug treatment and support centres)

<http://tdi.oebig.at>

Ludwig Boltzmann Institute of Addiction Research at Anton Proksch Institute

<http://www.api.or.at/lbi/index.htm>

Suchtforschung und Suchttherapie an der Medizinischen Universität Wien (Addiction Research and treatment at the Medical University of Vienna)

<http://www.sucht-addiction.info>

European Centre for Social Welfare Policy and Research

<http://www.euro.centre.org/>

Other websites

AIDS-Hilfe (AIDS support associations)

<http://www.aidshilfen.at>

Allgemeines Krankenhaus Wien (General Hospital Vienna)

<http://www.meduniwien.ac.at>

Anton Proksch Institute

<http://www.api.or.at>

ARGE Suchtvorbeugung (Working Group for Addiction Prevention)

<http://www.suchtvorbeugung.net>

Auftrieb (Advice for young people and information on addiction)

<http://www.jugendundkultur.at/de/auftrieb/home/>

b.a.s. (Styrian addiction advice association)

<http://www.bas.at>

Blue Monday Gesundheitsmanagement (health management association)

<http://www.blumonday.at>

Bundesarbeitsgemeinschaft Streetwork — Mobile Jugendarbeit Österreich (federal association of mobile street social work for young people in Austria)

<http://www.bast.at>

Carina treatment centre

<http://www.mariaebene.at/carina/>

Caritas Innsbruck

[http://www.caritas-tirol.at/auslandshilfe/wer-wir-sind/
caritas-welthaus-der-dioezese-innsbruck/](http://www.caritas-tirol.at/auslandshilfe/wer-wir-sind/caritas-welthaus-der-dioezese-innsbruck/)

Caritas Graz Kontaktladen (contact point)

<http://streetwork.caritas-steiermark.at/angebote-fuer-klientinnen/beratung-begleitung/>

ChEck iT! (pill testing services of VWS/Vienna Social Projects Association)

<http://checkyourdrugs.com>

CONTACT (hospital connection service)

<http://drogenhilfe.at/ueber-uns/beratung-behandlung-und-betreuung/liasondienste/contact/>

Dialog (support and treatment centre)

<http://www.dialog-on.at>

Do it yourself (low-threshold centre for drug users)

<http://www.doit.at>

Drogenambulanz der Medizinischen Universität Wien (drug outpatient department of the Medical University of Vienna)

<http://www.sucht-addiction.info>

Drogenberatung des Landes Steiermark (Drugs Advice Centre of the Province of Styria)

<http://www.drogenberatung.steiermark.at/>

ENCARE Austria

<http://www.encare.at>

Ex und Hopp (drug advice centre)

<http://www.exundhopp.at>

Fachzeitschrift für Online-Beratung und computervermittelte Kommunikation
(Magazine for online advice and computer-aided communication)

<http://www.e-beratungsjournal.net>

Fonds Gesundes Österreich

<http://www.fgoe.org/startseite>

Ganslwirt (low-threshold centre of VWS Vienna Social Projects Association)

<http://www.vws.or.at/ganslwirt>

Gesunde Gemeinden (healthy communities initiative)

<http://gesundesleben.at/lebensraum/gemeinde/gesunde-gemeinde>

Gesunde Schule (healthy schools initiative)

<http://www.gesundeschule.at>

Grüner Kreis (association for the rehabilitation and integration of addicted persons)
<http://www.gruenerkreis.at>

Haus am Seespitz (treatment centre)
<http://www.gpg-tirol.at/Haus-am-Seespitz-Maurach.147.0.html>

H.I.O.B. (drug advice centre)
<http://www.caritas-vorarlberg.at>

Waggon (advice services for young people)
<http://members.aon.at/waggon/>

Jugendstreetwork Graz (youth street social work)
<http://jugendstreetwork.caritas-steiermark.at/>

Klinische Abteilung für Biologische Psychiatrie, Universitätsklinik für Psychiatrie und Psychotherapie in Wien (Clinical Department of Biological Psychiatry, Vienna University Hospital of Psychiatry and Psychotherapy)
<http://www.medizin-medien.info/dynasite.cfm?dssid=4263>

Komfüdros (communication centre for drug users)
<http://www.caritas-tirol.at/hilfe-einrichtungen/menschen-mit-suchtproblemen/komfuedro/>

Kontaktstelle in Suchtfragen, Salzburg (addiction information centre)
<http://www.landesschulrat.salzburg.at//service/kis/index.php>

Krankenhaus Rosenhügel (hospital)
<http://www.wienkav.at/kav/nkr/>

Lukasfeld (treatment department)
<http://www.mariaebene.at>

Marienambulanz (outpatient centre)
<http://www.caritas-steiermark.at/hilfe-einrichtungen/fuer-menschen-in-not/gesundheit/marienambulanz/>

MDA basecamp (mobile prevention services in the Tyrol)
<http://www.mdabasecamp.com>

MDA basecamp (online advice and information)
<http://www.onlinedrogenberatung.at>

Needles or Pins (Dialog association; occupational reintegration)
http://www.dialog-on.at/article_69.html

Neustart (probation assistance, conflict management, social work)
<http://www.neustart.at/>

Oikos (association for addicted people)
<http://www.oikos-klagenfurt.at/>

Otto-Wagner-Spital — Drogeninstitut (Drug Department at Otto Wagner Hospital, Vienna)

http://www.wienkav.at/kav/ows/medstellen_anzeigen.asp?suchstring=912

Österreichische Caritaszentrale - Integration durch Arbeit KEG (Caritas employment integration service)

<http://web2.cylex.de/firma-home/oesterreichische-caritaszentrale---integration-durch-arbeit-keg-4402107.html>

Österreichische Gesellschaft für arzneimittelgestützte Behandlung von Suchtkranken (Austrian Society of Pharmacologically Assisted Treatment of Addiction)

<http://www.oegabs.at/index.php>

Österreichischer Verein für Drogenfachleute (Federation of Austrian Professionals Working in the Field of Drug Abuse)

<http://www.oevdf.at>

Österreichisches Netzwerk Gesundheitsfördernde Schulen (Austrian network of health-promoting schools)

<http://www.schulpsychologie.at/>

Plattform Drogentherapien (drug treatment platform for information on opioid addiction)

<http://www.drogensubstitution.at>

pro mente Upper Austria (support, advice and prevention services)

<http://www.promenteooe.at>

Rumtrieb (mobile youth social work)

<http://www.jugendundkultur.at/de/rumtrieb/>

Schulpsychologie Bildungsberatung (school psychology and education advice)

<http://www.schulpsychologie.at>

Schweizer Haus Hadersdorf (treatment centre)

<http://www.shh.at>

Stadt Wien (City of Vienna)

<http://www.magwien.gv.at>

Stiftung Maria Ebene (treatment centre)

<http://www.mariaebene.at>

Streetwork Graz (street social work)

<http://streetwork.caritas-steiermark.at/>

Substanz (association for accepting drug assistance)

<http://www.substanz.at>

Suchtberatungsstelle BIZ Obersteiermark (addiction advice centre, Styria)
<http://www.biz-obersteiermark.at/>

Supromobil (secondary prevention)
<http://www.supromobil.at>

taktisch klug (event services)
<http://www.taktischklug.at>

Therapiestation Erlenhof (treatment centre)
<http://www.therapiestation-erlenhof.at>

Therapiestation WALKABOUT (treatment centre)
<http://www.barmherzige-brueder.at/content/site/walkabout/startseite/aktuelles/index.html>

Tiroler JugendWeb — Drogen, Sucht, Hilfe (drug and addiction services for young people)
<http://www.startblatt.net/at/jugend/jugend-tirol/tiroler-jugendweb>

Verein für eine Legalisierung von Cannabis (legalise cannabis association)
<http://www.legalisieren.at>

Verein LOG IN (reintegration services)
<http://www.login-info.at>

Verein PASS (prevention and advice centre)
<http://www.pass.at/start.htm>

VIVA (prevention and advice services)
<http://www.gesundheit-kaernten.at/sucht/betreuung-beratungsstellen/drogenberatung-viva.html>

Vorarlberger Drogenhilfe (drug support services)
www.suchthaufen.at

VWS — Verein Wiener Sozialprojekte (Vienna Social Projects Association)
<http://www.vws.or.at>

Wiener Berufsbörse (Vienna Job Exchange)
<http://www.berufsboerse.at>

Annex

A. Tables, Map

B. List of Abbreviations

C. Standard Tables &
Structured Questionnaires

Annex A

Tables, Map

Table A1

Overview of selected general population surveys on drug experience among the Austrian population from 2004 to 2009

