



European Monitoring Centre
for Drugs and Drug Addiction



2011 NATIONAL REPORT (2010 data)
TO THE EMCDDA
by the National Reitox Focal Point

AUSTRIA

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

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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 of Health. 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 2010/11. In addition, every year specific themes are highlighted in more detail. For this report, the issues of drug-related health policies and services in prison as well as drug users with children have been selected.

Summary and Discussion of the Most Important Trends

Drug Policy: Legislation, Strategies and Economic Analysis

In 2011, a decree based on the Act of Pharmaceutical Products was issued which prohibits several substances with cannabinomimetic effects. The Act Accompanying the Budget of 2011 has brought about changes in the Narcotic Substances Act (SMG), in particular with regard to health-related interventions, resulting from the intention of the Federal Ministry of Justice (BMJ) to control the development of costs in this field: in future, the BMJ will take over the cost of inpatient treatment (according to SMG Section 39) for a maximum period of six months. Lower Austria adopted the new Addiction Plan 2011–15, which is based on a comprehensive concept of addiction and includes both substance-related and non-substance related forms of addiction. The Addiction Plan of Carinthia will continue to remain in force also from 2012 to 2016. It focuses on harm reduction and reintegration in the labour market as well as prevention activities addressing children in families with addiction problems.

Drug Use in the General Population and Specific Target Groups

New results of the drug monitoring system of Vienna are available for assessing the drug situation. A trend can only be derived for cannabis, where a rise in lifetime prevalence has shown. This corroborates the assumption that the decline in prevalence rates found in the latest nationwide survey is a methodological artefact. Therefore, methodological aspects have been discussed in detail in the context of a national REITOX Academy, and measures to improve the reliability of such surveys have been developed.

Prevention

In the reporting period the focus was on implementing and intensifying existing interventions, in particular services for families. Evaluations have shown good results for approaches with trained facilitators from the same social environment as the target group, as they have been able to motivate also parents who otherwise hardly take part in such projects. In community settings, process-oriented projects that take into account the specific local situation have proved their worth. It has become obvious that programmes from other countries have to be analysed in detail and adapted to the specific local situation before they are implemented.

Problem Drug Use

No new prevalence estimates of problem drug use are available. According to current analyses of the data base, a figure in the upper section of the interval from 25 000 to 37 000 of people showing patterns of PDU seems plausible (in Austria, PDU typically takes the form of poly-drug use with opiates). Reports from drug support centres indicate an increase in abuse of benzodiazepines and mephedrone, with the latter substance used in particular until summer 2010.

Drug-related Treatment: Treatment Demand and Treatment Availability

Endeavours to improve the availability of substitution treatment have not always developed as desired: there are still districts in Austria without any established doctor providing OST. Several working groups at federal level and in Vienna have discussed responses to benzodiazepine use including the preparation of guidelines for stabilising, controlling and reducing benzodiazepine use by clients addicted to opiates who are undergoing maintenance treatment. In Vienna, a new cooperation project with the police, public health departments and addiction support centres was started in order to prevent the abuse of substitution medicines. As the diverse needs of different target groups have meanwhile been realised to a greater extent while resources are getting tighter, the care and support centres have to find a balance between provision and funding of services. In the reporting period, the focus of activities was placed on addicted people with a background of immigration, senior drug users and young people showing high-risk patterns of drug use.

Recent data from the treatment sector confirm the finding that opioids continue to predominate as primary drugs while cocaine plays an insignificant role in this respect. Data acquisition for the substitution registry has been transferred to online routines, and currently data consolidation activities are under way. OST has further risen in importance as a frequent form of treatment.

Health Correlates and Consequences

Part of the data sources that are currently available indicate a recent further rise in prevalence rates of hepatitis C among IDUs, which were reported to be as high as 50% already in past years. However, in the absence of general monitoring in this field, it can neither be verified whether this is a general trend nor can further statements on reasons for this development be given. In this context, the results of a study from Tyrol deserve mention, which show that drug users still tend to follow high-risk patterns of use. The results of an HIV cohort study of 2010 indicate that the HIV prevalence rates of injecting drug users reported by treatment centres seem to be too low.

In 2010 a total of 170 directly drug-related deaths were registered, and another 17 cases might be drug-related but this could not be verified as no forensic tests had been performed. A study on drug-related deaths conducted in Vienna confirms the great risk of overdoses after release from prison and/or if drug users do not receive services by drug support centres. Therefore, steps aimed at a long-term integration in the drug support system of the largest possible number of drug users may be essential for preventing drug-related deaths.

Social Correlates and Social Reintegration

Drug addiction continues to go hand in hand with social problems such as homelessness and unemployment as well as indebtedness, but specific interventions may help reduce these problems. In 2010 the focus of activities in this field was on improving job placement structures and helping clients examine possible prospects for their future. Other services included spare-time activities and provision of day structure. In addition, new housing opportunities will be made available.

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

The number of drug-related reports to the police saw a rise in the past year, which was more pronounced regarding misdemeanours than felonies. Reports relating to ecstasy went down significantly, but this decline is offset in part by the increase in reports because of mephedrone use. A massive decrease also shows regarding temporary waivers of reports and alternatives to punishment. From 2009 to 2010, the number of convictions rose as well. The data regarding application of the principle of treatment instead of punishment have shown a continuous rise over the last few years.

Drug Markets

Cannabis continues to be the drug that is most often found in seizures, but in the party and clubbing scenes, research chemicals have played an increasingly important role. Last year saw a sharp rise in new substances in the market, which is a considerable challenge for prevention and legislation. As a rule, products with identical names and packaging also contain identical substances. As in previous years the data on the purity and concentration of illicit substances sold in Austria show considerable variations. Many substances used in the party scene and analysed by *ChEck IT!* contained dangerous ingredients such as levamisole in cocaine and PMA in speed, and users were warned about the high risk. As in the previous year, a very large share of pills bought as ecstasy again contained mCPP.

Selected Issue: Drug-related Health Policies and Services in Prison

The principle of equivalence of care generally also applies to services provided in prison. However, it has been impossible either in prison or outside prisons to implement this principle in all aspects. While substitution treatment is available in every prison in Austria, great differences are found with regard to implementation. Although a number of harm reduction interventions do exist in prisons, exchange of needles or syringes is not possible. Another problem addressed by experts is the new legislation under which cost coverage by the Federal Ministry of Justice for inpatient treatment is restricted to a maximum of six months. The effects of this amendment cannot yet be assessed. No standardised documentation of examinations and treatment in prison exists. Several guidelines are under revision, and quality standards will be drawn up.

Selected Issue: Drug Users with Children

Drug-using parents and their children are facing numerous problems with regard to both medical and psychological effects of addiction. No specific data on this issue are available, however. In recent years more attention has been drawn to this target group; further interventions have been planned, and guidelines for action and cooperation have been developed. The main objectives of interventions are to prevent negative health effects on new-born babies and during childhood, and also to reduce the elevated risk for (grown-up) children of drug users to develop addiction later in life.

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Introduction

This is the 16th 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 of Health. 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 of all EU member states and by the EU candidates, according to guidelines issued by the EMCDDA. These reports are essential as a basis for the EMCDDA's Annual report on the state of the drugs problem in Europe (latest publication: EMCDDA 2010).

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 report: GÖG/ÖBIG 2010a) and refers to the reporting period from summer 2010 to summer 2011, while routine statistics refer to the year 2010. In Part B of the report, two selected issues are presented in more detail. In the present report the corresponding chapters deal with drug-related health policies and services in prison as well as drug users with children. 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

The Narcotic Substances Act (SMG; BGBl I 1997/112 v. 5. 9. 1997) constitutes 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 policy papers 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

The reporting period has seen several modifications of the existing legal framework. Regarding control of psychoactive substances, the most important amendments concern research chemicals²: the Federal Minister for Health issued a decree based on the Act on Pharmaceutical Products under which it is prohibited to put into circulation, import and deliver incense blends with cannabinomimetic ingredients. This aims at preventing the criminalisation of users while inhibiting trade in the corresponding

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.

2

New synthetic substances with psychoactive effects sold in head shops (small shops selling paraphernalia for cannabis use and other articles typical of drug use), on the Internet, and in part also in the street.

substances. In October 2010, the existing Decree on Incense Blends with Cannabinomimetic Ingredients (BGBl II 2009/58 v. 3. 3. 2009; see GÖG/ÖBIG 2009b) was expanded to include other substances as well (BGBl II 2010/341 v. 29. 10. 2010). Eventually, in May 2011 a Decree was issued which, in a generic approach, covers groups of substances (BGBl II 2011/158 v. 13. 5. 2011). These substances include naphthoyl indoles, naphthylmethyl indoles, naphthoyl pyrroles, naphthylmethyl indenenes, phenylacetyl indoles and cyclohexyl phenoles. For each substance, its basic chemical structure as well as its chemical substitutions were defined. Any violation of the prohibition is punishable by an administrative fine of up to EUR 25 000, and in the case of repeat offences, up to EUR 50 000.

In addition, the Federal Ministry of Health is drafting a comprehensive regulation on research chemicals (Schopper, personal communication), which will also focus on prohibiting the production and putting into circulation of these substances provided that this is aimed at use for psychoactive effects. A decision of March 2011 by the Provincial Government of Vorarlberg has pursued the same approach (Neubacher, personal communication). This issue was also on the agenda of a working group of the advisory board for the information and early warning system on specific health risks connected with substance use.

The Act Accompanying the Budget of 2011 (BBG; BGBl I 2010/111 v. 30. 12. 2010) will also trigger considerable changes in the area of health-related measures taken under the SMG (Section 39): according to the BBG of 2011, the Ministry of Justice will take over the cost of health-related measures in the context of inpatient treatment for a maximum period of six months (see Chapter 9). The reason given for this restriction is that a trend towards short-term treatment has shown and that expenditure for health-related measures has to be contained (see Chapter 1.3) in view of the rise by 34% from 2005 (EUR 4.61 million) to 2009 (EUR 7.03 million). Experts had criticised the inflexible approach of this regulation already before the Act was adopted. It is not foreseeable at present which effects this restriction will have on subsequent legislation and thus on the implementation of the principle of treatment instead of punishment. Other amendments to the SMG resulting from the new Act Accompanying the Budget include the following:

- » The Federal Ministry of Justice will establish a separate medical office in charge of giving statements on the need for, and advisability of, treatment (Section 35, Para. 3).
- » According to Section 35, Para. 4, the public prosecutors shall no longer order examination regarding the need for health-related measures in cases of exclusively personal use of cannabis, mushrooms or psychotropic substances.
- » Section 35, Para. 8, rules that the clause on copayment in the case of settlement by diversion as regulated in Section 388 of the Code of Criminal Procedure (StPO; BGBl 1975/631 v. 29. 7. 2011) shall also apply to settlement by diversion according to Section 35 of the SMG.

- » Any suspension of sentence on grounds of undergoing health-related measures shall only be possible after consulting the public prosecutors on the case (Section 39, Para. 1). As in the case of Section 35, Para. 3, a separate medical office that is to be established may be consulted to deliver an opinion on the need for, and advisability of, treatment.
- » If a federal authority is obliged to take over the cost of treatment, instead of a contribution to treatment costs a lump sum may be paid, calculated on the basis of Section 381 of the Code of Criminal Procedure (Section 41, Para. 2).
- » Prisons and prison authorities are entitled to procure, process and possess narcotic substances, provided that these substances are needed for medical treatment under the applicable laws (SMG Section 6, Para. 4b).

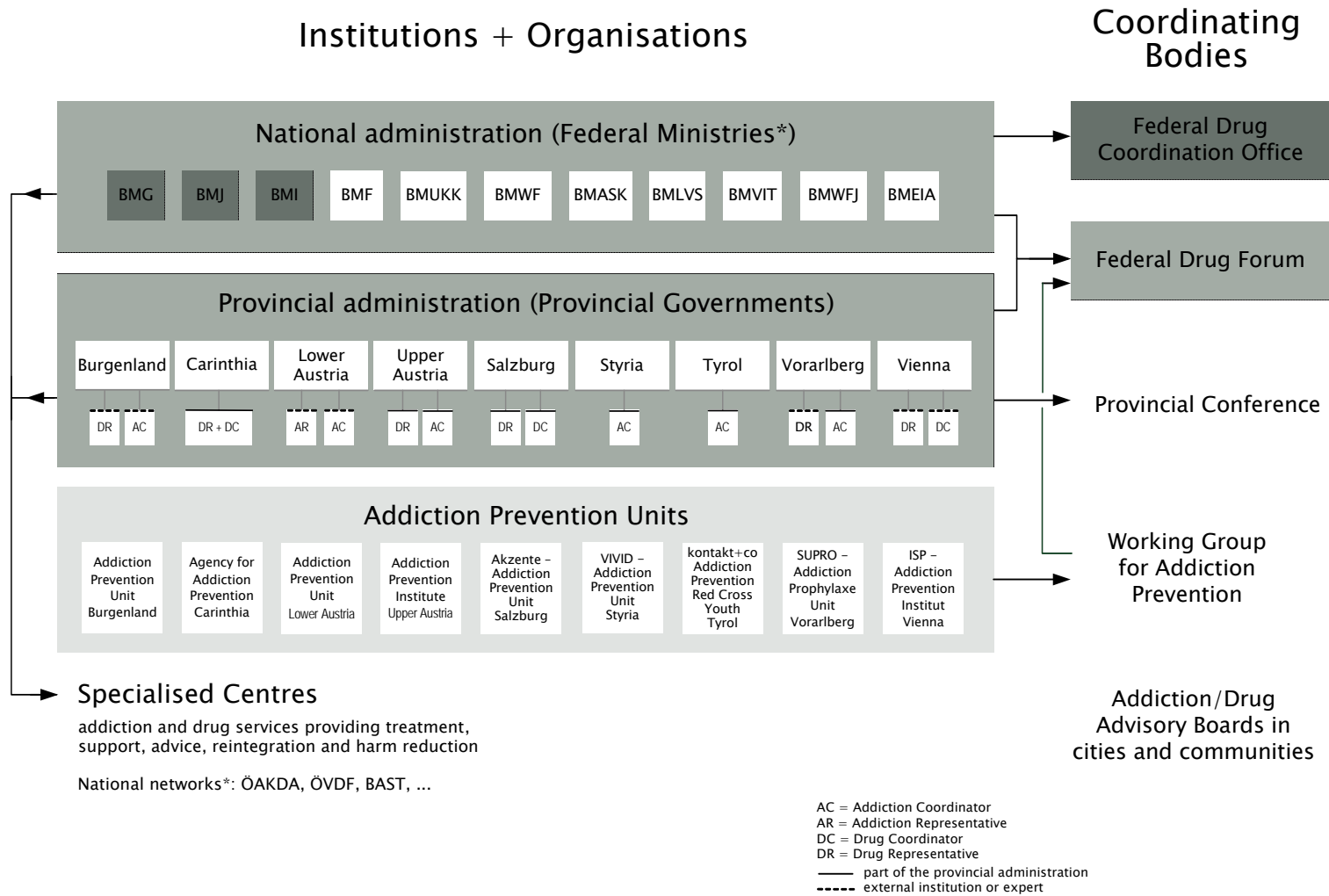
After an amendment to the Oral Substitution Further Training Decree adopted in June 2011 (BGBl II 2011/179 v. 15. 6. 2011), the lists of doctors entitled to carry out opioid substitution treatment (OST), which are maintained by the district administration authorities, are available on a web application provided by the Federal Ministry of Health. Access is granted to professionals involved in OST matters, who may thus get an overview of all qualified OST doctors in Austria.

The reporting period also saw an amendment to the Psychotropic Substances Decree (BGBl II 2011/202 v. 28. 6. 2011), which eases trade in buffer solutions containing barbiturates, which are used in medical and chemical laboratories.

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 2010, April 2011). The themes on the agenda included the permanent establishment of the Substitution Treatment Committee as regulated under Section 23k of the Narcotic Drugs Decree, implications for alternatives to punishment resulting from the amended Act Accompanying the Budget (see Chapter 1.1), autopsies in the case of drug-related deaths as well as plans to adopt new regulations (see Chapter 1.1). The working group on federal funding of drug treatment centres (see GÖG/ÖBIG 2010a) continued its activities, while other working groups were phased out after the completion of the manual on uniform implementation of Section 12 of the SMG (see GÖG/ÖBIG 2008c) and the position paper on harm reduction (see GÖG/ÖBIG 2010a), respectively.

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



* see List of Abbreviations

A national addiction strategy as planned in the Government Policy Statement 2008–13 (see GÖG/ÖBIG 2009b) is being prepared in the context of a Delphi study funded by the Federal Ministry of Health. The study is based on an expanded definition of prevention and takes into account both drug use as well as forms of addiction not related to substances.

The implementation of the Government Policy Statement also included the introduction of a means-tested minimum income scheme on the basis of an agreement between the Federal and Provincial Governments according to Section 15a of the Federal Constitutional Act (BGBl 2010/96 v. 7. 7. 2010). The benefits of the minimum income scheme (primarily a guaranteed minimum income, provision of a health insurance e-card, support of reintegration in the labour market) are granted to people who have no appropriate means of their own. The income scheme aims at combating poverty and introducing uniform minimum social welfare standards all over Austria as well as harmonised provincial regulations. The new type of minimum income is also granted to addicted people and is an important means of support for them (see Chapter 8.1).

Several provinces (Styria, Tyrol and Upper Austria) are modifying their **drug and addiction policy programmes**. Carinthia's Addiction Plan will continue to be in force also from 2012 to 2016; it focuses on harm reduction measures, improving occupational rehabilitation, and preventing the abuse of narcotic substances as well as psychological disorders in children living in families with addiction problems (Prehslauer, personal communication). Other measures aim at improving knowledge on addiction among the population and encouraging people to use addiction-related health care services. Media campaigns have been launched, and a free support hotline is available; funding is made available for establishing health and social care centres delivering addiction services, and services targeting relatives of addiction patients will be expanded.

In December 2010 Lower Austria adopted its new Addiction Plan 2011–15, which is based on four pillars: prevention, advice and treatment, social integration as well as quality assurance and documentation. It consists of a position paper which lays down the general approach to and guidelines for the issue of addiction, as well as a set of measures whose individual modules will be revised every five years (Fachstelle für Suchtprävention NÖ 2010). The general approach is based on a comprehensive concept of addiction which addresses both the personality of the individual in question as well as their social environment, and is oriented towards the Ottawa Charter of the WHO. Therefore the Addiction Plan of Lower Austria is not restricted to illicit substances or addiction characterised by drug use but also includes behavioural addiction that is not substance-related. The Plan underlines the role of health promotion and defines the goals of raising people's quality of life and improving the ways of addressing people in diverse situations in life and facing diverse problems. Specific priorities have been set for the years from 2011 to 2015 (see Chapters 3, 5 and 8). The field of

quality assurance and documentation is a new one and will mostly complement and optimise the existing documentation system, so that in future more flexible interpretation routines will be possible, which will also serve as a basis for regular addiction reporting.

Salzburg started to evaluate its Drug Policy Paper of 1999 and the Prevention Framework strategy of 2001, and to reassess the measures included in the two papers (Drogenkoordination des Landes Salzburg 2011). Special working groups were convened for this purpose.

The reporting period did not see any **new developments in drug policy** regarding new forms of services.

1.3 Economic analysis

The financial regulations in the field of drugs did not see changes in the reporting period. For more detailed information on financing of drug-related treatment please consult the report of last year (see GÖG/ÖBIG 2010a). Regarding budgets, no conclusive statements may be derived as most budgets do not specify drug-related items. For 2011, cuts in welfare budgets by up to 30% are said to be expected. These cuts will be handled differently in the individual provinces but will be relevant for prevention and addiction services in any case. However, no detailed information is available at present.

For information on expenditure for health-related measures by court authorities please consult the explanatory notes to the Act Accompanying the Budget of 2011 (see Chapter 9.3).

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 (see ST1). 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 come from the ESPAD surveys (2003 to 2007; see ST2). In Vienna, the time series of surveys concerning drug use go back to the year 1993 (see ST1). 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.

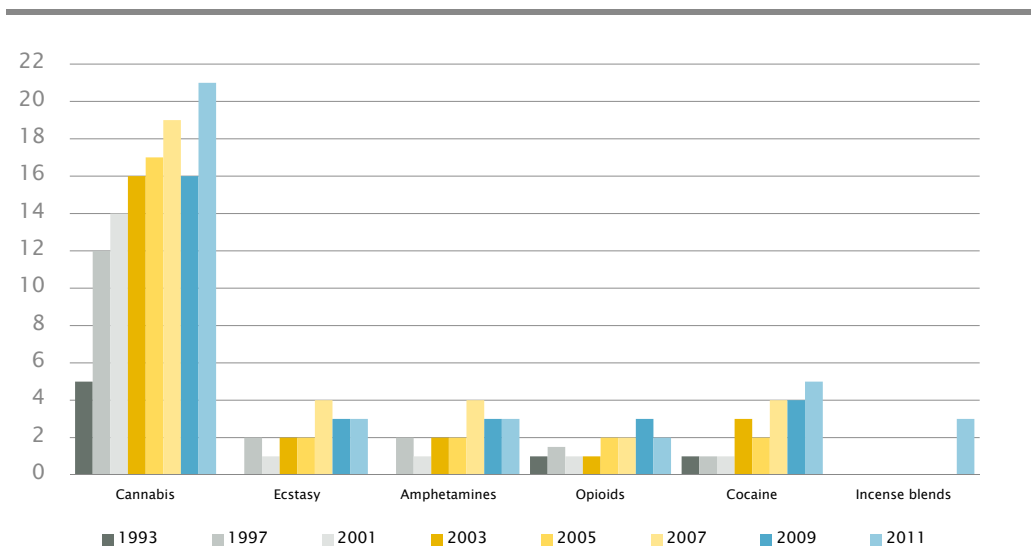
As to prevalence of drug use, a distinction is made between lifetime prevalence (drug use at some point in life), 12-months prevalence (drug use in the past year) and 30-day prevalence (drug use in the past month). Statements on current drug use can only be derived from 12-month or 30-day prevalence 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 among approximately 1% and a maximum of 2% (see Tables A1 and A2). 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. In most cases, use of illicit substances is limited to a short period in life, however. Regarding use of research chemicals and legal highs in the general population, few data are available, which, however, indicate insignificant prevalence levels, in contrast to the great interest in this theme as reflected by media coverage.

2.1 Drug use in the general population

In the reporting period drug use in the general population was studied in the 2011 drug monitoring survey of Vienna³ (IFES 2011) and the 2009 drug monitoring report of Upper Austria⁴ (Seyer et al. 2010).

Figure 2.1:
Lifetime experience of illicit drug use among the population of Vienna from 1993 to 2011 (percentages)



The original text describing drug categories was: cannabis = cannabis products such as hashish, marihuana, etc.; amphetamines = amphetamine, speed; opioids = opiates, e.g., opium, morphine, heroin, methadone, etc; incense blends = herbal smoking blends such as das Spice, Lava Red, etc.

Note: If no column is shown for a certain year, the corresponding drug was not surveyed in that year.

Source: IFES 2011; representation by GÖG/ÖBIG

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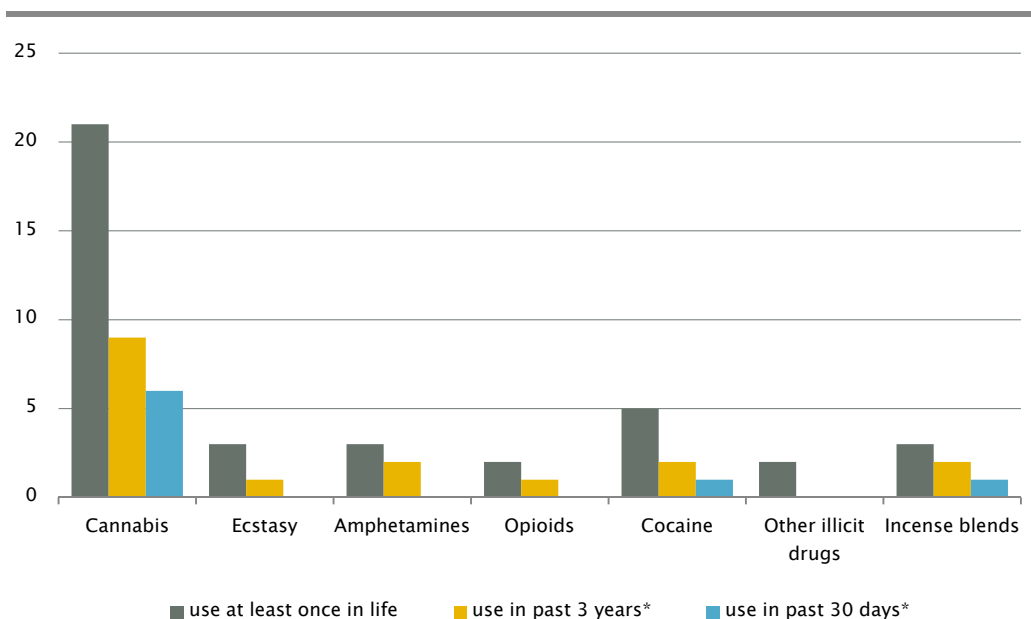
The 2011 drug monitoring survey of Vienna was conducted in March and April 2011 among a representative sample of 600 people (stratified multistage clustered random sampling from recent address data collected by the Institute for Empirical Social Studies). The respondents were interviewed in person at their homes. Surveys on experience of drug use have been carried out with similar methodologies every two years since 1993, on behalf of the Addiction and Drug Coordination Office of Vienna.

4

Every three years, the Institute of Addiction Prevention of Linz, Upper Austria, conducts a drug and addiction survey among a representative sample of respondents in the province of Upper Austria. The latest survey took place in May 2009, for which a total of 1 547 people aged 15 or older were interviewed in person by an interviewer of a similar age. The respondents were selected by means of quota sampling according to age and gender.

Valid statements on trends can only be given for cannabis: here, a rise in lifetime prevalence has shown in the long run. The same applies to cocaine, albeit at a considerably lower level (see Figure 2.1). Only a very small number of respondents in Vienna indicate experience of herbal smoking blends such as Spice, which was a much-discussed issue in the media (see GÖG/ÖBIG 2009b), and only two people (0.3%) said they had used the research chemical mephedrone.

Figure 2.2:
Lifetime prevalence and prevalence of use in the past 3 years and 30 days, respectively, among the population of Vienna in 2011 (percentages)



The original text describing drug categories was: cannabis = cannabis products such as hashish, marihuana, etc.; amphetamines = amphetamine, speed; opioids = opiates such as opium, morphine, heroin, methadone, etc; incense blends = herbal smoking blends such as Spice, Lava Red, etc.

Note: *Prevalence rates of less than 1% are not represented.

Source: IFES 2011; representation by GÖG/ÖBIG

Remarkably, different to the nationwide survey of 2008 (Uhl et al. 2009, see GÖG/ÖBIG 2010a), the lifetime prevalence rates of cannabis are similar across all age groups: between 21% and 25%, with the exception of people older than 60, who indicated use of cannabis at least once in life less often (14%). A share of 26% of men and only 15% of women said they had experience of cannabis. For other drugs, the prevalence rates indicated are so small that conclusions regarding differences according to age group or gender cannot be stated with any certainty. It is almost exclusively men who indicate experience of ecstasy, herbal smoking blends or amphetamines. Cocaine is also indicated considerably more often by men than by women.

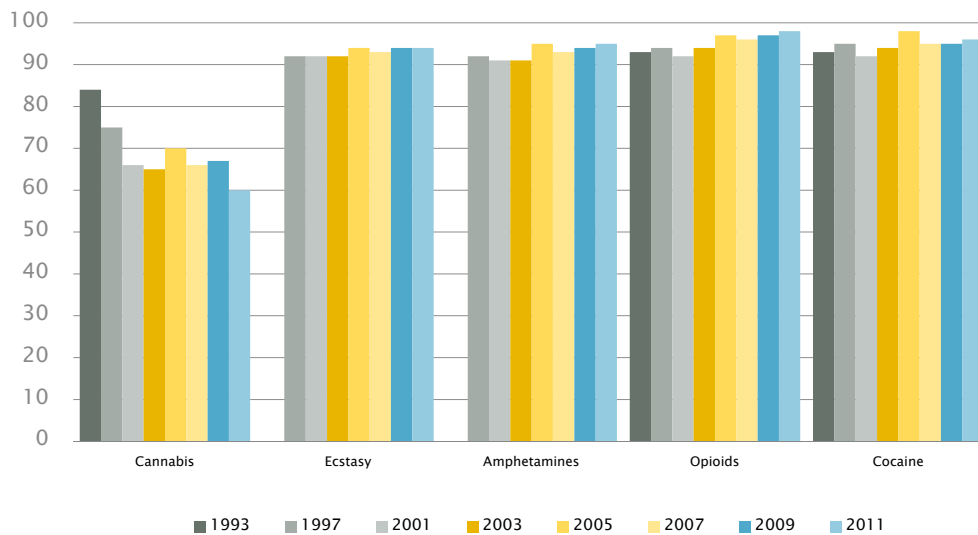
Figure 2.2 illustrates that in most cases, use of illicit drugs (different to alcohol and nicotine) is limited to certain stages in life.

The results of the drug monitoring survey conducted in Vienna confirm the hypothesis that the decline in prevalence rates found in the latest nationwide survey on drug use especially with regard to cannabis (lifetime prevalence rate in the population survey of 2004: 20%, compared to 12% in 2008; see GÖG/ÖBIG 2009b) is but a methodological artefact. This problem was extensively discussed by national and international experts at a national REITOX Academy on drug-related population surveys which took place in autumn 2010, during which also measures aimed at improving the reliability of such surveys were developed.

The prevalence rates given in the 2009 drug monitoring survey of Upper Austria roughly correspond to those of the drug monitoring survey conducted in Vienna, e.g., lifetime prevalence rates of cannabis of 20% among respondents between 15 and 59 and 3.5% in the case of ecstasy (see Table A1). In 2006 the lifetime prevalence rate of cannabis still was as high as 27.6%, and that of ecstasy, 7.3% (Seyer et al. 2007). The difference between the data of 2006 and 2009 cannot be explained by a decline in drug use and is likely to result from specific details in the surveying process.

The drug monitoring system of Vienna also permits a survey of changes in risk awareness and assessment of the danger of illicit drugs. It shows that, different to other illicit drugs, the share of people who regard cannabis as dangerous has declined in the course of time (see Figure 2.3).

Figure 2.3:
Perceived risks of drug effects among the population of Vienna from 1993 to 2011
(percentages)



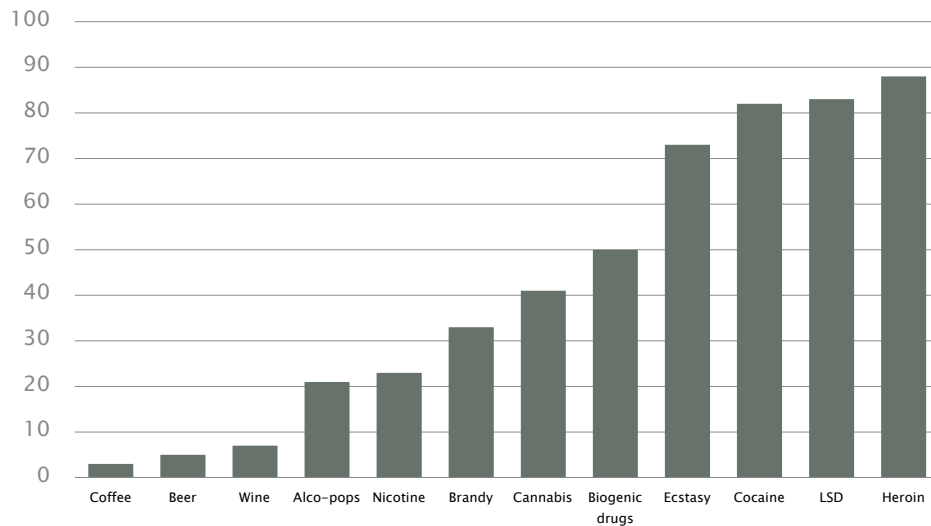
The original text describing drug categories was: cannabis = cannabis products such as hashish, marihuana, etc.; amphetamines = amphetamine, speed; opioids = opiates such as opium, morphine, heroin, methadone. The survey question was: What to you think of the effects of the following drugs - are they dangerous or not so dangerous?