Study (author(s), year of publication)	Area covered, year of data collection (period covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience	
				Age group	%
Bevölkerungsbefragung Österreich / general population survey, Austria (Uhl et al. 2005a)	Austria 2004 (lifetime)	General population aged 14 and older (n = 4 547)	Cannabis	14+	20.1
			Ecstasy	14+	3.0
			Amphetamines	14+	2.4
			Cocaine	14+	2.3
			Opioids	14+	0.7
			Biogenic drugs	14+	2.7
			LSD	14+	1.7
			Solvents and inhalants	14+	2.4
Wiener Suchtmittelstudie / drug survey, Vienna (IFES 2005)	Vienna 2005 (lifetime)	General population aged 15 and older (n = 600)	Cannabis	15+	17
			Ecstasy	15+	2
			Amphetamines	15+	2
			Cocaine	15+	2
			Opioids	15+	2
			Biogenic drugs	15+	3
			Other illicit drugs (e.g., LSD)	15+	2
Bevölkerungsbefragung OÖ / General population survey, Upper Austria (Seyer et al. 2007)	Upper Austria 2006 (lifetime)	General population aged 15 to 59 (n = 1 125)	Cannabis	15-59	27.6
			Ecstasy	15-59	7.3
			Amphetamines	15-59	7.6
			Cocaine	15-59	5.8
			Heroin	15-59	4.2
			Morphine	15-59	4.4
			LSD	15-59	4.6
			Solvents and inhalants	15-59	8.0
			Biogenic drugs	15-59	7.4
Gesundheitsbefragung Österreich (ATHIS) / Austrian Health Interview Survey (ATHIS) (Klimont et al. 2007)	Austria 2006/07 (lifetime)	General population aged 15 to 64 (n = 11 822)	Cannabis	15+	9.7
			Cannabis	15-24	13.0
			Cannabis	25-34	15.0
			Cannabis	35-44	10.1
			Cannabis	45-54	6.7
			Cannabis	55-64	2.8
Wiener Suchtmittelstudie / drug survey, Vienna (IFES 2008)	Vienna 2007 (lifetime)	General population aged 15 and older (n = 624)	Cannabis	15+	19
			Ecstasy	15+	4
			Amphetamines	15+	4
			Cocaine	15+	4
			Opioids	15+	2
			Biogenic drugs	15+	7
			Other illicit drugs (e.g., LSD)	15+	4
Bevölkerungsbefragung Österreich / general population survey, Austria (Uhl et al. 2009)	Austria 2008 (lifetime)	General population aged 14 and older (n = 4 196)	Cannabis	14+	12
			Ecstasy	14+	2
			Amphetamines	14+	2
			Cocaine	14+	2
			Opioids	14+	1
			Biogenic drugs	14+	2
			LSD	14+	2
			Solvents and inhalants	14+	2
Wiener Suchtmittelstudie / drug survey, Vienna (IFES 2009)	Vienna 2009 (lifetime)	General population aged 15 and older (n = 600)	Cannabis	15+	16
			Ecstasy	15+	3
			Amphetamines	15+	3
			Cocaine	15+	4
			Opioids	15+	3
			Biogenic drugs	15+	4
			Other illicit drugs (e.g., LSD)	15+	3

Summarised by GÖG/ÖBIG

Table A2

Overview of selected youth surveys on drug experience among young people in Austria from 2001 to 2007

Study (author(s), year of publication)	Area covered, year of data collection (period covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience	
				Age group	%
Schulstudie Burgenland / school survey, Burgenland (Schönfeldinger 2002)	Burgenland 2001 (lifetime)	Students of years 7 to 13 (n = 1 899)	Cannabis	12-19	20
			Ecstasy	12-19	4
			Cocaine	12-19	2
			Heroin	12-19	1
			Speed	12-19	3
			Hallucinogenic drugs	12-19	3
			Solvents and inhalants	12-19	20
			Biogenic drugs	12-19	8
HBSC-Studie / HBSC study (Dür und Mravlag 2002)	Austria 2001 (lifetime)	Students aged 15 (n = 1 292)	Cannabis	15	14
ESPAD Österreich / ESPAD Austria (Uhl et al. 2005b)	Austria 2003 (lifetime)	Students aged 14 to 17 (n = 5 281)	Cannabis	14-17	22
			Ecstasy	14-17	3
			Cocaine	14-17	2
			Crack	14-17	2
			Heroin	14-17	1
			Amphetamines	14-17	5
			GHB	14-17	1
			LSD	14-17	2
			Solvents and inhalants	14-17	15
			Magic mushrooms	14-17	4
Berufsschulstudie Steiermark / vocational school survey, Styria (Hutsteiner, Seebauer, Auferbauer 2005)	Styria 2005 (lifetime)	Trainees at vocational school aged 15 to 19 (n = 3 919)	Cannabis	15-20	27.1
			Party drugs	15-20	4.8
			Cocaine	15-20	2.0
			Crack	15-20	1.1
			Opiate	15-20	1.4
			Amphetamines	15-20	3.1
			Hallucinogenic drugs	15-20	1.8
			Solvents and inhalants	15-20	11.4
			Magic mushrooms	15-20	8.9
HBSC-Studie / HBSC study (Dür und Griebler 2007)	Austria 2005/06 (lifetime)	Students aged 15 (n = 1 239)	Cannabis	15	14

Continued next page

Table A2, continued

Study (author(s), year of publication)	Area covered, year of data collection (period covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience	
				Age group	%
Bevölkerungsbefragung OÖ / general population survey, Upper Austria (Seyer et al. 2007)	Upper Austria 2006 (lifetime)	Adolescents and young adults aged 15 to 124 (n = 669)	Cannabis	15-24	36.9
			Ecstasy	15-24	12.3
			Heroin	15-24	7.7
			Morphine	15-24	8.5
			Amphetamines	15-24	12.3
			Cocaine	15-24	10.0
			LSD	15-24	9.0
			Solvents and inhalants	15-24	16.5
			Biogenic drugs	15-24	13.0
Schulstudie Burgenland / school study Burgenland (Falbesoner und Lehner 2008)	Burgenland 2007 (lifetime)	Students of years 7 to 13 (n = 1 213)	Cannabis	12-19	11
			Ecstasy	12-19	2
			Cocaine	12-19	2
			Heroin	12-19	2
			Speed	12-19	3
			Solvents and inhalants	12-19	15
			Biogenic drugs	12-19	4
ESPAD Österreich / ESPAD Austria (ESPAD Austria 2007)	Austria 2007 (lifetime)	Students aged 15 to 16 (n = 4 574)	Cannabis	15-16	18.0
			Ecstasy	15-16	3.4
			Cocaine	15-16	3.2
			Crack	15-16	2.3
			Heroin	15-16	1.8
			Amphetamines	15-16	7.7
			GHB	15-16	2.3
			LSD	15-16	2.8
			Solvents and inhalants	15-16	14.1
			Magic mushrooms	15-16	4.1

Summarised by GÖG/ÖBIG

Table A3

Number of directly drug-related deaths in Austria by cause of death from 2000 to 2009

Cause of death	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Intoxication by opiate(s)	18	17	17	40	38	31	27	9	13	18
Poly-drug intoxication with opiate(s)	147	119	119	115	133	134	137	138	136	153
Poly-drug intoxication with narcotic drug(s) without opiates	2	3	3	8	4	4	5	5	4	1
Intoxication of unknown type	0	0	0	0	10	22	28	23	16	15
Directly drug-related deaths/total	167	139	139	163	185	191	197	175	169	187

Source: BMG, calculation and representation by GÖG/ÖBIG

Table A4

Number of directly drug-related deaths in Austria by province from 2000 to 2009

Province	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2009
Burgenland	0	0	0	2	5	3	3	5	1	1	20
Carinthia	2	5	7	6	4	6	7	4	6	5	52
Lower Austria	11	14	12	13	31	29	38	27	34	26	235
Upper Austria	11	8	6	13	15	13	14	12	20	21	133
Salzburg	6	7	7	5	7	8	6	3	11	13	73
Styria	11	9	13	14	12	17	12	16	21	10	135
Tyrol	11	16	13	13	15	17	16	11	18	15	145
Vorarlberg	5	11	6	5	8	6	6	7	2	14	70
Vienna	110	69	75	92	88	92	95	90	55	82	848
Unknown	0	0	0	0	0	0	0	0	1	0	1
Total	167	139	139	163	185	191	197	175	169	187	1 712

Source: BMG, calculation and representation by GÖG/ÖBIG

Table A5

Number of directly drug-related deaths in Austria by age group and total by gender from 2008 to 2009

Age group	2000		2001		2002		2003		2004		2005		2006		2007		2008 ¹		2009 ²	
	abs.	abs.	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%
19 and younger	19	11.4	20	15.1	18	12.9	20	12.3	40	21.6	28	14.7	40	20.3	24	13.7	22	13.0	18	9.6
20-24	33	19.8	21	14.4	20	14.4	37	22.7	40	21.6	48	25.1	51	25.9	46	26.3	45	26.6	39	20.9
25-29	31	18.6	19	13.7	24	17.3	28	17.2	30	16.2	36	18.8	34	17.3	23	13.1	37	21.9	35	18.7
30-34	27	16.2	27	19.4	23	16.5	24	14.7	19	10.2	25	13.1	19	9.7	35	20.0	21	12.4	28	15.0
35-39	27	16.8	25	18.0	24	17.3	29	17.8	23	12.4	19	9.9	15	7.6	22	12.6	16	9.5	22	11.8
40 or older	30	17.4	27	19.4	30	21.6	25	15.3	33	17.8	35	18.3	38	19.3	25	14.3	28	16.6	45	24.1
Total	167	100	139	100	139	100	163	100	185	100	191	100	197	100	175	100	169	100	187	100
Women	35	21.0	22	15.8	25	18.0	30	18.4	38	20.5	43	22.5	42	21.3	39	22.2	35	20.7	37	19.8
Men	132	79.0	117	84.2	114	82.0	133	81.6	147	79.5	148	77.4	155	78.7	136	77.7	134	79.3	150	80.2

¹ No autopsies performed in 30 suspicious cases.

² No autopsies performed in 19 suspicious cases.