Note: If a substance is not represented by a column, the question on dangerous effects was not asked in the corresponding year.

Source: IFES 2011; representation by GÖG/ÖBIG

It is not possible on the basis of the data obtained in Vienna to compare views on the danger of illicit drugs v. legal drugs, as the survey does not include legal substances. However, the drug monitoring survey of Upper Austria revealed that the respondents regarded legal psychoactive substances as considerably less dangerous than illicit drugs.

Figure 2.4:
Perceived risks of psychoactive substances among the population of Upper Austria in 2009 (percentages)



The original text describing drug categories was: brandy = brandy (fruit brandy, whisky, vodka, cognac, etc.); cannabis = cannabis drugs (hashish, marihuana); biogenic drugs = biogenic drugs (e.g., magic mushrooms, Angel's Trumpets, Jimsonweed).

Source: Seyer et al. 2010; representation by GÖG/ÖBIG

2.2 Drug use in the school and youth populations

In the reporting period, the report on a 2009 survey on addiction patterns of behaviour among young people in Lower Austria was published (Bittner et al. 2010)⁵. The Flash Eurobarometer series *Youth attitudes on drugs* (European Commission 2011a)⁶ also includes a number of data on drug use by young people in Austria.

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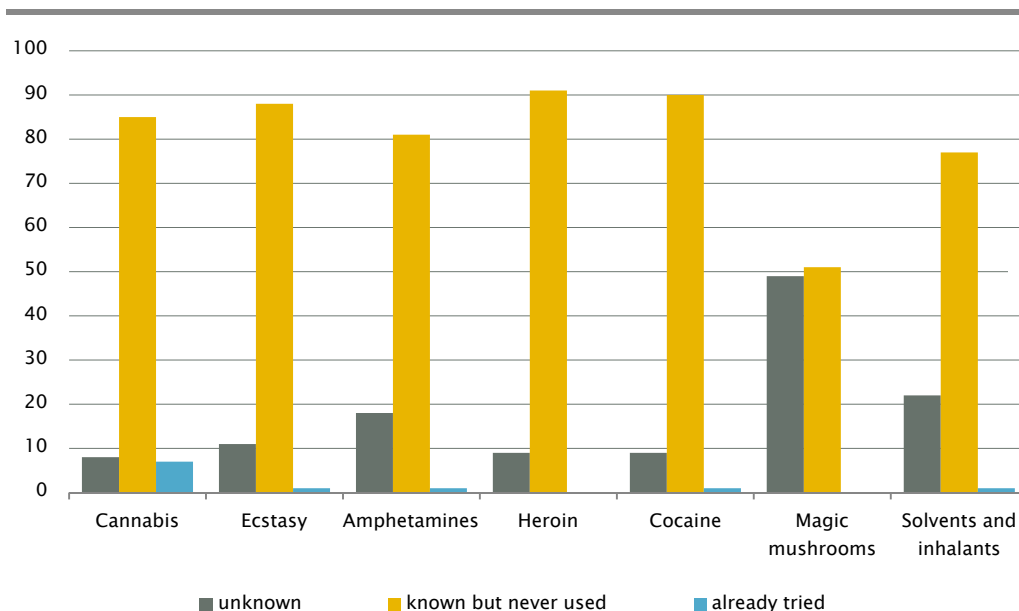
The survey on patterns of addiction behaviour among young people in Lower Austria was carried out by the *market* research institute in July and August 2009. A total of 722 young people aged between 13 and 18 were selected by means of quota sampling according to age group, gender and region, taking into account also their status of occupation/education as well as background of immigration. The respondents were interviewed face to face. The questionnaire had been drawn up by a working group in collaboration with the Centre for Social Affairs and Generations as well as the Lower Austria Unit for the Prevention of Addiction, Coordination and Advice.

6

The Flash Eurobarometer series was carried out from 9 to 13 May 2011 as a telephone survey among more than 12 000 randomly selected young people aged 15 to 24 across the EU. In Austria, 501 people were interviewed.

Figure 2.5:

Drug awareness and prevalence of drug use (lifetime prevalence) among young people in Lower Austria aged from 13 to 18, 2009 (percentages)



The original text describing drug categories was: cannabis = cannabis/marihuana/hashish/weed; amphetamines = uppers/amphetamines/speed.

Source: Bittner et al. 2010; representation by GÖG/ÖBIG

In Lower Austria, it was surveyed which illicit drugs the respondents had already heard of and if they had used these drugs at least once in the past. The lifetime prevalence rate of cannabis use was 6.8%, and 1% or less in the case of all other drugs (see Figure 2.5). If the prevalence rates of cannabis use are compared to those indicated in the ESPAD survey of 2007 (see GÖG/ÖBIG 2010a), a considerable discrepancy shows: among students of years 9 and 10 in eastern Austria (except Vienna) the lifetime prevalence rate of cannabis was 18%, one-year prevalence was 14% and the one-month prevalence was 6%. The differences in prevalence rates in the surveys conducted in Austria are likely to result from methodological differences in the study design (see Tables A1 and A2 as well as Chapter 2.1) and make it very difficult to obtain a realistic view of the actual situation.

The Flash Eurobarometer gives a lifetime prevalence rate of 18% for cannabis use among respondents between 15 and 24 in Austria; 8% indicated cannabis use in the past year and 2% in the past 30 days. A total of almost 4% said they had already used new legal substances that imitate the effects of illicit drugs.

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, whose results have not yet been published, however.

Research chemicals were found in 19% of the drug samples analysed by *ChEck iT!*, which permits the conclusion that such substances, apart from amphetamines and ecstasy, have played an increasingly important role in the party scene (VWS 2011d; see Chapter 10.3).

3 Prevention

Following the EMCDDA classification of prevention, this chapter has been divided into universal prevention, selective prevention and indicated prevention⁷. However, in practice the terms of primary and secondary prevention⁸ continue to be used to some extent. 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 substance-related. Interventions that specifically focus on use of legal substances have become increasingly important (e.g., programmes for smokers), as well as programmes addressing non-substance-related behavioural addiction (e.g., 7-step-plan for the prevention of gambling drawn up by ARGE Suchtvorbeugung, a working group for the prevention of addiction). This approach is also reflected in the new Addiction Plan 2011–15 of Lower Austria, which takes into account the real-life situation typical of young people as shown in the relevant studies and surveys (see Chapter 2.2). However, the focus of this report is 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

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Universal prevention is aimed at large groups of the population (e.g., school communities, towns) that, independent of their 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).

8

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.

advanced (see Tables A30 to A33 in Annex A). Current prevention measures taken are 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 promotion⁹. 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 older age groups, a frequent goal of interventions is to encourage drug users to face, and reflect on, their patterns of use.

The area of universal prevention often overlaps with interventions to prevent violence and with health promotion approaches. Therefore, in recent years these areas have often tended to be combined. For instance, Salzburg's KIS contact point for prevention activities in schools is in charge not only of addiction and health promotion matters but also of prevention of violence (Drogenkoordination des Landes Salzburg 2011). At federal level, the Ministry of Education (BMUKK) presently also focuses on the issue of

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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.

prevention of violence: the *Weisse Feder* anti-violence and fairness initiative¹⁰ includes activities that aim at enhancing social skills of students and generally improving the atmosphere at school, which in turn will also help prevent addiction.

Lower Austria's new Addiction Plan 2011–15 (see Chapter 1.2) includes an expansion of interventions carried out in cooperation with schools to promote life skills among children and young people. These interventions have been defined as high-priority matters (Fachstelle für Suchtprävention NÖ 2010).

2010 saw an evaluation of the *Clever & Cool* programme of the Addiction Prevention Institute of Upper Austria¹¹ (Hauer 2010, Hauer 2011). The results show that this approach met with much acceptance and was regarded as helpful. In the view of the teachers, the programme also had positive effects on students. A total of 93% said it had a favourable influence on the atmosphere at school, and the programme was an opportunity to communicate relevant knowhow. It also turned out that the phenomenon of bullying had been underrated. The evaluation showed great differences depending on module, in particular with regard to modules that required a great deal of reflection. *Clever & Cool* is implemented in cooperation with the Provincial Police of Upper Austria, among other organisations. In March 2011, an official cooperation agreement was concluded with the Provincial Police in order to ensure an effective long-term cooperation¹².

There are several sources indicating that the risk of developing patterns of addiction behaviour is elevated for children in lower secondary schools and polytechnic schools compared to students attending upper secondary school. As a consequence, more programmes specifically targeting these young people have been initiated. In addition, there is demand for services that respond to specific demands of individual schools. In Upper Austria, 20 participants completed the first training course for vocational school teachers to become addiction coordinators (GÖG/ÖBIG 2009b). The coordinators will be in charge of managing prevention activities at their schools and liaise between the

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<http://www.gemeinsam-gegen-gewalt.at/> (28 June 2011); website in German

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The evaluation was carried out in the school year 2009/10 by means of a questionnaire survey after each of the 11 modules and after the project had been completed. After the first half and at the end of the project, respectively, the teachers and trainers had an opportunity to communicate their experience (again by means of a questionnaire). In sum, data of 766 students in 33 classes, 72 trainers and 36 teachers were available.

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<http://praevention.at/news/index.php/action.view/entity.detail/key.814/nav.6/view.29/level.2/archiv.true/> (28 June 2011); website in German

vocational schools and specialised prevention centres in the respective region (Institut Suchtprävention 2011).

The prevention activities targeting **kindergartens** and **families** have been continued. They include further training programmes, provision of information material and parent meetings. An increasing number of interventions are oriented towards parenting skills. This is also regarded as an important area in Lower Austria's Addiction Plan 2011–15.

In the reporting period the three-year project *Familienbande* [Family Ties] (GÖG/ÖBIG 2009b) run in Salzburg was evaluated¹³. The evaluation has shown that the main goals of the project have been met (Kral et al. 2011). *Rettet Fantasia* [Save Fantasia], a subproject of *Familienbande* focusing on experiential education and the children's social skills, was combined with a parent meeting. The experience the students had made had been documented in an illustrated report, which helped motivate also those parents who did not often attend school-related events. The parent tables also proved to be a good way of addressing new participants and communities, but the success of such events turned out to depend on the person of the facilitator to a great degree. Facilitators who come from the same community as the participants are more likely to achieve good results than others. Long-term orientation is also important as it takes time to spread information by word of mouth and to find good facilitators and hosts. The themes covered are of great relevance as well: e.g., the issue of addiction turned out to be an interesting subject for parents with a background of immigration, while ethnic Austrians or Germans could better be motivated by the theme of puberty. The course programme *Hilfe, mein Kind pubertiert* [Help, my child is going through puberty] was attended primarily by those parents who are generally interested in educational programmes. The gender-specific low-budget weekend programme for fathers and sons also met with great interest. The project not only helped improve the participants' knowledge about drugs, prevention and protection, but they also grew more confident in interactions with children and young people, or found motivation to change their patterns of acting and reacting. While the project showed very promising results, further potential was detected with regard to addressing parents with a background of immigration (see Chapter 3.2) and organising further events for fathers and children (Rögl, personal communication).

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The evaluation was based on a questionnaire completed by parents taking part in the programme, personal interviews with the facilitators of the parent tables and the teachers who took part in the *Rettet Fantasia* [Save Fantasia] subproject. All parent tables and parent meetings taking place in October 2010 were taken into account for the evaluation. A total of 243 questionnaires were completed at parent meetings and 195 at parent tables. In January 2011 a 1.5-day workshop was held in order to carry out a cost-utility analysis. This workshop was attended by 37 participants in the project.

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, reflection and guidance for action on the part of trainers and other key persons at work and in residence halls for trainees. There are also interventions that aim at preventing the development of addiction among at-risk adults, and at finding adequate responses for such situations at work. Here the problem of drinking is predominant. Activities in this field also play an important role in the new Addiction Plan 2011–15 of Lower Austria.

In Vienna an expert meeting was held in November 2010 in order to promote prevention programmes for workplace settings. The discussion focused on addiction affecting daily work and finding problem-solving strategies for employers (SDW 2011a). The project *SUParb* focused on preventing addiction and early detection approaches in labour market contexts. Education and training institutions may apply for a certificate issued by the Vienna Institute of Addiction Prevention (ISP) that entitles them to organise further training courses following a specially designed curriculum. In such courses trainers working in programmes organised by the Public Employment Service acquire knowhow on addiction that helps them identify addiction diseases in their clients and encourages them to turn to centres specialising in addiction services. The Dialog association obtained a certificate early in 2011 and has since organised the corresponding training courses.

The campaign *I schau auf mi UND di* [Taking care of me and you] also deserves mention in this context. It is run by the Health Insurance Fund of Salzburg and the Chamber of Labour of Salzburg and aims at raising the awareness of mental health and psychological problems among young people in the workplace (APA 2010). The campaign responds to the fact that a large number of young people have been found to use psychopharmaceuticals. Prevention activities focusing on psychological health such as improving the atmosphere at work also have positive effects on the prevention of addiction. The *Akzente* prevention unit of Salzburg, for lack of funds, was unable to start further prevention activities in this field in the reporting period (Rögl, personal communication).

In the field of **youth work outside school settings**, no new activities have been reported.

Prevention at community level, apart from awareness raising among the general public, also includes developing and implementing activities oriented towards the specific situation of the region in question. Prevention programmes should be initiated from within the community whenever possible and should be adapted to its special needs.

The Addiction Prevention Institute of Upper Austria modified the CTC programme (see GÖG/ÖBIG 2010a) for Upper Austria. Experience has shown that programmes and

strategies that are transferred to another country generally have to be adapted to meet local demands and might even fail if the circumstances differ too much from those in the country of origin. In the case of CTC, a survey among students was to be carried out before the start of certain community prevention programmes. However, it showed that it was not sensible to carry out the survey, for both structural reasons (differences in school systems and school locations) and types of questions and themes covered (the questionnaire was oriented towards school routines typical of the U.S.) (Krenmayr, personal communication). However, other parts of the CTC programme were very helpful for planning future prevention activities. Still, at present, preference is given to approaches planned according to a guideline drawn up specifically for community prevention programmes,¹⁴ which takes into account the specific local situation and focuses on advice and process-orientation (see GÖG/ÖBIG 2009b). The cooperation with the European CTC network will be continued, however, in order to advance the prevention programmes of Upper Austria: the reporting period saw the start, under the heading of *Wir setzen Zeichen* [We're making a point], of community prevention programmes in six additional towns of Upper Austria (Institut Suchtprävention 2010). The general objective of these programmes is to prevent addiction and harmful patterns of behaviour or substance misuse that poses health hazards.

In Styria, a number of community-oriented prevention programmes were phased out (Ederer, personal communication). It has again shown how important the work of committed individuals is for the sustainability of a project. In towns where such persons could be counted on, a number of activities were continued even after the conclusion of the official project (e.g., *Brucker Modell*, *Check an Angel* and *Friday Sports Night* at Bruck/Mur).