Source: BMG, calculation and representation by GÖG/ÖBIG

Table A6
Distribution of directly drug-related deaths in Austria by cause of death and age in 2009

Cause of death		Age group										
		< 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	> 49	Total	
Intoxications	Opiates	One opiate	0	4	4	3	0	0	1	3	0	15
		Several opiates	1	0	1	1	0	0	0	0	0	3
		+ alcohol	0	1	0	5	0	3	1	2	1	13
		+ psychoactive medicines	0	7	21	10	13	6	7	2	9	75
		+ alcohol & psychoactive medicines	0	1	5	4	7	8	5	4	0	34
	Opiates and other narcotic drugs	Narcotic drug(s) only	0	0	0	3	1	1	0	0	0	5
		ND + alcohol	0	1	1	1	1	0	0	0	0	4
		ND + psychoactive medicines	0	1	5	3	5	1	0	1	0	16
		ND + alcohol & psychoactive medicines	0	1	0	2	1	0	2	0	0	6
	Narcotic drugs without opiates	Narcotic drug(s) only	0	0	0	0	0	0	0	0	0	0
		ND + alcohol	0	0	0	0	0	0	0	0	0	0
		ND + psychoactive medicines	0	0	0	0	0	0	0	0	0	0
		ND + alcohol & psychoactive medicines	0	0	0	0	0	1	0	0	0	1
	Intoxication of unknown type		0	1	2	3	0	2	4	2	1	15
Directly drug-related deaths/total		1	17	39	35	28	22	20	14	11	187	
of these: men		1	12	30	25	20	19	19	14	10	150	

ND = narcotic drug(s).

Source: BMG, calculation by GÖG/ÖBIG

Table A7

Distribution of directly drug-related deaths in Austria by cause of death and province in 2009

Cause of death		Province										
		B	C ¹	LA ²	UA ³	S	ST	T	VB	V ⁴	A ⁵	
Intoxications	Opiates	One opiate	0	0	5	3	1	0	3	1	2	15
		Several opiates	0	0	0	2	0	0	0	0	1	3
		+ alcohol	0	1	1	2	2	2	1	1	3	13
		+ psychoactive medicines	1	4	8	7	3	6	6	4	36	75
		+ alcohol & psychoactive medicines	0	0	1	2	2	0	4	6	19	34
	Opiate and other narcotic drugs	Narcotic drug(s) only	0	0	1	2	0	0	0	0	2	5
		ND + alcohol	0	0	0	0	2	1	0	1	0	4
		ND + psychoactive medicines	0	0	6	2	3	0	0	0	5	16
		ND + alcohol & psychoactive medicines	0	0	3	0	0	0	0	0	3	6
	Narcotic drugs without opiates	Narcotic drug(s) only	0	0	0	0	0	0	0	0	0	0
		ND + alcohol	0	0	0	0	0	0	0	0	0	0
		ND + psychoactive medicines	0	0	0	0	0	0	0	0	0	0
		ND + alcohol & psychoactive medicines	0	0	0	0	0	0	0	0	1	1
	Intoxication of unknown type		0	0	1	1	0	1	1	1	10	15
	Directly drug-related deaths/total		1	5	26	21	13	10	15	14	82	187
Verified directly drug-related deaths per 100 000 inhabitants aged 15 to 64		0.5	1.3	2.4	2.1	3.6	1.2	3.2	5.6	7.1	3.3	
Directly drug-related deaths per 100 000 inhabitants aged 15 to 64		0.5	1.6	2.8	2.9	3.6	1.2	3.2	5.6	7.8	3.7	

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, ST = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna, A = Austria.

ND = Narcotic drug(s).

- 1 No autopsy performed in 1 suspicious case.
- 2 No autopsies performed in 3 suspicious cases.
- 3 No autopsies performed in 7 suspicious cases.
- 4 No autopsies performed in 8 suspicious cases.
- 5 No autopsies performed in 19 suspicious cases.

Source: BMG, calculation by GÖG/ÖBIG

Table A8

Development of AIDS cases in Austria by risk situation from 2000 to 2009

Risk situation	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Homo-/bisexual contact	13	21	19	7	16	14	17	19	17	17
Injecting drug use	25	27	20	14	12	14	6	13	16	10
Heterosexual contact	29	33	41	22	32	17	30	22	25	25
Other cause/unknown	18	8	14	9	10	13	10	17	10	7
Total	91	93	97	53	71	59	64	72	70	59

Source: BMG, calculation by GÖG/ÖBIG

Table A9

Distribution of reports of violations of the Narcotic Substances Act in Austria by first offenders and repeat offenders, development from 2000 to 2009

Reports	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total numbers of reports	18 125	21 862	22 422	22 245	25 215	25 892	24 008	24 166	20 043	22 729
First offenders	9 343	11 033	11 269	12 117	14 346	15 569	15 808	16 053	13 634	14 893
Repeat offenders	8 296	10 052	10 380	9 288	9 990	9 520	7 636	7 569	5 990	7 258

Difference between sum of individual figures and total figure = unknown.

Note: all reports, not only narcotic substances, but also psychotropic substances.

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A10

Distribution of reports of violations of the Narcotic Substances Act (narcotic substances only) in Austria from 2000 to 2009

Province	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Burgenland	843	712	805	984	967	923	1 033	1 008	871	953
Carinthia	1 088	1 758	1 676	1 659	1 464	1 529	1 190	1 408	1 153	1 372
Lower Austria	2 624	2 975	3 319	3 017	3 531	3 632	3 050	3 464	2 583	3 165
Upper Austria	1 887	2 677	3 054	2 782	3 521	3 769	3 209	3 786	3 245	3 908
Salzburg	718	1 471	1 384	868	1 077	1 092	1 001	1 116	1 015	1 096
Styria	1 305	1 601	1 910	1 570	1 705	1 516	1 435	1 929	1 372	1 669
Tyrol	2 687	2 449	2 229	2 102	2 695	2 775	2 607	2 454	1 982	2 555
Vorarlberg	1 183	1 447	1 265	1 146	1 044	1 008	1 240	1 153	976	1 027
Vienna	5 233	6 212	6 210	7 652	8 524	8 797	7 925	6 611	5 883	6 056
Total	17 568	21 302	21 852	21 780	24 528	25 041	22 690	22 929	19 080	21 801

Difference between sum of individual figures and total figure = reports not attributable.

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A11

Distribution of reports of violations of the Narcotic Substances Act in Austria
by drug type from 2000 to 2009

Drug type	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Cannabis	17 001	19 760	19 939	17 706	20 252	20 900	19 021	19 063	15 063	17 513
Heroin and opioids	2 413	3 802	3 954	4 717	4 770	4 720	3 516	3 294	2 865	3 157
Cocaine + crack	2 494	3 416	3 762	4 785	5 365	5 491	4 252	4 263	3 551	3 930
Amphetamines + methamphetamine	-	-	1 532	1 727	1 843	1 795	1 639	2 112	1 405	1 749
LSD	477	506	327	214	196	160	164	196	101	193
Ecstasy	2 337	2 940	2 998	2 473	2 362	2 106	1 763	1 889	1 127	966
Medicines containing narcotic drugs	-	-	809	872	1 420	1 795	2 800	2 714	2 294	2 693
Other narcotic drugs	-	-	540	320	304	427	355	323	263	363
Psychotropic substances	-	-	3	11	11	4	14	20	13	16
Psychotropic medicines	780	821	736	603	892	1 081	1 687	1 535	1 185	1 174
Precursor substances	-	-	4	5	0	4	8	2	12	1

- = No data available.

Note: because of data broken down by type of drug, one report may have been listed under several headings, therefore the added figures may differ from the total number of reports.

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A12

Distribution of reports of violations of the Narcotic Substances Act in Austria
by drug type and province in 2009

Drug type	B	C	LA	UA	S	ST	T	VB	V	Total
Cannabis	909	1 456	2 474	3 325	925	1 561	2 641	975	3 247	17 513
Heroin and opioids	95	126	510	494	50	121	125	249	1 295	3 065
Cocaine + crack	168	260	532	587	131	182	383	187	1 500	3 930
Amphetamines + methamphetamine	164	51	470	518	111	155	72	36	172	1 749
LSD	42	1	29	25	9	13	38	13	23	193
Ecstasy	88	79	213	248	98	87	65	22	66	966
Medicines containing narcotic drugs	39	80	302	589	147	275	169	50	1 042	2 693
Other narcotic drugs	14	67	64	95	17	36	31	16	23	363
Psychotropic substances	0	1	1	1	0	3	7	1	2	16
Psychotropic medicines	21	19	80	108	15	76	118	20	717	1 174
Precursor substances	0	0	0	1	0	0	0	0	0	1

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, ST = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna, A = Austria.

Note: Because of data broken down by type of drug, one report may have been listed under several headings, therefore the added figures may differ from the total number of reports.

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A13

Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria from 2000 to 2009

Year	Total number of convictions under the SMG	Convictions under Section 28 SMG resp. Section 28 a SMG	Convictions under Section 27 SMG	Convictions in Austria	
				Total number	Under the SMG (percentages)
2000	3 240	933	2 245	41 624	7.8
2001	3 862	1 141	2 671	38 763	10.0
2002	4 394	1 108	3 243	41 078	10.7
2003	4 532	1 161	3 318	41 749	10.9
2004	5 706	1 441	4 229	45 185	12.6
2005	6 128	1 357	4 702	45 691	13.4
2006	5 795	1 464	4 246	43 414	13.3
2007	5 437	1 387	3 956	43 158	12.6
2008	4 291	1 332	2 899	38 226	11.2
2009	3 928	1 283	2 593	37 868	10.4

Until 2007:

Section 28 SMG = trafficking in, possession etc. of, large quantities of narcotic drugs (commercial trafficking);
Section 27 SMG = trafficking in, possession etc. of, small quantities of narcotic drugs.

As of 2008:

Section 27 SMG = illicit handling of narcotic substances;
Section 28 SMG = preparation for trafficking in narcotic substances;
Section 28a SMG = trafficking in narcotic substances.

Note: These figures only refer to the leading offence, i.e., the offence with the highest range of punishment, therefore not all convictions under the SMG are covered.

Source: Statistics Austria (criminal court statistics); representation by GÖG/ÖBIG

Table A14

Final convictions under the Narcotic Substances Act (SMG) in Austria by age, gender and basis of conviction in 2009

Basis of conviction		14-19 years	20-24 years	25-29 years	30-34 years	> 34 years	Total
SMG total	Men	554	1 232	750	383	611	3 530
	Women	60	142	76	37	83	398
Section 28 SMG/28a SMG	Men	77	333	266	149	311	1 136
	Women	16	52	29	17	33	147
Section 27 SMG	Men	474	896	478	228	275	2 351
	Women	44	88	44	20	46	242

Until 2007:

Section 28 SMG = trafficking in, possession etc. of, large quantities of narcotic drugs (commercial trafficking);
Section 27 SMG = trafficking in, possession etc., of small quantities of narcotic drugs.

As of 2008:

Section 27 SMG = illicit handling of narcotic substances;
Section 28 SMG = preparation for trafficking in narcotic substances;
Section 28a SMG = trafficking in narcotic substances.

Note: These figures only refer to the leading offence, i.e., the offence with the highest range of punishment, therefore not all convictions under the SMG are covered.

Source: Statistics Austria (criminal court statistics); representation by GÖG/ÖBIG

Table A15

Final convictions under the Narcotic Substances Act (SMG), young people and adults, basis of conviction and type of punishment in 2009

Basis of conviction		Fine	Prison sentence			Other punishment ¹	Total
			Probation	No probation	Partial probation		
SMG total	Young people	49	96	27	23	16	211
	Adults	819	1 134	1 067	554	143	3 717
Section 28 SMG / Section 28a SMG (felonies)	Young people	3	15	8	1	0	27
	Adults	32	300	552	318	54	1 256
Section 27 SMG (misdemeanours)	Young people	46	81	19	22	16	184
	Adults	780	808	499	234	88	2 409

Young people = persons younger than 18 at the time of the offence.

Until 2007:

Section 28 SMG = trafficking in, possession etc. of, large quantities of narcotic drugs (commercial trafficking);

Section 27 SMG = trafficking in, possession etc. of, small quantities of narcotic drugs.

As of 2008:

Section 27 SMG = illicit handling of narcotic substances;

Section 28 SMG = preparation for trafficking in narcotic substances;

Section 28a SMG = trafficking in narcotic substances.

¹ Other punishment: partial probation (Section 43(2) StGB), referrals to institutions (Section 21(1), 21(2), 22 and 23 StGB), no additional punishment (Section 40 StGB) and, only in the case of young people, conviction with punishment reserved (Section 13 JGG) and conviction without punishment (Section 12 JGG).

Note: These figures only refer to the leading offence, i.e., the offence with the highest range of punishment, therefore not all convictions under the SMG are covered.

Source: Statistics Austria (criminal court statistics); representation by GÖG/ÖBIG

Table A16

Development of alternatives to punishment applied in Austria from 2000 to 2009

Waiving of reports/ suspension of proceedings	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total	8 049	8 145	8 974	9 023	9 666	11 660	10 379	10 175	9 384	10 627
Section 35 SMG (waiving of reports)	6 924	7 346	7 817	7 902	8 599	10 668	9 173	9 008	8 399	9 661
Of these: Section 35 (4) SMG (cannabis)	1 410	1 570	1 876	1 499	2 016	2 697	1 895	1 841	2 249	2 780
Section 37 SMG (dismissal of proceedings)	1 125	799	1 157	1 121	1 067	992	1 206	1 167	985	966

Until 2007:

Section 35 SMG = temporary waiving of reports by the public prosecutor;

Section 35 (4) SMG = waiving of reports in the case of small quantities of cannabis for personal use;

Section 37 SMG = temporary dismissal of proceedings by the court.

As of 2008:

§ 35 SMG = temporary waiver of report by the public prosecutor's office;

Section 35 (4) SMG = waiving of reports in the case of small quantities of cannabis for personal use;

Section 37 SMG = temporary dismissal of proceedings by the court.

Note: Data on Section 39 of the SMG (suspension of sentence — treatment instead of punishment) are not available at present.

Source: BMG, calculation and representation by GÖG/ÖBIG

Table A17

Number of seizures of narcotic drugs/substances in Austria from 2000 to 2009

Narcotic drug/substances	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Cannabis	4 833	5 249	5 294	5 422	6 202	6 012	5 770	5 732	5 050	5 733
Heroin	478	895	836	1 263	1 383	1 371	883	765	673	901
Cocaine	554	768	863	1 271	1 475	1 507	1 044	1 087	936	984
Amphetamines + methamphetamine	142	161	239	321	342	328	334	380	299	400
LSD	42	32	20	33	29	20	20	39	20	39
Ecstasy	330	352	308	276	286	295	248	250	181	131
Medicines containing narcotic drugs	311	418	392	445	812	1 117	1 571	1 234	1 015	1 121
Other narcotic drugs	130	123	139	84	87	97	84	92	58	79
Psychotropic substances	65	1	0	6	5	2	2	10	1	2
Psychotropic medicines	501	566	515	432	678	823	1 300	1 019	843	697
Precursor substances	8	0	2	2	0	2	7	1	12	0

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A18

Seizures of narcotic drugs/substances in Austria by quantity from 2000 to 2009

Narcotic drug/substance	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Cannabis (kg)	1 806	456	743.1	925.9	1 680.9	819.9	1 880.4	1 276.0	873.6	1 139.3
Heroin (kg)	230	288	59.5	42.8	235.0	282.2	34.3	117.0	104.0	189.6
Cocaine (kg)	20	108	36.9	58.3	75.5	244.9	61.8	78.1	78.38	53.2
Amphetamines + methamphetamine (kg)	1.6	2.9	9.5	54.3	27.6	9.6	38.9	19.4	13.00	64.9
LSD (trips)	865	572	851	298	2 227.5	2 108.5	10 831.5	1 058	225.50	1 581.0
Ecstasy (number of pills)	162 093	256 299	383 451	422 103	122 663	114 104	30 855	66 167	45 335	5 847.5
Medicines containing narcotic drugs (no. of pills)	2 309	3 755	3 919	10 827	9 031	9 057	12 253	10 376	7 180	8 233.5
Other narcotic drugs (kg)	3.5	10.2	6.0	1.8	21.4	5.0	2.4	3.6	2.9	5.3
Psychotropic substances (kg)	1.29	0.00	0.00	0.15	0.05	0.00	0.03	0.20	0.00	0.01
Psychotropic medicines (units)	38 507	32 377	20 081	15 650	21 119	27 105	44 416	26 289	24 675	36 624.5
Precursor substances (kg)	0.93	0.00	241.00	25.00	0.00	0.10	9.85	0.17	22.16	0.0

Source: BMI/.BK; representation by GÖG/ÖBIG

Table A19

Ingredients of samples bought as ecstasy and analysed by the ChEck iT! project at parties and clubbing from 2000 to 2009

Ingredients	Samples bought as ecstasy (percentages)									
	2000 (n=319)	2001 (n=268)	2002 (n=269)	2003 (n=143)	2004 (n=93)	2005 (n=53)	2006 (n=134)	2007 (n=117)	2008 (n=146)	2009 (n=105)
MDMA	83.4	77.2	68.0	83.2	72.0	67.9	74.6	60.7	61.6	15.2
MDMA + MDE	3.1	2.2	14.1	7.7	9.7	0.0	1.5	0.0	0.0	0.0
MDMA + MDA	0.9	1.5	6.7	0.0	0.0	0.0	0.7	0.0	0.0	0.0
MDE and/or MDA	1.3	7.1	0.4	0.0	7.5	0.0	0.0	0.0	1.4	1.0
MDMA + caffeine	1.6	0.0	0.7	0.7	1.1	5.7	5.2	0.9	0.7	1.0
MDMA + amphetamines	0.6	0.4	0.0	0.7	0.0	1.9	1.5	0.0	0.0	0.0
MDMA + various combinations*	2.2	0.4	0.0	3.5	1.1	13.2	0.0	6.0	7.5	1.9
PMA/PMMA	1.3	0.4	0.0	0.7	0.0	0.0	0.0	0.0	0.0	1.0
Amphetamines	0.0	0.0	1.9	1.4	0.0	1.9	4.5	0.0	0.7	1.0
Methamphetamine	0.6	2.6	1.5	0.0	0.0	0.0	0.7	0.0	0.0	1.0
Caffeine	0.9	0.0	1.5	0.0	1.1	0.0	0.7	1.7	0.0	0.0
Chinine/chinidine	0.6	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
mCPP/mCPP + various combinations**	0.0	0.0	0.0	0.0	0.0	0.0	1.5	16.2	17.8	52.4
Various combinations*	3.4	7.1	5.2	2.1	7.5	9.4	9.0	14.5	10.3	25.7

* Various combinations: combinations of more than two amphetamine derivatives and/or other substances and/or unknown substances.