Other activities in the reporting period included intensified public relations work in order to raise the awareness of prevention among the general public (Stiftung Maria Ebene 2011) and the expansion to other provinces of the *Peer Drive Clean* EU Project, which was started in 2008 as a pilot project in Upper Austria (GÖG/ÖBIG 2009b) and has meanwhile been evaluated.

Approximately one year ago, Carinthia, following the model of Lower Austria, started to organise information events for the Federal Army in order to address conscripts (Drobesch-Binter, personal communication). A quiz is held, which provides an opportunity to discuss the participants' answers. The quiz has met with great interest on the part of the conscripts. This approach also makes it easier for young men with problems to accept advice and treatment services.

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See <http://www.praevention.at/seiten/index.php/nav.481/view.496/level.4/> (29 June 2011); website in German

Upper Austria drew up curricula for university and master training programmes on prevention of addiction and violence (GÖG/ÖBIG 2008c), which have meanwhile been started (Institut Suchtprävention 2011). The first certification course was run as a pilot study followed by an evaluation¹⁵. The assessment of both the quality of teachers and the subjects taught was very favourable. However, people who had already gathered knowhow on this theme before were less satisfied than people without previous experience. The results of the evaluation formed the basis for the university and master study programmes that followed the certification course and started in May 2011.

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). In January 2011 the *kontakt+co* Addiction Prevention Unit of Tyrol and staff of the Public Employment Service analysed the general situation of their work and clients and found out that approximately 6% of **young people taking part in specialised programmes of the Public Employment Service (AMS)** showed problem patterns of use of legal drugs (mainly alcohol) and illicit substances (mainly cannabis) (Kern, personal communication) and consequently have problems either in the programmes in which they are participating or regarding job placement. However, only 1% of the young people concerned get addiction-related support or treatment. In order to help AMS staff and trainers to respond to such issues, specific guidelines were prepared and training in motivational interviewing was organised. The guidelines also explain which general attitude should be taken when working with young drug users and how to get the message across to them. If rules are violated this will have consequences, which are in line with the mandate of the AMS to prevent the young people from leaving the AMS programme. In the case of problems the parents of the youth concerned are informed by way of a standardised formal procedure.

For programmes targeting **children in families with addiction problems** please consult Chapter 12.

15

For this purpose a longitudinal study with an interactive questionnaire was carried out, which also included participant observation and the corresponding reports. See also <http://www.emcdda.europa.eu/best-practice/examples> (29 June 2011).

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 party scenes are relevant settings. According to the new Addiction Plan 2011–15 of Lower Austria, more programmes will be started to help young people develop risk competence.

The status of immigrant may generally involve an elevated risk of developing patterns of addiction behaviour. 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 due to specific social factors, and who cannot adequately be addressed in the context of universal prevention.

In autumn 2010 *ARGE Suchtvorbeugung* (Working Group for Addiction Prevention) held its annual meeting at Altlenzbach, Lower Austria. The issue of immigration and prevention was a major topic on the agenda: the discussion covered both the theoretical background of immigration and specific experience of practitioners, illustrated by model projects. It has provided an important basis for developing services for specific target groups with a background of immigration in the next few years. One of the model projects presented was *Gesundheit kommt nach Hause* [Health coming home]¹⁶ of the association *beratungsgruppe.at*. The project specifically addresses mothers with a background of immigration and is implemented in Vienna and Lower Austria. The goal is helping the mothers in question acquire knowhow on a broad range of health-related themes, communicated by qualified health tutors. As the subsequent evaluation¹⁷ has shown, this approach has been very effective with regard to addressing educationally and socially disadvantaged mothers who, or whose families, have immigrated from Turkey (Reiter 2011). It has turned out to be essential for the success of the project that the participants trust the health tutors, who should come from their community, that the trainers of the tutors have adequate knowhow and that the tutors receive support and instruction at the implementation stage. Another important factor was training material specifically prepared for the project, appropriate general conditions and in particular an approach based on respect. Frankl (personal communication) pointed out that the project also had very positive effects on the health tutors them-

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<http://www.gekona.at/index.php?SID=57> (5 Aug.2011); website in German

17

The evaluation included a focus group of three health tutors, interviews with the project managers as well as participant observation of a training unit. In addition, after each training module the 113 participants provided feedback. Weekly reflexion manuals and self-assessment questionnaires of the eight health tutors were also available.

selves as they became more self-confident and started to explore their own potential for development.

A similar approach is found in Salzburg's project *Familienbande* [Family ties] (see Chapter 3.1): in the reporting period several parent tables for ethnic Turk mothers were organised (Rögl, personal communication). The Addiction Prevention Institute of Upper Austria, in its community project *Wir setzen Zeichen* [We're making a point] run in Wels, has also pursued this approach. The *MammaMia* pilot project targeting mothers with a background of immigration¹⁸ has been implemented since February 2011. 12 specially trained facilitators organise rounds of discussion for groups of at least six mothers which are held in their mother tongues. At least four discussion meetings are planned, which, at the first project stage, focus on empowering children. The facilitators get a small payment for their work and receive a final certificate. The merits of this approach began to show shortly after the start of the programme. Gathering knowhow, acquiring social and communication skills and taking part in an exchange in new networks were factors that helped the mothers build self-confidence in everyday life. This in turn has enabled them to use their knowledge and skills in their social environment.

Vienna reports that new approaches to communication and cooperation are needed for implementing the events planned in the context of SUPMIG (see GÖG/ÖBIG 2010a), which address representatives of the Turkish-speaking community (Verein Dialog 2011). Even though a few training programmes were held by multipliers such as imams and Muslim Religious Education teachers it showed that further steps are needed in order to meet the project goal. Therefore further activities in this direction will be continued.

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. Activities aimed at early detection and early intervention, i.e., steps taken before signs of addiction show in a drug user, are defined as part of indicated preven-

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<http://www.praevention.at/seiten/index.php/nav.18/view.549/level.3/> (28 June 2011); website in German

tion. No new interventions were started in the reporting period. Vorarlberg reports an increasing number of young people and their parents or others in their social environment who have required the crisis intervention services (advice and coaching) that are provided in the context of the programme *Choice* (GÖG/ÖBIG 2010a; Stiftung Maria Ebene 2011).

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 campaigns in the context of public relations for individual, mostly community-oriented, projects, or awareness-raising campaigns on legal substances: for instance, in spring 2011 the *echt cool* [cool indeed] information campaign of the Federal Ministry of Health¹⁹ was started. In this context information material on smoking and alcohol was made available to primary and secondary schools.

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http://bmg.gv.at/home/Presse/Presseunterlagen/Kampagnen/_echt_cool_Informationsoffensive_an_Volksschulen_gegen_Alkohol_und_Zigaretten (25 March 2011); text 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'²⁰. 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 and 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 nationwide documentation system of clients of Austrian drug services (DOKLI) 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 2010). 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 the centres for compulsory treatment, however (see GÖG/ÖBIG 2011a).

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 and ST8). 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 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

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

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 poly-drug use with opioids. The latest estimates covering the year 2009 have been discussed in detail in our report of last year (GÖG/ÖBIG 2010a). Because of data quality issues (ghost case problems²¹) only a fairly large interval of 25 000 to 37 000 of people showing patterns of PDU with opiates can be indicated. The data consolidation activities carried out in the context of the project *eSuchtmittel*²² have shown that the share of ghost cases in the substitution registry is likely to be somewhat smaller than previously assumed (see Chapter 5.4). Taking this factor into account, a figure in the upper section of the interval from 25 000 to 37 000 seems to be plausible as a prevalence estimate.

If the prevalence estimates of 2009²³ 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).

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

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In the context of the project *eSuchtmittel*/[eDrugs] the substitution registry of the Ministry of Health will be transferred to an online database, and several relevant measures to assure data quality are taken.

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The following figures refer to the year 2009 (most recent prevalence estimate available). One may safely assume, however, that these figures have not changed considerably in the past two years.

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 2010): 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 problem drug users 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).

In Vienna an increase in abuse of benzodiazepines among people undergoing substitution treatment has been registered in recent years. Two main types of benzodiazepines are (ab)used most often: flunitrazepam and oxazepam (Springer et al. 2008; see Chapters 5.1 and 6.2).

The *Kontaktladen* low-threshold centre in Graz reports considerable changes in patterns of use among part of its clients, i.e., towards mephedrone, which could legally be bought until August 2010 (see GÖG/ÖBIG 2010a; see Chapters 9.1 and 10). Injecting use of mephedrone, often to excessive degrees, continued also after this substance was classified as an illicit drug. Mephedrone has massive physical and psychological side-effects, which may lead to serious problems: phlebitis, general physical decline, depression, sleeping disorders and a massive craving for drugs (Caritas, Diözese Graz-Seckau, 2011; see also Chapter 7.2.). Meanwhile the mephedrone boom seems to have declined, however (Ederer, personal communication; Zeder, personal communication). It cannot yet be said if long-term patterns of mephedrone PDU will develop. At present, no prevalence and incidence estimates can be given. Apart from the above information concerning Graz, mephedrone use has also been registered in the province of Vorarlberg (Neubacher, personal communication).

4.2 Data on PDU from non-treatment sources

Salzburg and Carinthia provided data on patterns of use by people examined according to Section 12 of the SMG²⁴ (Drogenkoordination des Landes Salzburg 2011; Drogen-

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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.

koordination des Landes Kärnten 2011a). As in previous years, the drug users examined in Salzburg had primarily taken cannabis (90% out of 546 people examined). Between 8% and 15% of examinations were related to use of cocaine, ecstasy, speed and opioids, and 2% of persons examined had taken hallucinogenic drugs. 69% of examinations was carried out because of use of a single substance, 21% resulted from use of two substances and 9% from use of three or more substances. In Carinthia, a total of 837 examinations by public health officers were carried out in 2010, and in 457 patients drug problems were diagnosed. Again, the majority of patients (70%) had used cannabis as their primary drug (opioids: 21%; alcohol: 5%, other drugs: less than 3%).

In the context of the SDDCARE project (see GÖG/ÖBIG 2010a, see Chapter 8.2) the patterns of use of older drug users were studied in both a secondary analysis of treatment data and qualitative interviews of clients. The authors report that generational effects have been found: users older than 35 tend to prefer opioids more often than younger drug users. Among the oldest age group (drug users over 50) other (in part also legal) substances predominate. The latter development is probably due to the fact that older users tend to show less conspicuous patterns of use. Particularly in the qualitative interviews, the respondents indicated manifold changes in patterns of use in the course of life, and the start of OST often initiates major changes (Eisenbach-Stangl and Spirig, 2010; Eisenbach-Stangl. et al., 2010).

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 or other forms of problem drug use is available.

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 advice and treatment centres are not oriented towards specific substances, and increasingly often also include services for users of legal substances and non-substance-related forms of addiction (e.g., gambling). However, there are also services, particularly in inpatient settings, that distinguish between legal and illicit substances. 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, 5.2 and 5.3. For detailed descriptions of available services please consult the websites as well as the annual reports and newsletters of the individual centres, GÖG/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 entered. Vienna's BADO Basic Documentation of drug treatment and support centres is another important source of data.

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 the reporting period, Lower Austria adopted the new Addiction Plan 2011-15, and the Addiction Plan of Carinthia was extended to the period from 2012 to 2016 (see Chapter 1.2). The Addiction Plan of Lower Austria, in the chapter on treatment, includes the goal to create new services for children and young people and to provide a support network for relatives of addicted people all over the province (Fachstelle für Suchtprävention NÖ 2010). It is also intended to improve the OST services by established doctors for opioid users. Another goal, while not of top priority, is to modify the existing support and treatment services that address specific target groups. The Addiction Plan is based on a broad definition of addiction also with regard to advice and treatment (see Chapter 1.2) and includes the goal to provide services for people showing non-substance-related addictive patterns of behaviour.

Regarding new **decrees** adopted in the reporting period, the only change is a modification of the Further Training Decree (see Chapter 1.1): the list of doctors who are qualified for OST of opioid addicts is now available on a web application of the Federal Ministry of Health.

The endeavours to improve the **availability of substitution treatment** for patients addicted to opioids have been continued in the reporting period but the situation has not always developed as desired: there are regions where the number of established doctors entitled to provide OST has gone down further. For instance, in Lower Austria only 50 doctors deliver OST at present, compared to around 305 before the first Further Training Decree entered into force (Hörhan, personal communication). Map 5.1 shows that there are six provinces where at least one district does not have any doctor who is entitled to provide substitution treatment. As a result, many patients have no option but to seek treatment in another region. For instance, the Vienna-based Dialog

association has taken on a considerable share of clients from Lower Austria (Verein Dialog 2011). In Graz (Styria) the situation is extremely precarious: the fact that one established doctor was no longer available in 2010 led to a serious bottleneck in substitution treatment (Ederer, personal communication). At present, patients are referred to the addiction clinic of the Sigmund Freud Provincial Neurological Hospital (LSF) for diagnosing and further treatment. In future, an interdisciplinary contact point will take over these tasks. In addition to diagnosing and further treatment, it will also perform case management functions and provide low-threshold access to OST. The current situation is regarded as inadequate also with regard to (further) training. Training in addiction care services is only provided at the addiction clinic of LSF.

One way to improve the situation is **remuneration agreements** between the medical associations and the provincial health insurance funds (see GÖG/ÖBIG 2010a). In 2010, as a result of discussions in the working group on substitution, it was possible to conclude an agreement on financing OST in the drug support centres at St. Johann/Pongau and Zell/See in the province of Salzburg: the Provincial Health Insurance Fund of Salzburg will pay a lump sum per quarter for every client treated in the above centres (Drogenkoordination des Landes Salzburg 2011). The general condition for provision of OST in these centres were adapted accordingly (right to issue prescriptions, hiring of additional social workers), but so far, it has not been possible to hire a doctor providing OST. Lower Austria still has no regulations for remuneration of substitution treatment (Hörhan, personal communication).

Diversification of treatment options is another strategy that deserves mention here (see GÖG/ÖBIG 2010a): e.g., in Salzburg an agreement was made with the SUST Substitution Centre for Opiate Addicts. Now two forms of treatment are available depending on the patient's stability: comprehensive, multiprofessional care including daily dispensing of the substitution substance at the SUST centre, and a less intensive treatment option where individual appointments are scheduled for delivery of care and assistance services, with a long-term prescription issued by SUST (Drogenkoordination des Landes Salzburg 2011). In the latter case, clients may get their substitution medicine in a pharmacy.

In order to control the **abuse of substitution medicines** (see Chapter 9.1), the Addiction and Drug Coordination Office of Vienna (SDW) initiated a cooperation project with the police, the Public Health Services (MA 15) and the Social Welfare and Public Health Law Department (MA 40) of the City of Vienna as well as the Institute for Addiction Diagnostics (ISD). The project was tested around Karlsplatz square and as it showed good results, it was expanded early in 2011 to cover all of Vienna (SDW 2011a). The following procedure has been agreed upon: in the case of a report to the police because of suspected trafficking in substitution medicines, the MA 40 department is contacted immediately and will in turn immediately inform MA 15. If the person under suspicion is addicted to drugs, the next step is to inform the Institute for Addiction Diagnostics.

If the person under suspicion is in substitution treatment, the competent public health officer will contact the doctor who has issued the corresponding prescriptions, and the take-home regulations and regulations for administering the substitution medicine will then be restricted so that it is more difficult or impossible for the patient to set aside part of the medicine prescribed: the patient has to open the morphine capsule in the pharmacy, empty its contents in a glass of water and drink the solution on the spot. Supervised consumption is also required for other substitution substances that have been prescribed. Take-home medication on grounds of holidays is only available after thorough examination of the case. If it is suspected that extremely high doses of benzodiazepines have been described, parts of which were actually used for trafficking, this problem will also be discussed with the doctor providing treatment. Any measures taken in this context are documented by MA 15. If the person reported to the police is a drug user, they are referred to ISD for addiction diagnosing. The project will be analysed by the Addiction and Drug Coordination Office of Vienna by means of a standardised assessment.

In Vienna, the discussion started in 2008 on **abuse of benzodiazepines** by clients with opiate addiction undergoing maintenance treatment (see GÖG/ÖBIG 2009b) has been continued. This issue is also discussed by a Ministry of Health committee on substitution treatment of opioid users established in 2010. In addition, guidelines are being prepared that aim at stabilising, controlling and reducing the use of benzodiazepines and ensuring adequate treatment of any psychiatric diseases among this group of users. Regarding the current state of discussions and the resulting recommendations, the Addiction and Drug Coordination Office of Vienna (SDW 2011a) says that a number of reports and experience by practitioners point to a rise in benzodiazepine use both in general and among clients in OST, as well as prescriptions of high doses (see Chapter 4). In addition, there are indications of counterfeit prescriptions. Therefore the following recommendations are discussed:

- » Any dose of benzodiazepines prescribed in the context of treating multiple drug users should not be higher than the approved dose. If a higher dose is used, it should be reduced in the long run. If a dose higher than the approved therapeutic dose is prescribed (off-label prescription), the treating doctor is accountable and liable to a greater degree and is obliged to give reasons for the dose prescribed and has to document their course of action.
- » Any opioid and benzodiazepine or other psychotropic medicine should be prescribed by one doctor who has received training in addiction treatment. If a patient is treated by several doctors with different areas of specialisation, these doctors should inform each other on any medicines they have prescribed.
- » The treatment of polydrug users should follow a long-term treatment plan. Short-term prescriptions for people who obviously suffer from an addiction should only be issued on the basis of a precise indication and/or after consulting the doctor delivering OST.

- » If the prescription of benzodiazepines is covered by the patient's statutory health insurance, doctors must not issue a private-patient prescription.
- » As flunitrazepam may lead to dependence and because of its pharmacokinetics, as well as the resulting risk of overdoses in the context of PDU, it should not be prescribed. It is recommended to substitute flunitrazepam with the lowest possible maintenance dose of oxazepam, diazepam or clonazepam.
- » In the case of demand for greater doses of benzodiazepines, the patient should be examined by a psychiatrist and, if necessary, should receive treatment including prescription of psychopharmaceuticals instead of benzodiazepines.
- » Outpatient withdrawal from benzodiazepine treatment should be encouraged by means of appropriate training programmes.
- » For some clients a monthly dose of benzodiazepines may be defined and applied via the automatic approval system of the social insurance institutions (ABS). Approval is granted only once a month and documented in the ABS. During this period patients should obtain their daily dose in a pharmacy, similar to the procedure for provision of substitution medicines.

Confirming earlier findings, a recent study²⁵ on the expansion of the existing OST system (Meidlinger 2011) has shown that the majority of experts interviewed indicated need for a diversification of the existing services and advocated both injectable maintenance prescribing as well as prescription of diacetylmorphine. According to this study, the target group of this type of treatment includes injecting drug users and drug users who are unable to remain, or cannot be integrated, in the existing treatment system. This approach, apart from the will of policy makers, would require comprehensive and competent information activities in order to gain social acceptance of such services.

5.2 Treatment systems

Map 5.1 gives an overview of the distribution of doctors in Austria who, as at June 2011, are entitled to deliver OST to opioid users. It shows the share of doctors who are actually entitled to provide substitution treatment in the entire treatment potential (i.e., doctors who, because of their specialisation, would be qualified for delivering

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The study is based on 11 guided interviews with experts of various drug support and treatment centres in Vienna and Tyrol, followed by a qualitative content analysis according to Mayring.

OST²⁶). One has to bear in mind, however, that not all doctors who are qualified for providing OST actually accept new patients (e.g., this is stated in reports from Lower Austria). The present data situation does not permit conclusions as to the actual demand for substitution treatment either. However, the map provides information on the distribution of doctors who are entitled to both defining of initial doses and provision of continued treatment on the one hand and those who may only provide continued treatment on the other.

For an overview of centres specialising in addiction services (except centres exclusively oriented towards alcohol addiction) please consult Maps 5.2 and 5.3. 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. Drug addicts might also 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.

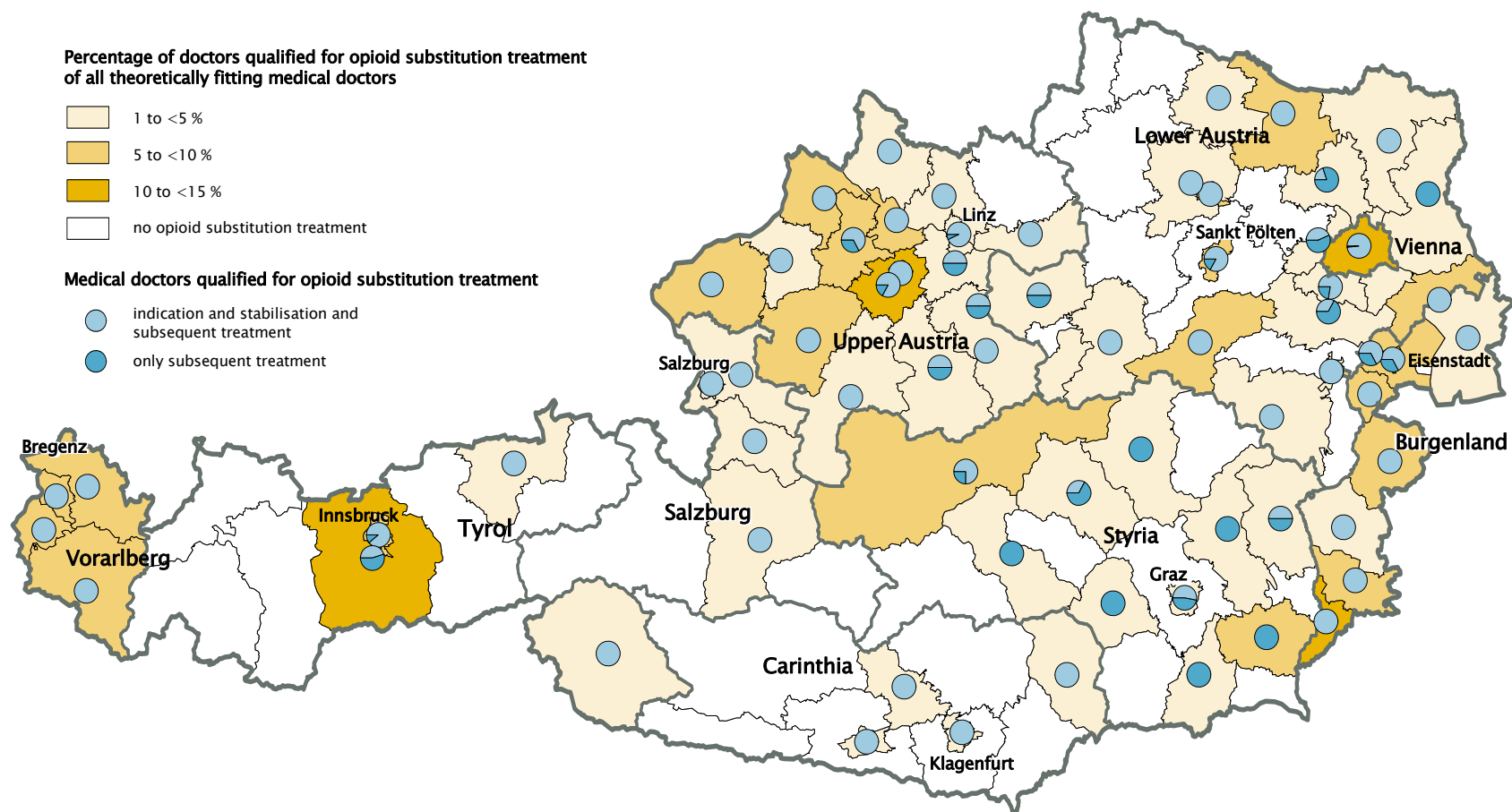
The **capacities** of drug services in Austria have continually been expanded but are still insufficient. This is reflected in waiting lists and in waiting times which, depending on treatment centre and type of treatment, may be up to several weeks or months, but great differences show between individual regions. For instance, in Vorarlberg waiting times of several months before admission to the Carina or Lukasfeld treatment centres have been reported, and the caseload of the three advice centres of Maria Ebene Foundation is very high as well, also regarding substitution treatment (Stiftung Maria Ebene 2011).

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The map includes all doctors who, according to the list of doctors of the Austrian Medical Association, are either general practitioners or psychiatrists, or doctors specialising in psychotherapy or child and youth psychiatry (additional specialisation: neuropaediatrics).

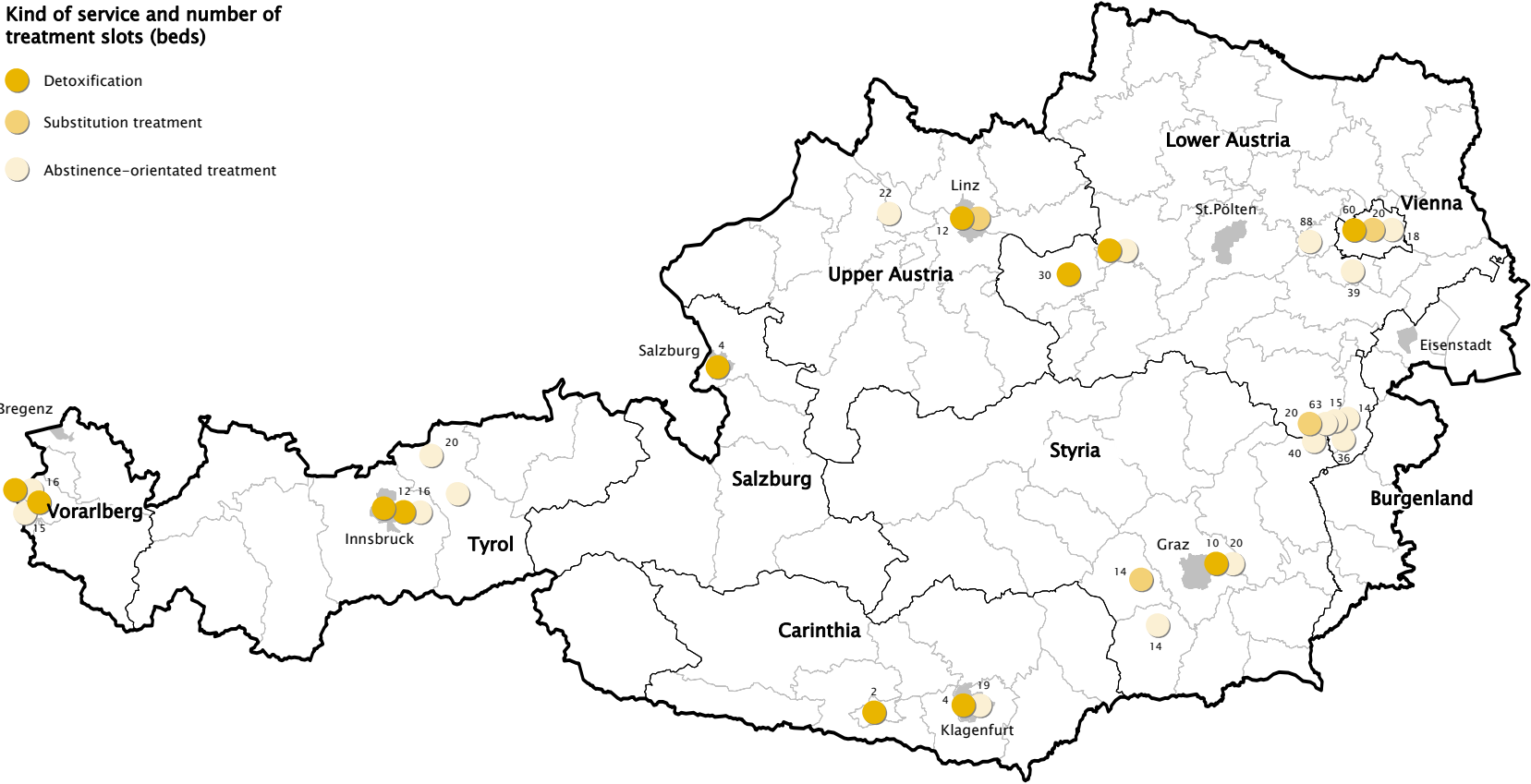
The data on established doctors are from 2010, and their main office address is given. The data on doctors entitled to OST have been taken from the list of OST doctors (LISA) maintained at the Ministry of Health.

Map 5.1: Distribution of doctors entitled to deliver oral opioid substitution treatment as at June 2011



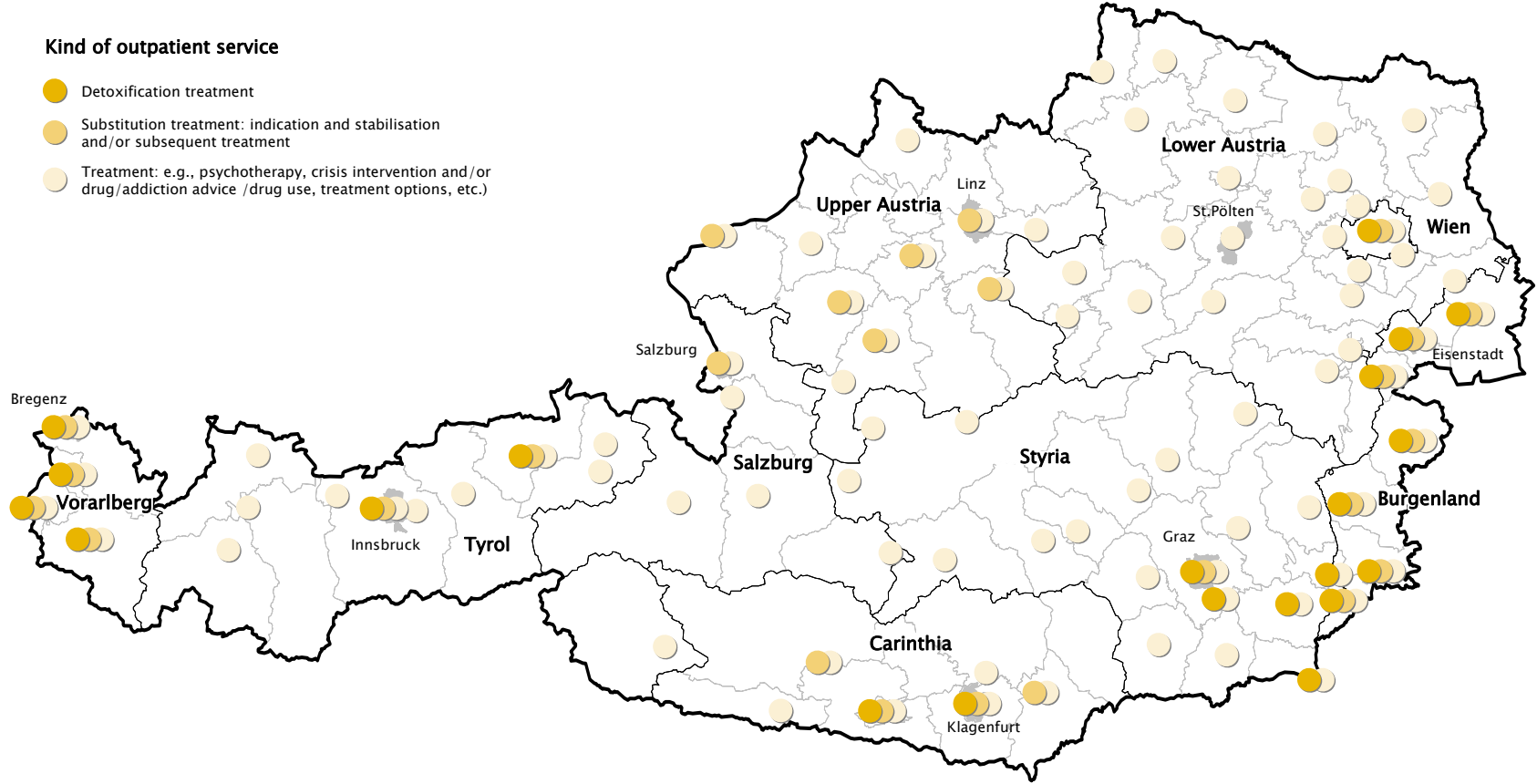
Source: BMG (LISA list) and list of doctors of the Austrian Medical Association; representation by GÖG/ÖBIG

Map 5.2: Specialised providers of inpatient treatment services for addiction patients in 2011



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

Map 5.3: Specialised outpatient advice, support and treatment services for addiction patients in 2011



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

According to the Dialog association each provider of support services had to refuse new clients temporarily in 2010 (Verein Dialog 2011). In order to improve the system of scheduling of contacts with clients, an instrument was developed that analyses the caseload in the current week and, based on available resources, calculates the number of new clients that may be admitted. Another consequence of the high caseload is that treatment plans are analysed in detail so that particularly stable clients may be referred to providers of less specialised services. In spite of tight resources, from 2009 to 2010 the number of relatives receiving support by Dialog rose by approximately 23%. In Salzburg, although the number of inpatient treatment slots had not been increased, waiting times for admission could be avoided (Drogenkoordination des Landes Salzburg 2011). This is attributed to the good cooperation between the University Hospital and the drug support centres, but in particular to the fact that withdrawal treatment is also provided by psychiatric hospitals in other provinces. This is possible only in cases where drug treatment has already been agreed upon and if the support centre in question has concluded a cooperation agreement with a psychiatric hospital.