** mCPP + various combinations: mCPP and one or more additional substances.

Source: Vienna Social Projects Association (VWS); representation by GÖG/ÖBIG

Table A20

Ingredients of samples bought as speed and analysed by the ChEck iT! project at parties and clubbing from 2000 to 2009

Ingredients	Samples bought as speed (percentages)									
	2000 (n=93)	2001 (n=51)	2002 (n=87)	2003 (n=57)	2004 (n=41)	2005 (n=33)	2006 (n=75)	2007 (n=129)	2008 (n=99)	2009 (n=113)
Amphetamines	57.0	60.8	46.0	35.1	22.0	33.3	24.0	22.5	15.2	9.7
Amphetamines + caffeine	9.7	9.8	8.0	15.8	19.5	6.1	29.3	10.1	27.3	50.4
Amphetamines + methamphetamine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0
Amphetamines + various combinations*	7.5	3.9	17.2	29.8	39.0	24.2	24.0	31.8	34.3	15.0
Methamphetamine	3.2	2.0	3.4	1.8	2.4	3.0	0.0	10.1	1.0	0.9
Caffeine	3.2	11.8	8.0	0.0	4.9	9.1	1.3	1.6	3.0	8.8
MDMA	3.2	0.0	1.1	0.0	0.0	6.1	4.0	0.0	1.0	0.0
Various combinations*	16.1	11.8	16.1	17.5	12.2	18.2	17	23.3	14.1	14.2
mCPP/mCPP + various combinations**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	2.0	0.9

* Various combinations: combinations of more than two amphetamine derivatives and/or other substances and/or unknown substances.

** mCPP + various combinations: mCPP and one or more additional substances.

Source: Vienna Social Projects Association (VWS); representation by GÖG/ÖBIG

Table A21

Number of persons currently registered for substitution treatment in Austria in the BMG monitoring system by treatment/continued treatment and province in 2009

Treatment	B	C	LA	UA	S	ST	T	VB	V
Continued treatment	172	368	1 270	897	416	1 040	503	501	5 221
First treatment	59	109	443	324	76	180	269	119	1 282
Total	231	477	1 713	1 221	492	1 220	772	620	6 503

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, ST = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna

Note: **Continued treatment** means treatment started before the respective year, or repeated treatment of persons who have already undergone substitution treatment before. **First treatment** means treatment of persons who have never undergone substitution treatment before. The figures relate to treatments reported to the BMG and in part differ considerably from the figures collected at provincial level.

The total number of substitution treatments is higher than the sum of substitution treatments by province since records of the provinces are incomplete in some cases.

Source: BMG, calculation and representation by GÖG/ÖBIG

Table A22

Persons starting drug treatment or requiring addiction services in 2009, by age and gender; percentages

Age	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
0 to 4	0	0	0	0	0	0	0	0	0	0	1	0
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	1	1	1	3	2	3	0	2	1	0	0	0
15 to 19	16	18	16	18	17	17	15	23	17	7	11	8
20 to 24	26	27	26	22	30	24	28	31	29	32	39	34
25 to 29	20	19	20	19	25	21	23	21	23	27	24	27
30 to 34	13	11	13	17	13	16	14	9	13	16	13	15
35 to 39	8	8	8	10	6	9	8	5	7	8	6	7
40 to 44	7	8	7	6	4	5	5	4	5	5	4	5
45 to 49	5	5	5	4	1	3	4	3	3	2	1	2
50 to 54	2	2	2	1	1	1	2	1	2	1	0	1
55 to 59	1	0	1	0	0	0	1	1	1	1	0	1
60 to 64	0	0	0	0	1	0	0	0	0	0	0	0
65 to 69	0	0	0	0	0	0	0	0	0	0	0	0
70 to 74	0	0	0	0	0	0	0	0	0	0	0	0
75 to 79	0	0	0	0	0	0	0	0	0	0	0	0
80 or older	0	0	0	0	0	0	0	0	0	0	0	0
Valid indications	4 885	1 348	6 233	482	181	663	3 148	1 039	4 187	1 260	402	1 662
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Missing	-	-	-	-	-	-	-	-	-	-	-	-

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients.

Source: GÖG/ÖBIG 2010a, DOKLI analysis 2009

Table A23

Persons starting drug treatment or requiring addiction services in 2009, by gender and livelihood, percentages

Livelihood/employment	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Gainful employment	-	-	-	17	16	17	31	26	30	9	7	8
Registered as unemployed	-	-	-	36	20	32	37	28	35	47	36	44
Welfare assistance	-	-	-	7	15	9	8	15	10	17	25	19
Child, school student, university student	-	-	-	6	13	8	4	12	6	2	4	2
Military service, alternative military service, parenthood leave, retired	-	-	-	3	5	4	5	9	6	7	11	8
Housework, (re)training, other	-	-	-	2	1	2	6	5	6	0	2	1
No gainful employment, other form of livelihood	-	-	-	7	8	7	5	3	4	2	3	2
No gainful employment, other form of livelihood unknown	-	-	-	22	21	22	5	3	4	15	13	15
Valid indications	-	-	-	412	146	558	2 998	980	3 978	1 162	369	1 531
Unknown	-	-	-	60	28	88	109	41	150	46	17	63
Missing	-	-	-	10	7	17	41	18	59	52	16	68

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients.

The corresponding data are not collected for short-term contacts.

Source: GÖG/ÖBIG 2010a, DOKLI-analyses of client year 2009

Table A24

Persons starting drug treatment or requiring addiction services in 2009,
by place of residence and gender; percentages

Place of residence	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Burgenland	-	-	-	-	-	-	2	1	2	3	2	3
Carinthia	-	-	-	-	-	-	9	9	9	1	4	2
Lower Austria	-	-	-	-	-	-	10	12	11	13	14	13
Upper Austria	-	-	-	-	-	-	11	8	10	14	10	13
Salzburg	-	-	-	-	-	-	3	3	3	2	3	2
Styria	-	-	-	-	-	-	6	8	7	10	11	10
Tyrol	-	-	-	-	-	-	12	9	11	8	12	9
Vorarlberg	-	-	-	-	-	-	12	8	11	7	4	7
Vienna	-	-	-	-	-	-	35	41	36	41	38	41
Foreign country	-	-	-	-	-	-	0	1	0	1	1	1
Valid indications	-	-	-	-	-	-	3 065	999	4 064	1 188	381	1 569
Unknown	-	-	-	-	-	-	74	31	105	44	13	57
Missing	-	-	-	-	-	-	9	9	18	28	8	36

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients.

The corresponding data are not collected for short-term contacts and low-threshold assistance.

Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009

Table A25

Persons starting drug treatment or requiring addiction services in 2009, by present housing situation and gender; percentages

Present housing situation	Short-term contacts			Low-threshold services			Long-term care outpatient			Long-term care inpatient		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Stable (e.g., flat of one's own)	-	-	-	41	43	41	85	87	86	70	75	71
Unstable (e.g., homeless)	-	-	-	39	44	40	6	7	6	12	11	12
In institution, plus stable housing situation	-	-	-	10	5	9	6	4	6	13	10	13
In institution, plus unstable housing situation	-	-	-	11	7	10	3	2	3	4	4	4
Valid indications	-	-	-	415	149	564	3 067	1 002	4 069	1 160	366	1 526
Unknown	-	-	-	59	25	84	70	31	101	73	26	99
Missing	-	-	-	8	7	15	11	6	17	27	10	37

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients.

The clients' current housing situation is not surveyed in the case of short-term contacts.

Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009

Table A26

Persons starting drug treatment or requiring addiction services in 2009, by primary drug and gender; percentages

Primary drug (multiple indications admissible)	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Opioids	38	47	40	53	56	54	54	62	56	79	84	80
Heroin	27	34	28	35	33	35	38	41	39	61	56	60
Methadone	2	4	3	2	0	1	6	7	6	13	13	13
Other substitution substances	13	17	14	25	26	25	22	28	24	40	50	42
Other opioids, or opioids not specified	1	1	1	1	1	1	3	3	3	3	3	3
Cocaine group	9	9	9	14	10	13	12	9	11	22	16	20
Cocaine	8	9	9	14	10	13	12	8	11	22	16	20
Crack	0	0	0	0	0	0	0	0	0	0	0	0
Cocaine not specified	0	0	0	0	0	0	0	0	0	0	0	0
Stimulants	2	3	3	1	2	1	4	3	3	8	6	8
Amphetamines (e.g., speed)	2	2	2	1	1	1	3	2	3	7	5	6
MDMA (ecstasy), other derivatives	1	1	1	0	1	1	2	1	2	5	3	4
Stimulants not specified	0	0	0	0	0	0	0	0	0	0	1	0
Tranquillisers/hypnotics	9	12	10	15	12	14	10	14	11	20	27	22
Benzodiazepines	9	11	9	15	12	14	10	13	11	20	27	22
Barbiturates	0	0	0	0	0	0	0	0	0	0	0	0
Other hypnotics/ tranquillisers	0	1	0	0	1	0	0	0	0	0	1	0
Hallucinogenic	0	1	0	0	0	0	1	0	1	2	1	2
LSD	0	1	0	0	0	0	1	0	1	2	1	2
Hallucinogenic drugs not specified	0	0	0	0	0	0	0	0	0	0	0	0
Cannabis	32	23	30	20	20	20	36	26	34	24	18	22
Solvents and inhalants	0	0	0	1	0	1	0	0	0	0	0	0
Alcohol	7	6	6	6	5	6	5	5	5	8	8	8
Biogenic drugs	0	0	0	0	0	0	0	0	0	1	0	1
Other drugs	0	0	0	0	0	0	0	0	0	1	0	0
Only use not relevant for treatment	24	23	24	10	13	11	4	4	4	1	1	1
Additional drug only	4	3	4	9	6	8	9	9	9	5	4	4
Valid indications	5 693	1 605	7 298	602	200	802	4 056	1 333	5 389	2 380	731	3 111
Number of persons with valid indications	4 325	1 188	5 513	427	153	580	2 709	882	3 591	1 121	355	1 476
Unknown	487	130	617	45	25	70	229	95	324	74	25	99
Missing	73	30	103	10	3	13	210	62	272	65	22	87

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Bold type indicates main categories.