Over the last few years Burgenland has been able to increase its resources so that now counselling by a medical specialist is available at least once a week in all advice and support centres of Community Mental Health Centres (PSD) of Burgenland (Miksch, personal communication). As of April 2010, all PSD centres have been accredited as centres in conformity with Section 15 of the SMG. In the province of Salzburg the support centres at St. Johann/Pongau and Tamsweg were able to slightly expand their services (Drogenkoordination des Landes Salzburg 2011). Since 2010 the centres of St. Johann/Pongau and Zell/See have also provided counselling by a doctor at certain times. In December 2010 a new Drug Advice Association of Tyrol was established (Kern, personal communication). Its activities focus on advice and support services for persons showing patterns of problem use of illicit drugs.

In spring 2001 construction works for a withdrawal department next to the Lukasfeld treatment centre in Vorarlberg were started (Neubacher, personal communication). May 2011 saw the opening of the building annex of the Carina treatment centre. The patients of the Carina centre had been employed as workers in the construction process (see GÖG/ÖBIG 2010a)²⁷ as acquiring manual work skills is part of Carina's treatment approach and encourages clients to think about new ways of leading their lives, and this activity has positive effects on the relationships between clients and therapists.

A number of centres have provided new services in order to address **new target groups** and have modified existing services in order to **meet the specific needs of their clients**.

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<http://www.mariaebene.at/admin/web/carina.php?textID=6821&katID=200> (20 May 2011); website in German

However, the centres have to find a balance between the provision of additional diversified and highly specialised services for different target groups on the one hand and what can realistically be achieved on the other (due to limited resources). This indeed poses a challenge as the diverse needs of different target groups have meanwhile been realised to a greater extent. For instance, in the reporting period, the target groups of older drug users and addiction patients of different ethnic origins have been in the focus of this discussion. For the latter group a new cooperation project was started between the Drug Advice Centre of the Province of Styria (Drogenberatung des Landes Steiermark (2011) and *Omega*, a transcultural centre focusing on mental and physical health and integration: cooperation structures with interpreters were established so that within short time mother-tongue support services can be made available to addicted people with a background of immigration. This pool of interpreters was created when the drug support centres registered a rising demand for drug advice and treatment delivered to clients with mother-tongues other than German.

Meanwhile, additional recommendations have been made regarding services for older drug users (see GÖG/ÖBIG 2009b and 2010a): appropriate support structures are needed for the provision of medical care, which ideally should be combined with psychosocial care (Eisenbach-Stangl and Spirig 2010). Particularly those clients who want to control and reduce their drug use need flexible treatment programmes oriented towards their individual needs. Plans in this area should also consider the need for service provision in rural regions and smaller towns. Another aspect one has to bear in mind is the different shares of men and women (3 out of 4 clients are men) while the gender-specific needs should by no means be ignored.

Young users of mephedrone constitute another new target group registered in 2010 by both low-threshold centres (see Chapter 7) and drug advice services. According to Dialog (2011), the services required in this context include not only medical and psychosocial care but also information on the effects and possible risks and hazards of individual substances. In addition, both outpatient and inpatient care is needed for a rising number of young people suffering from psychiatric disorders who turn to Dialog for support. *b.a.s.* (2011) of Styria reports that young people of this group had to be referred to medical treatment centres and that their parents and other relatives needed advice and information.

The reporting period saw the evaluation of specialised services for young people provided by *IS Gudrunstrasse*, an integrative addiction advice centre in Vienna. Initial results of the evaluation were presented at the conference of Dialog which took place in autumn 2010.²⁸ It showed that the young people concerned were facing stress and

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<http://www.30dialoge.at/dialog-der-generationen-fachtagung/> (2 March 2011); website in German

problems to such an extent that easy, quick access to low-threshold interventions was essential. However, the counsellors also need enough time to build rapport. For part of the young clients, finding ways to survive is the most pressing problem, which also includes substitution treatment. Follow-up settings are helpful in the context of these care interventions, and flexibility of services is a crucial aspect. Another group of young people do not yet show patterns of problem drug use but such problems exist in their social environment. It would be necessary to refer these clients to other centres providing services that are better oriented towards their specific needs, but this has sometimes been very difficult (Verein Dialog 2011). The *girrrls action* service was evaluated and as its positive outcome showed it has now been established as a regular service.

In spring 2011 *b.a.s.* (Styria) started its online advice service²⁹, after their staff received special training in online support provision, which is oriented towards professional criteria. Online advice may be obtained anonymously, which is regarded as a sensible complement to the existing services and makes it easier for addicted persons and their relatives to contact a drug support centre. The exchange by e-mail may already trigger a process of reflection, which is the first step towards problem-solving and may also encourage clients to come to the centre for a personal talk.

In Lower Austria, a strategy for services addressing relatives of people with addiction problems is under preparation in order to sharpen the focus of services provided and introduce quality standards in this area (Hörhan, personal communication). The role of support groups will also be strengthened.

In 2010 the focus of discussions at the Carina treatment centre was on early childhood trauma, and new diagnostic criteria were adopted in order to cover all aspects of complex traumatisation. According to the latest catamnestic study³⁰ carried out at Carina (Stiftung Maria Ebene 2010), in 2009 a share of 63% of patients had completed treatment and around one third had prematurely ended treatment or had been discharged. This share has been at similar levels for the past four years. The abstinence rate was 61% (illicit substances) and 39% (alcohol), respectively, based on information by those persons who were available after one year. Taking into account also clients who could not be contacted and assuming that they have relapsed, the abstinence

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http://www.suchtfraagen.at/default.asp?id=news_details&snr=60 (30 May 2011); website in German

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A total of 49 clients treated in 2009 were contacted by phone one year after the completion of therapy. The survey is based on a questionnaire of the German Society for Addiction Research and Addiction Treatment (DGSS) which is regularly updated. The questionnaire was either completed on the spot or sent by mail. The response rate was 53%, i.e., it was possible to contact and interview a total of 26 people.

rates are 33% (illicit drugs) and 29% (alcohol). An approximate share of 90% of clients took part in aftercare sessions and more than 90% said their quality of life had improved compared to the time before treatment. A share of 65% thought that the outcome of the treatment was good or very good, and 81% was satisfied or very satisfied with the treatment. One year after the completion of inpatient treatment, 35% of patients were undergoing substitution treatment.

The Lukasfeld treatment centre registered a rise in the average time of stay in 2010, again paralleled by an increase in the number of patients who did not complete the regular treatment programme (Stiftung Maria Ebene 2011). This is attributed to the fact that many clients are very young and to a rising trend of secret use by inpatients of substances that cannot be detected. In addition, those clients who undergo treatment as an alternative to punishment more often tend to abandon treatment because there are no immediate negative consequences in the form of court sanctions. Finally, the increasing share of patients who use opioids as their primary drug might also be a relevant aspect. A positive sign is that the majority of clients who have prematurely terminated treatment or have been discharged say that they would like to resume treatment at a later point in time.

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 events are organised, and on the other, measures are taken in the individual centres themselves, also regarding organisational structures. In Lower Austria, quality assurance and documentation have been included in the Addiction Plan 2011–15 as a new area of activity (see Chapter 1). The corresponding plans include the creation of an addiction database covering the entire province in order to permit analysis and documentation. The existing quality assurance measures were analysed and were found to be sufficient (Hörhan, personal communication). Further activities will include the creation of a standardised interface which, while ensuring data protection, will facilitate referrals of clients from one type of addiction-related centre to another.

In Carinthia a coordination team on outpatient drug services was established in which the heads of all outpatient centres are represented (Prehslauer, personal communication). The team will be in charge of coordinating the diversification of outpatient services and ensuring the continuity of support services provided by different centres as well as inpatient v. outpatient services.

In Vienna the list of services provided by inpatient treatment centres and the questionnaire on multidimensional diagnosing (see GÖG/ÖBIG 2010a) were evaluated and optimised in 2010 (SDW 2011a). In addition a multidimensional documentation system was drawn up, based on the list of services and multidimensional diagnosing (MD). The new system will replace the present BADO documentation. An important new element of the future system is that it documents individual services provided. It will also be

possible to represent the course of treatment over time, with pseudonymised clients. This will permit conclusions as to types of service delivered as well as effectiveness of treatment approaches and use of resources. It will also be possible to document individual services delivered, broken down by target group. In 2010 Vienna's pilot project of examination by the Institute for Addiction Diagnostics in order to get the required second opinion³¹ was established as a regular service and subsequently expanded: a second opinion is required whenever people want to undergo long-term treatment at the *Anton Proksch Institute (API)*, *Schweizer Haus Hadersdorf* or *Grüner Kreis* and apply for financial support by the Addiction and Drug Coordination Office of Vienna.

Again, many **events** took place in the reporting period to promote discussion and exchange among experts. It is not possible in the context of this report to describe all of them. In January 2011 API held a conference on the present state of transcultural substitution treatment as well as prospects for the future, to discuss transcultural influencing factors and their relevance for addiction services. Caritas Graz organised the second round of study meetings on complex addiction interventions, which took place in Graz in March 2011. The main theme of discussion was different aspects and models of integrated addiction services. The 14th Substitution Forum was held in Mondsee in April 2011, which focused on OST and comorbidity but also included discussions on the present state of substitution treatment³². In autumn 2011 Dialog, in the context of activities to celebrate its 30th anniversary (see GÖG/ÖBIG 2010a), organised an expert meeting³³ on dialogue across generations. The themes of discussion included experience regarding services delivered to young people and need for services targeting older drug users as well as addicted people with a background of immigration.

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A second opinion has to be obtained in order to verify and confirm the original indication before starting inpatient treatment subsidised by the Addiction and Drug Coordination Office of Vienna.

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<http://www.drogensubstitution.at/news/detail/artikel/substitutions-forum-mondsee-9-und-10-april-2011.htm> (1 August 2011); website in German

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<http://www.30dialoge.at/dialog-der-generationen-fachtagung/> (2 March 2011); blog in German

5.3 Characteristics of treated clients

The client year 2010 is the fifth year for which data of the DOKLI nationwide documentation system of clients of Austrian drug services are available ³⁴.

The drug treatment centres in Austria that are covered by the DOKLI system communicated data on a total of 3 802 people who had started **long-term outpatient treatment** in 2010. For 1 589 of them this was their first drug treatment in life. 1 469 patients started long-term **inpatient treatment**, and for 257 clients this was their first long-term drug treatment. In addition to these persons undergoing drug treatment in a traditional sense, DOKLI also registered 754 clients requiring **support by low-threshold centres** and 6 896 people receiving drug support and advisory services in the form of **short-term contacts**. Generally speaking, the data gathered for 2010 correspond to those of previous years.

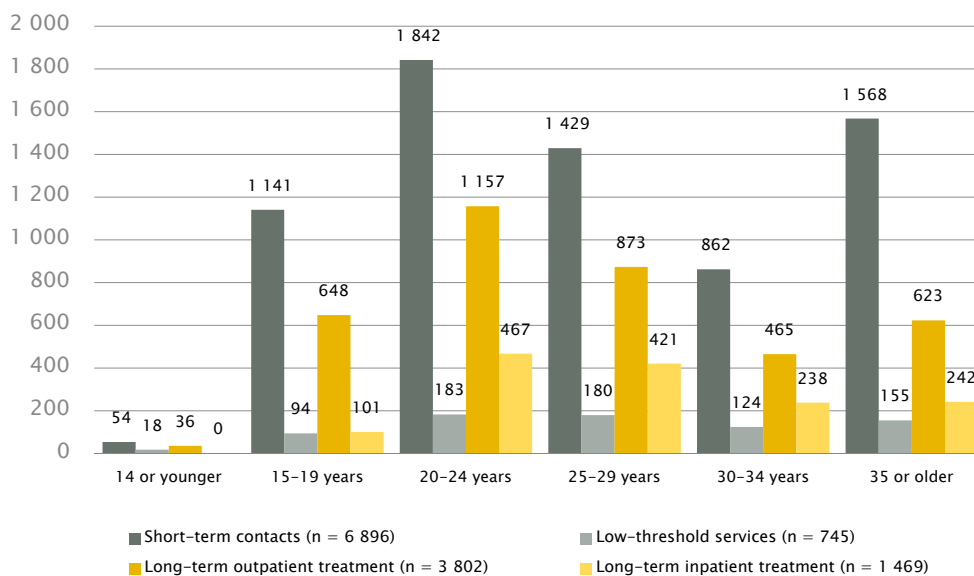
Approximately one out of five clients treated is younger than 20 – except in inpatient settings, where they account for 7% of patients. A share between 48% (low-threshold centres and short-term contacts) and 61% (long-term inpatient treatment) is between 20 and 29 years old (see Figure 5.1 and Table A23).

In all settings studied, the share of women clients was between 21% and 29%.

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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 2010 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 2009 16% of clients registered in BADO were provided services by more than one centre (two centres: 13%; more than two centres: 3%; see GÖG/ÖBIG 2011a, IFES 2010). 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-related treatment in 2010, by age and type of service



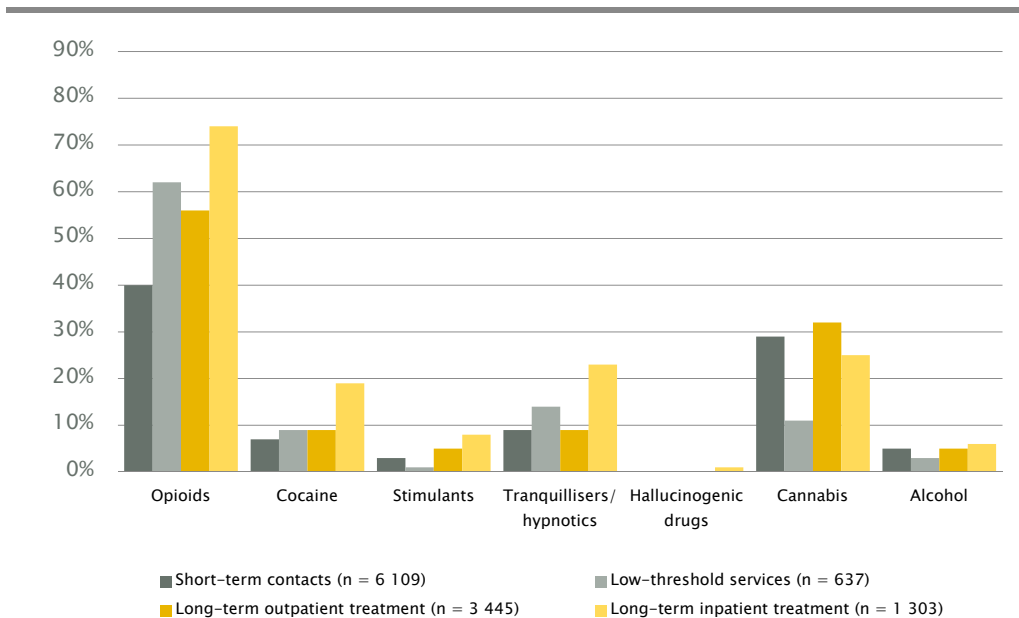
Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

In the traditional treatment settings (long-term outpatient and inpatient treatment) opiates predominate as primary drugs³⁵. Cocaine continues to play an insignificant role in this respect (see Figure 5.1 and Table A27). This underlines that in Austria, different to a number of other EU countries, opioids definitely predominate with regard to drug use that requires treatment (see, e.g., EMCDDA 2010). The share of cannabis indicated as respondents' primary drug is between 11% and 32%, depending on the setting surveyed. In part, this has to be qualified, however, as a very high percentage of people who use only cannabis are referred to compulsory treatment.

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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 problem drugs (secondary 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. Secondary 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 2011a).

Figure 5.2:
Primary drug(s) used by people starting drug-related treatment in 2010, by type of service (percentages)



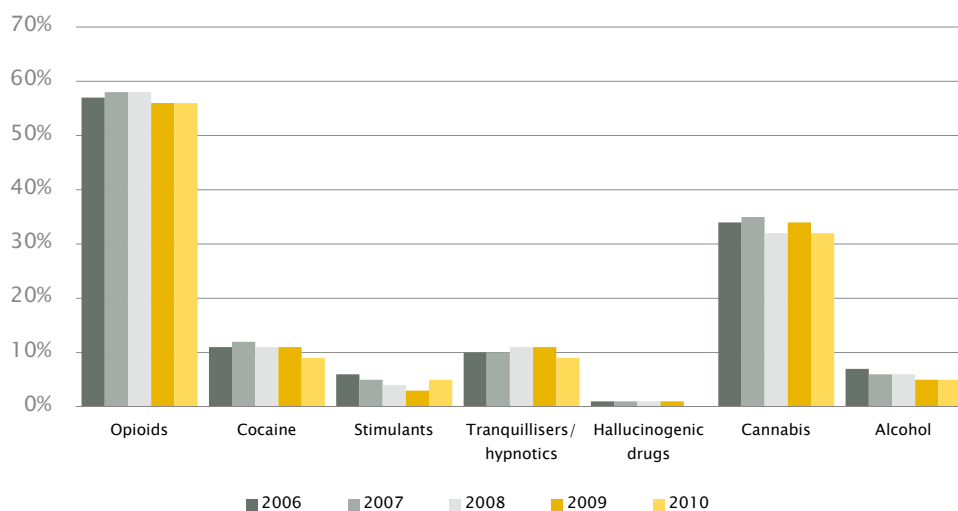
Note: Multiple answers were permitted.

Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

The patterns of use of DOKLI clients have hardly changed in the past five years (see Figure 5.2).

Further details regarding age of first use and preferred mode of administration can only be given for clients in long-term inpatient or outpatient treatment. The median of age of first use shows that a majority of clients begin to use drugs between 16 and 20. A younger age is only found for cannabis as well as solvents and inhalants (15 years) and alcohol (14 years). As in previous years, the age of first use has shown to be younger among women than among men regarding almost all types of drug (see Figure 5.3). For a detailed analysis of this fact and other gender-related differences please consult the focal issue of the DOKLI report of last year (GÖG/ÖBIG 2009a and GÖG/ÖBIG 2010a, respectively).

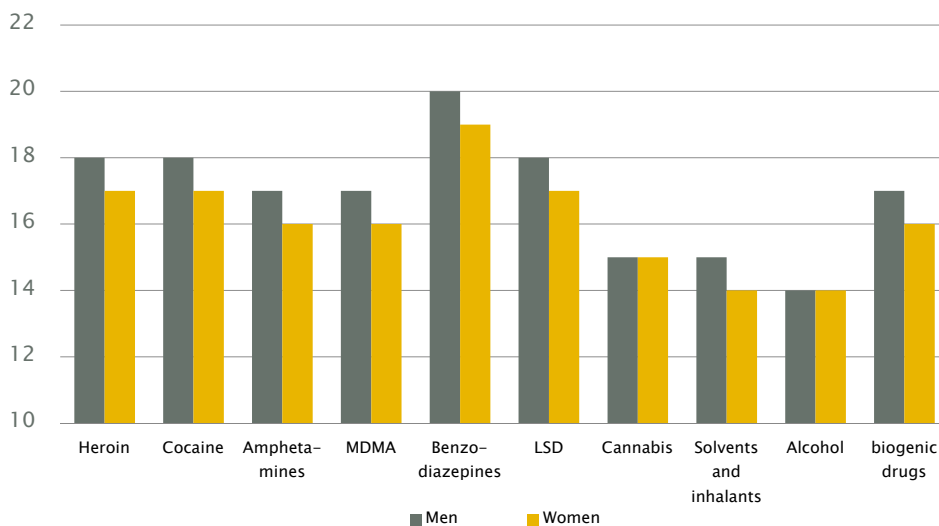
Figure 5.3:
Primary drug(s) of people entering drug-related long-term inpatient treatment, from 2006 to 2010 (percentages)



Note: Multiple answers were permitted.

Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

Figure 5.4:
Age of first use (median) of people entering long-term outpatient treatment in 2010, by substance and gender

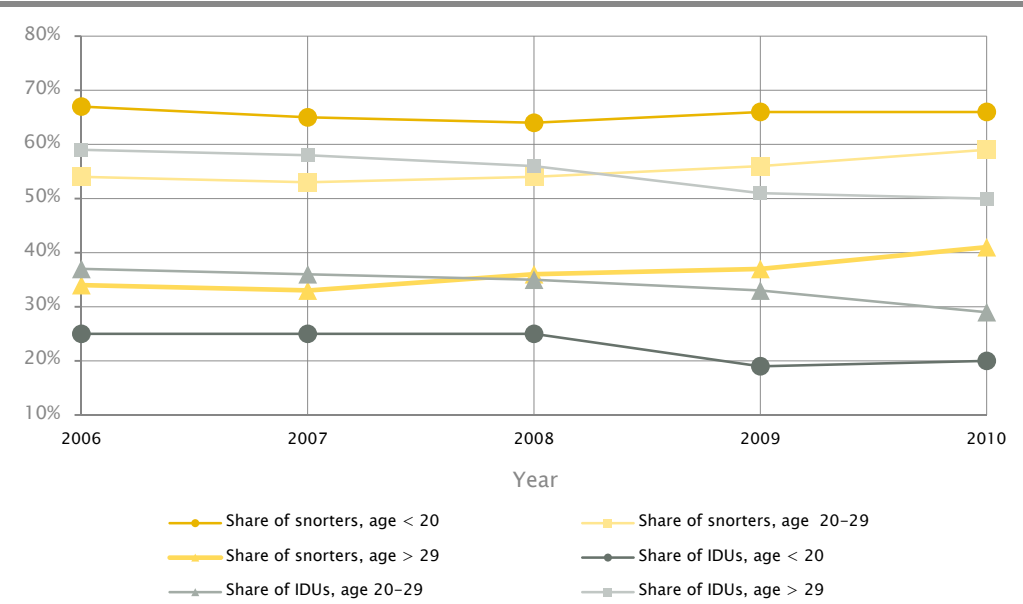


Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

Approximately half of all clients turning to inpatient or long-term outpatient treatment centres have already started OST at that point of time (substitution treatment entered in the course of care provision is not documented in this context). In low-threshold centres, the corresponding share is 76%. In all settings, the percentage of people in substitution treatment tends to rise with age of clients.

The DOKLI data of 2010 again confirm that snorting is a frequent way of administering heroin or opioids, which is most relevant with regard to harm reduction.

Figure 5.5:
Preferred form of use of heroin from 2006 to 2010 among people entering long-term outpatient treatment, by age group (percentages)



Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

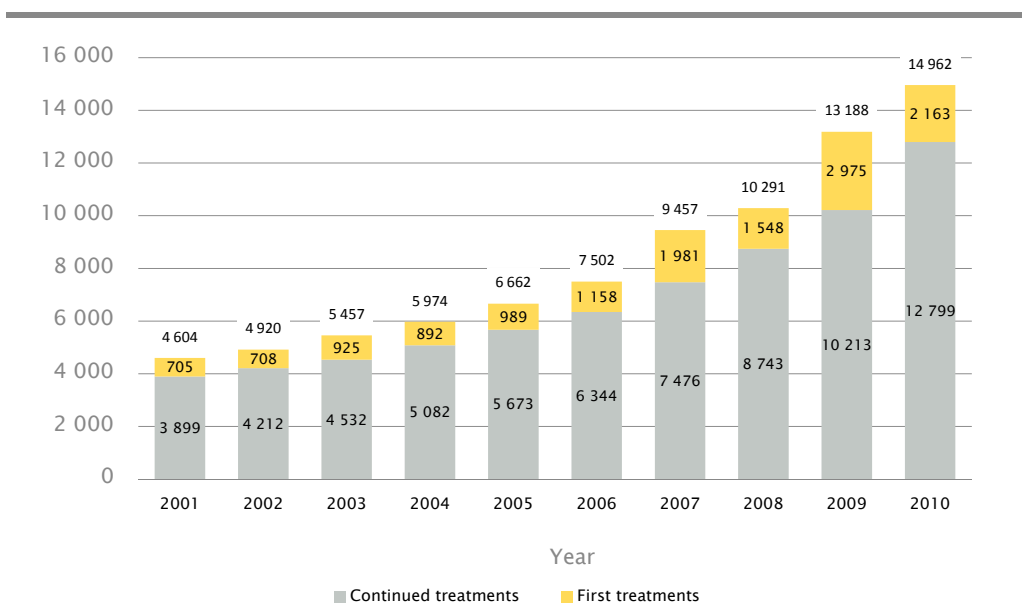
Persons undergoing long-term outpatient treatment most often name snorting (55%) as their preferred mode of administration of heroin, followed by injecting use (34%). In inpatient settings, the corresponding shares are 42% and 48%, respectively. The number of people who indicate injecting as their most frequent way of drug use is rising with age of clients (see Figure 5.5). This is an interesting result, which was analysed in more detail in the selected issue of the 2008 DOKLI report (GÖG/ÖBIG 2008a, or Busch and Eggerth 2010, respectively). 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.

Figure 5.5 illustrates that in the course of time the share of snorters has tended to go up among older age groups since the time when the DOKLI documentation routines were established. Apparently, a rising number of heroin users successfully stick to snorting for a considerable period before they switch to injecting use.

5.4 Trends of treated population and treatment provision

As DOKLI has been available since 2006 only, few statements on trends can be given (see Chapter 5.3). However, time series going back over many years exist for substitution treatment monitoring.

Figure 5.6:
Development of annual reports of the number of people currently undergoing OST by first treatment and continued treatment from 2001 to 2010



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 2010a) 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 treating doctors³⁶. Although these reports are not always complete and frequently not provided in due time (see ÖBIG 2003, GÖG/ÖBIG 2010c), they still give a general impression of both quantitative developments and characteristics of clients (see Figure 5.6).

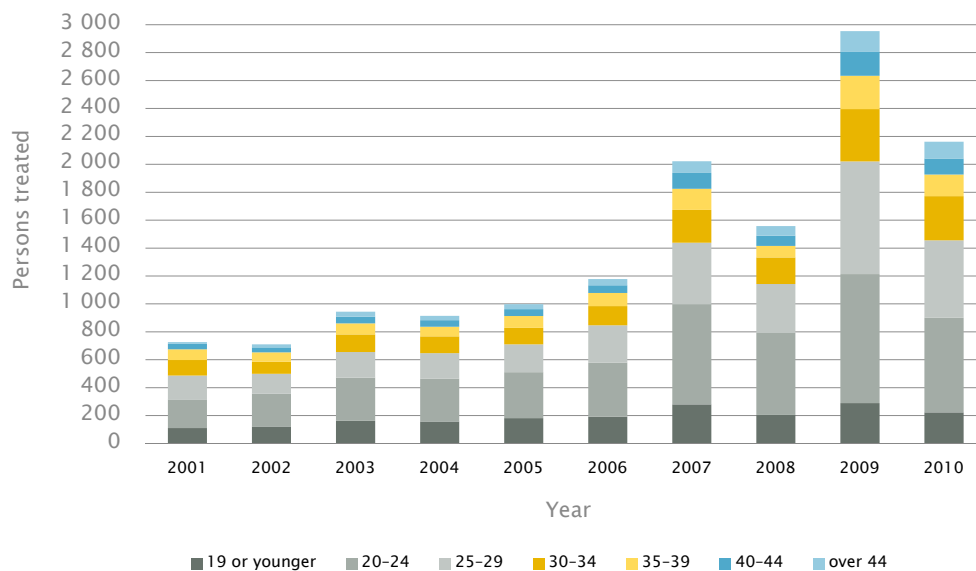
The problem of ghost cases (see Chapter 4.1). has been a significant deficit regarding data quality. In order to get this problem under control, the Ministry of Health started comprehensive correction routines in 2007, based on enquiries to treating doctors, and it may safely be assumed that the amendment to the Narcotic Drugs Decree (see GÖG/ÖBIG 2007b), which entered into force on 1 March 2007, has considerably improved reporting practices. These corrections and other modifications have resulted in a number of differences compared to the figures given in previous years. 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 (14 962) 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. As a result of the *eSuchtmittel* project, data acquisition for the substitution registry was transferred to online routines, and extensive measures for securing data quality were implemented. Consolidated data will probably be available in 2012 (covering the year 2011). In the context of the current data consolidation it has also shown that the share of ghost cases is slightly smaller than has previously been assumed.

Because of the methodological problems described above, it is not possible at present to provide ample epidemiological data. However, 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 detailed analysis of data by age and province would not make sense. A list of reported substitution treatments by province is given in Table A22.

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

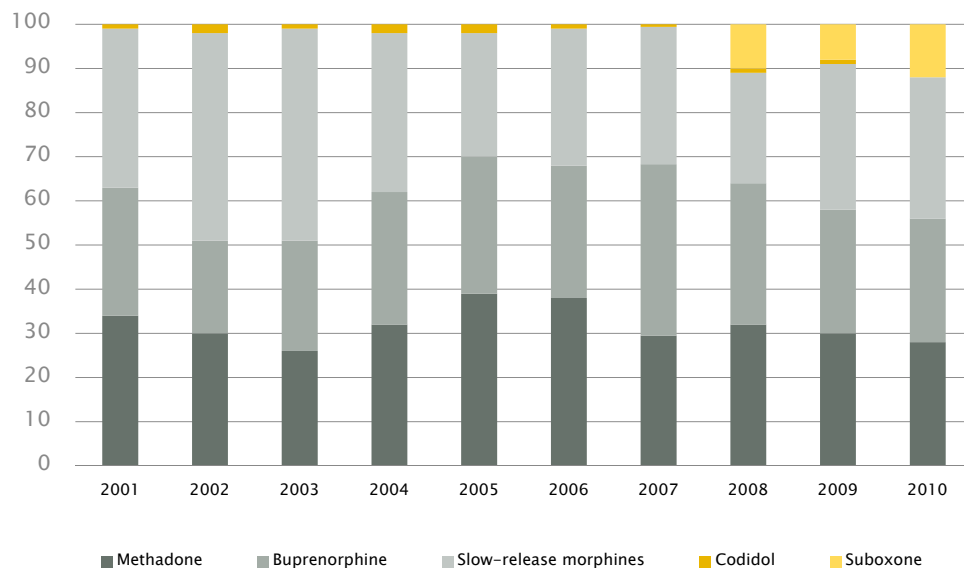
Figure 5.7:
First substitution treatment in life, by age from 2001 to 2010



Source: BMG; calculation and representation by GÖG/ÖBIG

Caution is also advised when analysing types of substance prescribed for first treatment because part of the treatments, due to the reasons mentioned above, might incorrectly have been entered as first treatments. Regarding substitution medicines prescribed, no relevant changes compared to the year before have been registered (see Figure 5.8). As in past years, an analysis of the DOKLI data shows 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 who started OST before turning to a drug support centre, slow-release morphine was prescribed most often (45% of long-term outpatient clients; 64% of clients receiving low-threshold or inpatient services, respectively), and the share of substitution patients who were administered methadone was between 16% and 30%, while buprenorphine was taken by only 3% to 20% of patients (GÖG/ÖBIG 2011a). Buprenorphine has increasingly often been prescribed to younger clients.