Sampled population: all clients.

Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009

Table A27

Persons starting drug treatment or requiring addiction services in 2009, by injecting drug use and age; percentages

Injecting drug use	Short-term contacts			Low-threshold services			Long-term out-patient treatment			Long-term inpatient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
No	68	61	67	33	25	31	61	56	60	24	19	23
Yes	32	39	33	67	75	69	39	44	40	76	81	77
Valid indications	4 174	1 153	5 327	348	125	473	2 948	974	3 922	1 134	370	1 504
Unknown	577	165	742	89	31	120	186	59	245	84	22	106
Missing	134	30	164	45	25	70	14	6	20	42	10	52

Note: All lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients.

Source: GÖG/ÖBIG 2010a, DOKLI analysis of client year 2009

Table A28

Exchange and sale of syringes by provinces in 2009

Province	Number of syringe provision points	Number of vending machines	Number of syringes provided (exchanged or sold)
Burgenland	0	0	0
Carinthia ¹	-	-	-
Lower Austria	0	0	0
Upper Austria	3	1	163 610
Salzburg	1	2	9 400 ²
Styria ³	2	2	386 822
Tyrol	3	3	322 028
Vorarlberg	4	7	237 641
Vienna	2	0	2 846 993
Total	15	15	3 966 494

¹ No information/data provided.

² Date not complete.

³ Syringes are only available in Graz, the capital of Styria.

Source: Standard Table 10: Syringe Availability 2010, calculation by GÖG/ÖBIG

Table A29

Current health problems of clients of Vienna's drug treatment and support centres (BADO), 2004–2008

Current health problems	2004	2005	2006	2007	2008
Chronic hepatitis C	30	35	31	29	29
Dental problems	19	23	21	19	19
Gastrointestinal problems	11	16	14	12	12
Psychiatric diseases	9	10	12	13	11
Dermatological and venous problems	7	10	8	7	7
Aids, HIV infection	4	4	4	4	4
Spasms, epileptic seizures	5	6	6	5	5
Chronic hepatitis B	4	4	3	2	3
Chronic ill health	1	1	1	1	2
Gynaecological problems	2	4	4	4	3
STD (sexually transmitted diseases)	*	1	1	*	*
Other health problems	9	8	8	9	11
No current health problems	41	35	38	39	39

* share of less than 1%.

Note: Any information on health-related problems exclusively relates to indications by clients and is based neither on specific diagnostic questions nor on medical findings.

Source: IFES 2009b; representation by GÖG/ÖBIG

Standardised interventions organised by the regional addiction prevention units and implemented at nationwide level

The following programmes were devised by, or in cooperation with, the addiction prevention units and aim at promoting life skills. In order to guarantee sustainability, the teachers involved are trained and certified by experts (providing theoretical background and methods), who also assist them at the implementation stage. Obligatory reflection meetings are held to ensure quality and to advance the programmes. Standardised materials are available, and the parents are integrated by means of information events, letters that are sent to them, and through the school councils (in which heads of school, teachers, parents and students are represented).

The programme *Eigenständig werden* (Become Independent) is implemented in primary schools (children aged 6 to 10) in at least ten lessons per year. It pursues the principles of a comprehensive view of human beings, orientation towards personal resources, interactive learning and integration of group processes. In the individual provinces, the programme has been run since 2002 (B, C, S, ST, T, VB), 2004 (LA) and 2006 (V), respectively, and includes a 24-lesson training course for primary school teachers.

Table A30

Become Independent, school year 2009/10

Province	Number of completed trainings SY 2009/10	Number of training lessons for teachers ¹ SY 2009/10	Number of certified teachers SY 2009/10	Share of teachers reached (%)	Number of primary schools reached SY 2009/10	Share of primary schools reached (%)	Number of events for parents SY 2009/10	Number of workshops SY 2009/10	Number of primary school teachers reached by SY 2009/10	Share of primary school teachers reached by SY 2009/10 (%)	Number of primary schools reached by SY 2009/10	Share of primary schools reached by SY 2009/10 (%)
B	2	56	24	2.4	11	5.6	n.a.	n.a.	125	12.6	67	34.2
C	3	84	41	8.7	13	5.1	4	1	203	8.7	83	33.1
LA	5	152	61	1.1	7	1.1	1	0	469	8.1	124	19.7
UA	11	308	215	3.6	35	6.1	n.a.	n.a.	1 011	16.9	298	51.8
S	4	108	53	2.7	26	13.8	0	3	268	13.9	90	47.9
ST	4	124	52	1.3	32	6.0	0	7	304	7.8	149	28.1
T	3	78	45	1.4	32	8.3	2	2	270	8.6	139	35.9
VB	9	228	180	11.1	20	12.0	n.a.	n.a.	367	22.6	48	28.9
V	10	252	200	3.7	32	11.8	n.a.	n.a.	1 043	18.9	200	75.0

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg; ST = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna, n.a. = not available, SY = school year.

¹ including reflection meeting.

Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; representation by GÖG/ÖBIG

The programme *plus* is implemented in years 5 to 8 of secondary school (students aged 10 to 14). It consists of four annual focuses, each of which includes five themes of 10 lessons. The principles of the programme presentations take into account the age and growing competence of the children as well as links between different problem areas (violence, sexuality, consumption and addiction), challenges in everyday life and gender-related needs and demands. In the individual provinces, the programme has been run since 2008 (S, ST, T) and 2009 (B, C, LA, UA, VB, V), respectively

Table A31

The *plus* programme, school year 2009/10

Province	Number of further training courses for teachers since 2008	Total number of training units for teachers since 2008	Number of teachers with completed training SY 2009/10	Share of teachers reached (%)	Number of schools reached SY 2009/10	Number of forms reached SY 2009/10	Share of schools reached SY 2009/10 (%)	Number of teachers reached by SY 2009/10	Share of teachers reached by SY 2009/10 (%)	Number of schools reached by SY 2009/10	Share of schools reached by SY 2009/10 (%)	Number of forms reached by SY 2009/10
B	2	32	10	0.6	2	5	2	10	10	2	3.8	5
C	2	38	35	1.0	5	17	5.4	35	1.0	5	5.4	17
LA	1	16	16	0.2	1	4	0.3	16	0.2	1	0.3	4
UA	3	48	51	0.5	12	n.a.	4.3	51	0.5	12	4.3	n.a.
S	2	40	20	0.6	7	15	7	20	0.6	7	7	15
ST	3	62	49	n.a.	12	20	5.3	49	n.a.	16	n.a.	28
T	3	36	32	0.7	12	32	8.8	32	0.7	12	8.8	32
VB	2	38	31	1.2	12	n.a.	17.6	31	1.23	12	17.6	n.a.
V	1	20	24	0.2	9	14	4.2	24	0.2	9	4.2	14

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg; ST = Styria, T = Tirol, VB = Vorarlberg, V = Vienna, n.a. = not available

Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; representation by GÖG/ÖBIG

Under the name *movin'*, the addiction prevention units organise standardised motivational interviewing courses, a technique used both in prevention settings and addiction support centres. Motivational interviewing permits a supportive atmosphere and rapport, which enhances the motivation to change behaviour. The courses, on average, comprise 20 hours in which the basic approaches and strategies of this method are communicated by means of practical exercises, role play and reflection on the role plays. In the individual provinces, the programme has been run since 2004 (V), 2005 (C, LA, ST, T), 2007 (S) or 2009 (VB), respectively.

Table A32
movin, 2009

Province	Direct/final target group (age group)	Indirect target group (advisors, counsellors, multipliers)	Number of courses/course series in 2009	Number of training lessons for multipliers in 2009	Number of certified participants in 2009	Documentation yes/no	Process evaluation yes/no
C ¹	Young people from 12 to 21	Social education workers, social workers, teachers	3	48	33	yes	yes
LA	Clients of probation officers and court authorities as well as offenders or people in danger of delinquency	Probation officers	1	30	10	yes	yes
UA	Young people from 12 to 21	Students of social work college and postgraduate study courses; youth social workers, addiction support teams, youth welfare workers, street social workers, provincial youth officers, youth directors	4	16	63	yes	yes
UA	Young people from 12 to 21	Trainers in courses of the Public Employment Service	1	24	16	yes	yes
S	Young people from 12 to 21 (in youth centres, or clients of support services)	Detached youth work teams, school medical officers, trainers, police officers specialising in prevention, smokers' support services	5	80	90	yes	yes
ST	Young people from 12 to 21	Detached youth work teams, youth social workers and counsellors, social education workers	2	40	28	yes	yes
ST	Young people from 12 to 21	Addiction prevention teams	1	18	13	yes	yes
T	Young people from 12 to 21	Advisors, social workers	1	20	9	yes	yes
VB	Young people from 12 to 21, clients of addiction support centres and occupational integration services	Detached youth work teams, addiction support centres, occupational reintegration services	1	24	7	yes	yes
V	Young people from 12 to 21	Detached youth work teams; key persons in schools, apprenticeship training and enterprises	7	176	124	yes	yes

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg; ST = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna, n.a. = not available

¹ Data basis: 2010.

Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; representation by GÖG/ÖBIG

Proven regional interventions run for more than one year, organised by the regional addiction prevention units

Table A33

Selected prevention activities in different settings

Setting	Name of project/programme (province) [Translation of name]	Direct target group (age group)	Indirect target group (multipliers)	Short description
Kindergartens	<i>ENCARE</i> Hilfe für Kinder in suchtblasteten Familien (ST) [Support for children in families with addiction problems]	Children in families with addiction problems	Teachers	The course consists of four parts and aims at communicating strategies for early detection of the effects on children that addiction of their parents may have, and at providing adequate support. This includes basic knowhow on prenatal noxae, bonding dynamics of early infancy, systemic relationships, co-dependence, role typology according to Wegscheider, evasiveness and early initiation of drug use, in order to be able to act in a supportive way to contribute to prevention. A distinction is made between personal relationships, school as a source of 'outside' experience, and support with regard to getting advice and counselling.
Families	<i>Echt ... nichts für schwache Nerven!</i> (LA) [Indeed — not for the faint of heart]	Parents	Parents	A one-hour theatre play as an introduction in order to confront parents with the diversity of family life. A family that seems to be just ordinary is living everyday life. Respect and lively communication are found as easily as the proverbial needle in a haystack. The audience may reflect on the play, dissociate themselves from what they have seen or identify with it. The goal is to motivate parents to discuss and analyse different aspects of parenting. In addition, they are encouraged to take part in further events on the issues of parenting and prevention of addiction.
Lower secondary schools	<i>Just for mi</i> (K)	Students of year 7 or older (aged 13 to 15)	Teachers and parents	Just for mi is a project extending over a year and aimed at prevention of addiction and violence. It includes addiction prevention training for teachers, establishing a working group within the school, organising information events for parents and parent workshops for further discussion. In 36 lessons, focal issues of addiction are treated in the form of project teaching across traditional school subjects.
Schools	<i>Expertengestützte schulische Suchtinformation</i> (T) [Addiction information in schools supported by experts]	Students of year 8	Addiction counsellors, school medical officers, police officers specialising in prevention	External addiction experts (from the fields of prevention, medicine, police, addiction counselling and advice) may provide invaluable input at school and thus assist teachers. However, they need specific preparation, and a simple, systematic form of documentation has to be used. In lessons of one to two hours, basic information on addiction is communicated (but not in-depth prevention knowhow), for which uniform presentation materials and teaching aids are available (information leaflets for students, posters). Approximately 200 classes with a total of around 5 000 students can be reached each year.

Continued next page

Table A33, continued

Setting	Name of project/ programme (province) [Translation of name]	Direct target group (age group)	Indirect target group (multipliers)	Short description
Schools	<i>Clever & Cool</i> (UA)	Students aged 14 to 15	Teachers and parents	In a one-year school project consisting of 11 modules (with a total of 33 lessons) for students, further training for teachers as well as a lecture and workshop for parents, basic knowhow on addiction and the development of addiction is communicated. The young people are also encouraged to learn more about themselves and others, to improve their strategies for overcoming problems and conflicts and to cope with stress and aggression. Other aspects communicated include taking feelings seriously, standing one's ground, and reflecting on one's patterns of use and consumption.
Schools	<i>GrenzGang</i> (V) [Walking the line]	Students aged 14 to 19	Teachers, parents, trainers	In a prevention project week for groups of students, adventure-based methods are used to encourage perception and reflection on one's limits as well as facing at-risk behaviour.
Schools	<i>Klartext: Sucht</i> (VB) [Outspoken: Addiction]	Students of year 7 or older (aged 12 to 19)	Teachers, parents	The project consists of further training for teachers, an obligatory information event for parents and a workshop with the students. In the one-day further training course (8 lessons), information and teaching aids are provided and methods for communicating issues such as addiction, drinking, nicotine and new media are suggested. The project is implemented by the teachers after completing their training and extends over several lessons. The concrete situation in life of the students is always taken into account. The event for parents is organised in cooperation with SUPRO and integrates the parents as persons with especially close relationships to the students. As a concluding event, a workshop with the students, also organised by SUPRO, takes place.
Vocational orientation courses of the Public Employment Service	<i>Wie ich bin</i> (B) [The way I am]	Adolescents and young adults	Trainers	This project is an opportunity for young people to discover their personal resources and to develop their skills in order to manage different stages in life. The focus is placed on a critical approach to one's own patterns of use and consumption as well as finding alternative problem solving strategies.
Youth centres and clubs	<i>AngeRAUSCHt</i> — Rausch, Risiko & Jugendschutz (S) [Half geared-up — drinking, risk and protection of young people]	Young people aged 14 to 17	Youth social workers	A workshop of two to three hours for young people (groups between 8 and 25 persons) provides information on alcohol/drinking for pleasure, feeling drunk or high, raising awareness of risk and risk competence, and (statutory) protection of young people. After preparation with the youth director in charge, the project is implemented by staff of the Addiction Prevention Unit and police officers specially trained in the field of prevention. The workshop integrates methods for reflecting on drunkenness and trying risky behaviour (e.g. glasses simulating inebriation, risk line). A follow-up workshop for youth social workers can be organised if required.

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, ST = Styria, T = Tirol, VB = Vorarlberg, V = Vienna, n.a. = not available.

Note: The projects and programmes chosen correspond to the criteria of this report (see Chapter 3), they have been run for more than one year and illustrate approaches in different settings.

Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; representation by GÖG/ÖBIG

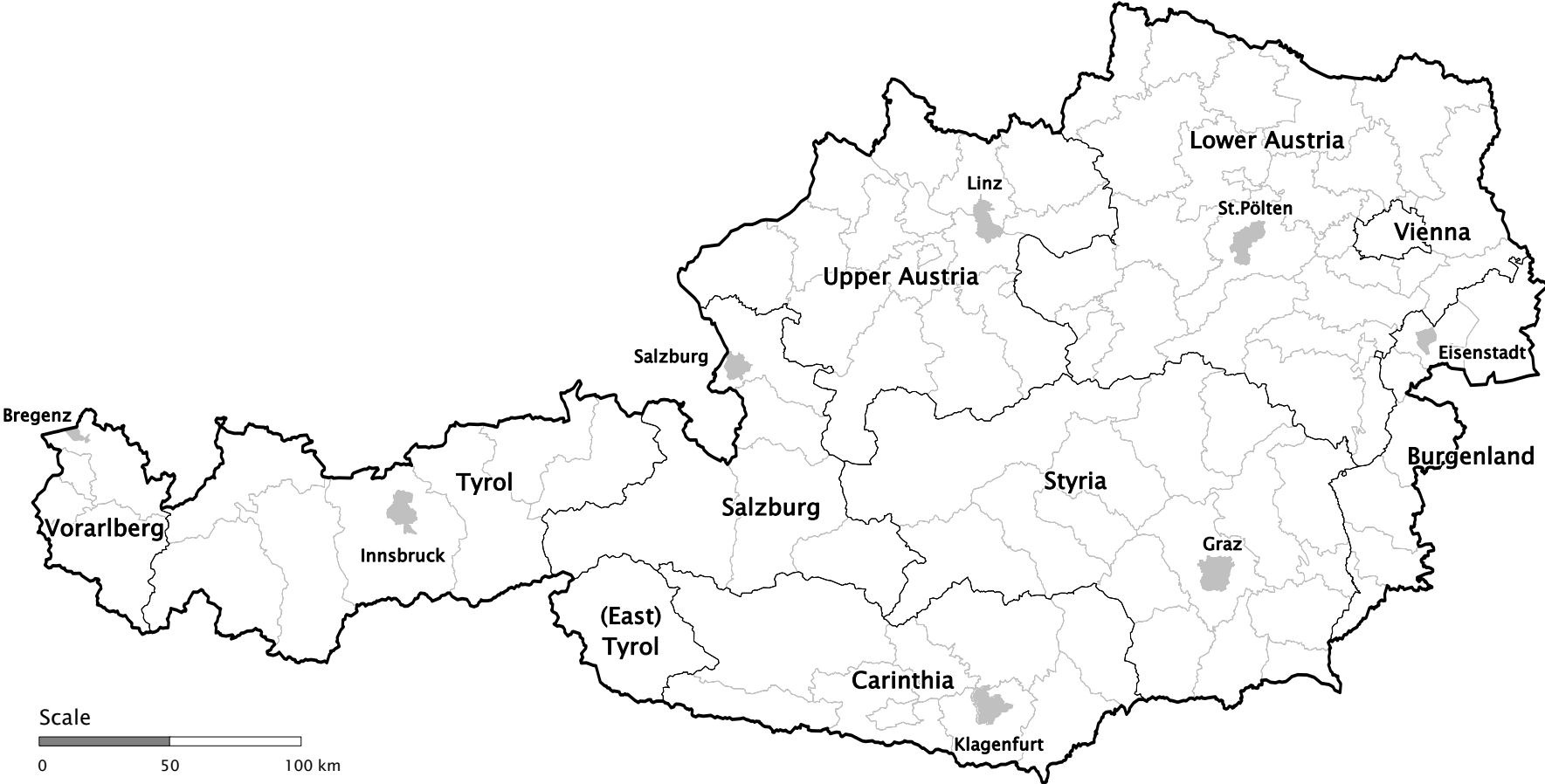
Table A34

Austrian population statistics by age group and gender in 2009

Age group	Men	Women	Total
0 to under 4 years	202 000	192 503	394 503
5 to under 9 years	208 866	197 985	406 851
10 to under 14 years	230 922	220 159	451 081
15 to under 19 years	257 224	244 423	501 647
20 to under 24 years	263 097	257 367	520 464
25 to under 29 years	278 069	275 625	553 694
30 to under 34 years	266 591	265 745	532 336
35 to under 39 years	305 885	308 814	614 699
40 to under 44 years	359 704	351 468	711 172
45 to under 49 years	348 545	341 749	690 294
50 to under 54 years	289 488	293 105	582 593
55 to under 59 years	240 480	250 209	490 689
60 to under 64 years	216 614	232 230	448 844
65 to under 69 years	223 390	251 459	474 849
70 to under 74 years	145 726	176 045	321 771
75 to under 79 years	113 765	158 684	272 449
80 to under 84 years	76 781	140 675	217 456
85 years or older	45 719	131 929	177 648
Total	4 072 866	4 290 174	8 363 040
0 to 14 years	641 788	610 647	1 252 435
15 to 29 years	798 390	777 415	1 575 805
30 to 44 years	932 180	926 027	1 858 207
45 to 59 years	878 513	885 063	1 763 576
60 to 74 years	585 730	659 734	1 245 464
75 years or older	236 265	431 288	667 553
Total	4 072 866	4 290 174	8 363 040

Source: Statistics Austria, calculation by GÖG/ÖBIG

Map A1
Overview of provinces, provincial capitals and districts



Source: representation by GÖG/ÖBIG

Annex B

List of Abbreviations

AIDS	acquired immune deficiency syndrome
APA	Austria Press Agency
ASB	Workers' Samaritan Federation Austria
ATHIS	Austrian Health Interview Survey
BADO	basic documentation of clients of drug services in Vienna
BGBI	Federal Collection of Statutes
BMASK	Federal Ministry of Labour, Social Affairs and Consumer Protection
BMeiA	Federal Ministry of European and International Affairs
BMF	Federal Ministry of Finance
BMG	Federal Ministry of Health
BMGF	Federal Ministry of Health and Women
BMGFJ	Federal Ministry of Health, Family and Youth
BMI	Federal Ministry of the Interior
BMI/.BK	Federal Ministry of the Interior / Federal Criminal Agency
BMJ	Federal Ministry of Justice
BMLFUW	Federal Ministry of Agriculture, Forestry, Environment and Water Management
BMLVS	Federal Ministry of Defence
BMUKK	Federal Ministry of Education, the Arts and Culture
BMVIT	Federal Ministry of Transport, Innovation and Technology
BMWF	Federal Ministry of Science and Research
BMWFJ	Federal Ministry of Economy, Family and Youth
BQLL	Federal Quality Guideline
BQRL	Federal Quality Directive
COFOG	Classification of Functions of Government
CRC	capture–recapture
DC	Drug Coordinator
DR	Drug Representative
DOKLI	nationwide documentation system of clients of Austrian drug services
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EDDRA	Exchange on Drug Demand Reduction Action
ENCARE	European Network for Children Affected by Risky Environments within the Family
ESPAD	European School Survey Project on Alcohol and other Drugs
EU	European Union
FGÖ	Health Austria Fund
GÖG	Gesundheit Österreich GmbH
GÖG/ÖBIG	Health Austria / Austrian Health Institute
GÖG/FGÖ	Health Austria / Health Austria Fund
HBSC	Health Behaviour in School–aged Children (WHO study)
HBV	hepatitis B virus
HBVc–Ab	hepatitis B core antibody (= HBc–Ab)
HBVs–Ab	hepatitis B surface antibody (= HBs–Ab)

HCV	hepatitis C virus
HCV–Ab	HCV antibody
HCV–RNA	RNA (ribonucleic acid) of the hepatitis C virus
HIV	human Immunodeficiency virus
ICD–10	International Classification of Diseases and Related Health Problems
IFES	Institute for Empirical Social Studies
ISD	Institute for Addiction Diagnostics
ISP	Addiction Prevention Institute
JGG	Juvenile Court Act
KIJA	child and youth advisory office
LA	Lower Austria
LSD	d–lysergic acid diethylamide
MDA	3,4–methylenedioxyamphetamine
MDE	3,4–methylenedioxy–N–ethylamphetamine
MDMA	3,4–methylenedioxy–methylamphetamine
MUMOK	Museum of Modern Art, Vienna
OST	opioid substitution treatment
ÖAKDA	Austrian Working Group for Communicative Drug Work
ÖBIG	Austrian Health Institute
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
ÖGPB	Austrian Society of Neuropsychopharmacology and Biological Psychiatry
PCR	polymerase chain reaction
PMA	paramethoxyamphetamine
PSD	Psychosocial Services
REITOX	European Information Network on Drugs and Drug Addiction (Réseau Européen d’Information sur les Drogues et les Toxicomanies)
SAM	Social, Safe, Active and Mobile
SDW	Addiction and Drug Coordination Office of Vienna
SMG	Narcotic Substances Act
SQ	Structured Questionnaire
ST	Standard Table
StGB	Penal Code
Tb	tuberculosis
UA	Upper Austria
UN	United Nations
VWS	Vienna Social Projects Association
WBB	Vienna Job Exchange
WHO	World Health Organization

Annex C

Standard Tables & Structured Questionnaires

List of Standard Tables of 2010 and Structured Questionnaires for Austria

The following list gives an overview of all Standard Tables and Structured Questionnaires (both updated versions and versions not updated in recent years). If no year of update is given, the Table or Questionnaire has been updated in the reporting year. If you are interested in obtaining any table or questionnaire please contact Ms Monika Löbau: monika.loebau@goeg.at).

- STANDARD TABLE 01 BASIC RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE (latest update: 2009)
- STANDARD TABLE 02 METHODOLOGY AND RESULTS OF SCHOOL SURVEYS ON DRUG USE (latest update: 2009)
- STANDARD TABLE 03 CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS (DOKLI) (latest update: 2008)
- STANDARD TABLE 03 CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS (substitution treatment) (latest update 2008)
- STANDARD TABLE TDI: CHARACTERISTICS OF INDIVIDUALS STARTING TREATMENT FOR DRUGS BY TYPE OF TREATMENT (DOKLI)
- STANDARD TABLE TDI: CHARACTERISTICS OF INDIVIDUALS STARTING TREATMENT FOR DRUGS BY TYPE OF TREATMENT (substitution treatment)
- STANDARD TABLE 05 ACUTE/DIRECTLY DRUG-RELATED DEATHS
- STANDARD TABLE 06 EVOLUTION OF ACUTE/DIRECTLY DRUG-RELATED DEATHS
- STANDARD TABLE 07 NATIONAL PREVALENCE ESTIMATES ON PROBLEM DRUG USE
- STANDARD TABLE 08 LOCAL PREVALENCE ESTIMATES ON PROBLEM DRUG USE
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Anton Proksch Institute: HBV, HCV, HIV)
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Lukasfeld short-term treatment department: HBV, HCV, HIV)
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Marienambulanz outpatient department Graz: HBV, HCV, HIV)
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (VWS/Vienna Social Projects Association – Ganslwirt low-threshold centre: HBV, HCV, HIV)
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (drug outpatient department of General Hospital Vienna: HCV, HIV) (latest update: 2008)
- STANDARD TABLE 09 PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (drug-related deaths: HCV, HIV) (latest update: 2008)

STANDARD TABLE 09	PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (DOKLI: HBV, HCV, HIV)
STANDARD TABLE 10	SYRINGE AVAILABILITY
STANDARD TABLE 11	ARRESTS/REPORTS FOR DRUG LAW OFFENCES
STANDARD TABLE 12	DRUG USE AMONG PRISONERS
STANDARD TABLE 13	NUMBER AND QUANTITY OF SEIZURES OF ILLICIT DRUGS
STANDARD TABLE 14	PURITY AT STREET LEVEL OF ILLICIT DRUGS
STANDARD TABLE 15	COMPOSITION OF ILLICIT DRUG TABLETS
STANDARD TABLE 16	PRICE AT STREET LEVEL OF ILLICIT DRUGS
STANDARD TABLE 18	OVERALL MORTALITY AND CAUSES OF DEATHS AMONG COHORTS OF DRUG USERS RECRUITED IN TREATMENT
STANDARD TABLE 24	ACCESS TO TREATMENT (latest update: 2008)
STRUCTURED QUESTIONNAIRE 22/25	UNIVERSAL PREVENTION
STRUCTURED QUESTIONNAIRE 23/29	PREVENTION AND REDUCTION OF HEALTH-RELATED HARM ASSOCIATED WITH DRUG USE (latest update: 2008)
STRUCTURED QUESTIONNAIRE 26	SELECTIVE PREVENTION
STRUCTURED QUESTIONNAIRE 27	Part 1: TREATMENT PROGRAMMES (latest update: 2008); Part 2: QUALITY ASSURANCE TREATMENT (latest update: 2008)
STRUCTURED QUESTIONNAIRE 28	SOCIAL REINTEGRATION AND REDUCTION OF SOCIAL INCLUSION OF DRUG USERS
STRUCTURED QUESTIONNAIRE 31	TREATMENT AS AN ALTERNATIVE TO IMPRISONMENT APPLICABLE FOR DRUG USING OFFENDERS IN THE EUROPEAN UNION (latest update: 2006)
STRUCTURED QUESTIONNAIRE 32	POLICY AND INSTITUTIONAL FRAMEWORK (latest update: 2006)