Figure 5.8:
Trends regarding substitution medicines used for first treatment from 2001 to 2010
(percentages)



Source: BMG; calculation and representation by GÖG/ÖBIG

Due to the aforementioned problems regarding data quality of the substitution registry no update has been made of the estimate presented in the 2009 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 two years.

6 Health Correlates and Consequences

Infectious diseases, particularly HIV and hepatitis, are of great relevance because of the risk of transmission due to injecting drug use.

A monitoring system (reporting obligation, surveillance) exists only for hepatitis C, but the corresponding data are not likely to be complete and thus are hardly conclusive (ÖBIG 2006). Data on vaccination rates regarding hepatitis A and B are given in the 2009 Health Report of Austria (GÖG/ÖBIG 2009c). The data sources mentioned do not permit analyses as to the specific group of injecting drug users, because data on this group are not gathered separately. While no surveillance system has been established for HIV infections, AIDS is a notifiable disease. The corresponding notifications (including the suspected way of transmission) are considered for the annual AIDS statistics of the Ministry of Health. Since highly active antiretroviral therapy (HAART) has become available, this form of statistics has lost its importance, however, as only few AIDS cases are reported (mostly end stage cases, cases of treatment failure or cases diagnosed at a late stage; Klein, personal communication). The Austrian HIV cohort started in 2001, in which a total of 4 553 HIV infections were covered by 1 January 2010, is another important source of data (e.g., AGES 2010).

Regarding infectious diseases among IDUs few data are available, which are not representative by any means (see ST9) and only refer to samples from treatment centres and low-threshold services. The two most important data sources are the DOKLI treatment documentation system and the data gathered in the context of voluntary testing services at the *ganslwirt* low-threshold centre. In both cases, not all clients are tested, and one has to take into account that the motivation for testing depends on the status of infection of the client in question (e.g., a person who already knows that they have HIV a infection usually will not want to have another test). While such a bias does not apply to drug-related deaths, here the problem is that not all autopsy reports specify whether hepatitis C and HIV infections were found or not, and this group of drug users are likely to have followed high-risk patterns of use. The lack of a reliable monitoring system for drug-related infectious diseases is a considerable shortcoming and makes it very difficult to provide statements on trends.

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.

In Austria, the Ministry of Health has collected data on drug-related deaths (DRDs) 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 drug poisoning (overdoses). However, the problem described in detail in the

report of last year continues to exist, i.e., the number of autopsies including toxicological testing has declined, which would be important, however, in order to verify and analyse the substances involved if fatal drug poisoning is suspected (see GÖG/ÖBIG 2010a). Data on drug-related deaths are given in ST5, ST6 and ST18.

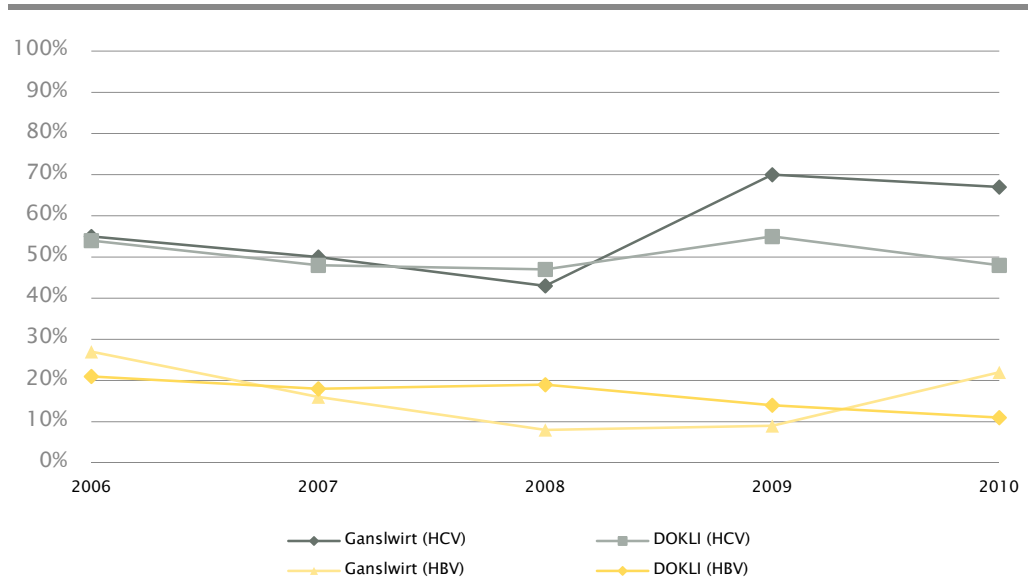
6.1 Drug-related infectious diseases

In the early 1990s the HIV prevalence rate still was as high as around 20% in the group of injecting drug users but has gone down to low levels since then (0% to 5%), although a number of data sources report slightly higher percentages (e.g. drug-related deaths in 2009: 5% to 12%; see GÖG/ÖBIG 2010a). In the case of hepatitis B, the prevalence rates range from 0% to 36% in the reporting year, depending on data source. In the majority of cases it can be excluded that any positive finding may result from previous vaccination (see also footnotes to Table 6.1). The hepatitis C antibody (HCV-Ab-) prevalence rate remained stable at a level of approximately 50% for several years in the past and was between 38% and 73% in 2010. The two most important sources of data have recently indicated a possible rise (see Table 6.1 and Figure 6.2).

Figure 6.1 gives the developments of hepatitis B and C rates in the past five years according to the two largest data sources available. The rise in HCV rates starting in 2008 that shows in both data sources gives rise to concern. However, on grounds of data quality and data collection settings, it cannot be verified whether this is a general trend. In order to obtain reliable facts on the prevalence of infectious diseases in drug users an improvement of national monitoring routines would be of great importance (e.g., conducting a representative seroprevalence study).

Regarding HCV-RNA results, a chronic development of the disease shows in a high share of patients testing positive for HCV-Ab. However, the percentages reported for HCV-RNA prevalence among positive HCV-Ab results greatly differ (Lukasfeld: 47%, Marienambulanz: 52%, DOKLI: 65%, ganslwirt: 69%). Regarding HCV genotypes, neither national data nor reports by individual centres are available for the reporting year.

Figure 6.1:
HCV and HBV infection rates covered by DOKLI and ganslwirt from 2006 to 2010



Note: For legend to sources of data see Table 6.1.

Source: ST 9; representation by GÖG/ÖBIG

Table 6.1:
Data on hepatitis B, hepatitis C–Ab and HIV infection rates, 2010

Source of data	HBV rate	HCV–Ab rate	HIV rate
Lukasfeld treatment department	0% (0/58) ¹	38% (22/58)	0% (0/58)
Low-threshold centre ganslwirt	22% (20/91) ²	67% (82/122)	1% (1/125)
Caritas Marienambulanz clinic	36% (40/111) ³	73% (81/111)	0% (0/111)
DOKLI	11% (32/305)	48% (202/425)	1% (3/411)
Drug-related deaths (fatal poisonings) in 2010	not available	21% (33/161) ⁴ 43% (33/76) ⁴	3% (4/161) ⁴ 5% (4/75) ⁴

- 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 who definitely had contact to hepatitis B (either positive HBsAG or HBcAC testing or according to their case history/previous test results).
- 3 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 vaccination.
- 4 Out of a total number of 161 expert opinions on directly drug-related deaths only 75 or 76, respectively, 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–Ab and HIV infection prevalence rates.

Sources: ST9; representation by GÖG/ÖBIG

For Vienna, data on drug-related infectious diseases obtained from case histories are given in the section on current health problems of the BADO report (see Table A30; IFES 2010). Self-reports by clients for Vienna's BADO documentation indicate a prevalence rate of 26% regarding chronic HCV and of 2% regarding chronic HBV. These percentages are at a similar level as in previous years. HIV prevalence has also remained stable: at 4% (based on self-reporting), which is considerably higher, however, than the shares given in the majority of data sources listed in Table 6.1 (IFES 2010). An almost linear correlation between rises in hepatitis C infections and age of clients has shown: in the group under 21, the prevalence rate is as low as 6% but goes up to 40% in the group older than 30. The study design (self-reporting by clients) does not permit a distinction between positive testing for HCV antibodies and positive HCV-RNA results.

According to the 17th Report of the Austrian HIV Cohort Study (AHIVCOS)³⁷ (AGES 2010) a total of 384 (16%) out of 2 430 members of the current cohort (= all patients with CD4 cell counts from July to December 2010) had acquired the HIV infection through injecting drug use. Estimates by AIDS Hilfe Wien³⁸ indicate between 12 000 and 15 000 people with HIV infections. Other estimates give a total of 9 000 infections (e.g. Aidshilfe Salzburg³⁹). The AHIVCOS team derives a total of 6 600 persons. Assuming that the current cohort does not include a systematic bias regarding injecting drug use as the mode of transmission, the total number of people in Austria who have acquired HIV infections because of injecting drug use is between 1 056 and 2 400, depending on the estimate of HIV-positive patients. If this figure is related to the estimated number of IDUs (between 12 500 and 18 500; see Chapter 4.1), the HIV rates reported by the drug support and treatment centres which are given in Table 6.1 seem very small. A possible reason for these differences might be that many patients

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The Austrian HIV cohort study (AHIVCOS) was started in 2001 at five Austrian HIV treatment centres (General Hospital Wien, Vienna Otto Wagner Hospital, General Hospital Linz, Provincial Hospital Innsbruck, Provincial Hospital Graz-West). As of 2008 the Provincial Hospitals of Salzburg and Klagenfurt have also taken part in AHIVCOS. A special software (HIV Patient Management System) has been used for the study. By 1 January 2010, a total of 4 553 patients with HIV infections had been included in the cohort. The study team assumes that the cohort covers approximately two thirds of all HIV patients in ART treatment and about 60% of all HIV patients who do not receive ART. The total number of patients with HIV infections is assumed to be at a comparatively low level in Austria: the estimate is around 6 600 patients. The current cohort includes those 2 430 persons who had undergone CD4-cell testing between July and December 2010. The study analyses both the most likely mode of transmission and demographic characteristics of clients, as well as numerous medical parameters (AGES 2010).

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<http://www.aids.at/index.php?id=15> (22 July 2011); website in German

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<http://www.aidshilfe-salzburg.at/?page=15> (22 July 2011); website in German

with HIV infections stop taking drugs or are treated in another centre that is not part of the specialised drug advice and support system. In addition, people testing positive for HIV at some time in the past usually do not undergo a second test later and consequently are not included in the statistics. The figures reported from treatment centres given in Table 6.1 thus rather reflect incidence (first diagnoses) than prevalence rates.

The AHIVCOS study also includes data on hepatitis B and C coinfections. While the chronic hepatitis B coinfection rate is 3%, and 15% in the case of hepatitis C, in the entire current cohort, the corresponding percentages among patients whose infections go back to injecting use are 6% and 66%, respectively. In other words, coinfections, especially with hepatitis C, have turned out to be a considerable problems among HIV-positive patients who were infected because of injecting drug use.

The reports to the long-term national statistics on AIDS diseases show that injecting drug use ranks last (4 cases, i.e., 13%) regarding risk situations, behind heterosexual contacts (n = 11) and homosexual contacts (n = 5). Another 11 cases were entered under 'other/unknown' in 2010 (BMG 2011; see Table A8). The statistics on AIDS deaths according to risk situation and year show that, out of a total of 22 deaths listed, 8 people (36%) had been infected as a result of injecting drug use (BMG 2011).

Data on other drug-related infections are available only for tuberculosis (TB). Of the 216 persons for whom tuberculosis entries exist in the corresponding DOKLI data set (see Chapter 5.3), none had a positive TB diagnosis, and three 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 391 people. The latest data again point to a low TB vaccination coverage: it was 5% in the last few years (GÖG/ÖBIG 2009a; GÖG/ÖBIG 2010b, GÖG/ÖBIG 2011a).

The DOKLI data set on hepatitis A vaccinations includes 521 people, and regarding hepatitis B vaccinations, 622 people. The **vaccination coverage** of 27% 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 2011a). However, these figures, reflect previous vaccinations rather than the present status of immunisation, (GÖG/ÖBIG 2009a). The vaccination coverage among the general population is at a level similar to the coverage among IDUs (GÖG/ÖBIG 2009c), in spite of the fact that injecting drug users are a specific target group of hepatitis A and B vaccination programmes.

6.2 Other drug-related health correlates and consequences

According to the statistics of Vienna's BADO documentation system, 63% of people covered indicated current health problems⁴⁰. Apart from chronic hepatitis C (26%) the clients of Vienna's drug treatment centres most frequently named dental problems (19%), followed by gastrointestinal problems (13%), psychiatric problems (14%), and other diseases (13%). In the past five years, no significant changes have shown with regard to indications of the individual health-care problems listed (see Table A30). As a rule, women tend to indicate health-related problems to a somewhat greater degree than men (67% v. 61%). This difference is mostly found with regard to gastrointestinal problems and psychiatric diseases. In addition, 11% of female clients said they had gynaecological problems (IFES 2010).

The DOKLI data also provide information on psychiatric comorbidity (see Chapter 5.3). In 120 out of 201 people (51%) 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 2011a).

According to the statistics on problems addressed in advice sessions at the *ganslwirt* centre, the issue of mental health was raised in 31% of the talks, and physical problems were discussed in 26% of cases (drug use: 31%; housing: 77%; VWS 2011b; see Chapter 8.2). *Streetwork* registered discussions of mental health problems in around half of advice and care sessions (VWS 2011c), and *TaBeNo Süd* in about one out of three talks with clients (VWS 2011k). The increase in benzodiazepine misuse among people in OST is also seen as a result of psychiatric comorbidity that has not adequately been diagnosed and treated (SDW 2011a; see Chapters 4.1 and 5.1).

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)

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These indications of health problem are exclusively based on self-reports by clients and not on diagnostic interviews, medical findings or test results.

obtained in the context of forensic examinations of cases directly drug-related death. As in previous years, these findings reveal pronounced organic damage among drug users. In the majority of indirectly drug-related deaths⁴¹ (21 people), the cause of death was a disease such as myocarditis, cirrhosis (in part resulting from hepatitis C) or cancer; three persons died of AIDS, three had fatal accidents and two committed suicide (but not by lethal overdosing of drugs; see GÖG/ÖBIG (2011b)). One person died of butane gas poisoning but had also used cocaine.

Statements on the prevalence of psychiatric or physical comorbidity cannot be made because the samples in question are not representative, among other reasons. The available data should 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 2011b). Based on autopsy findings, in 2010 a total of 170 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 170 and 187 deaths might directly be drug-related. As already mentioned last year (see GÖG/ÖBIG 2010a), in a significant number of cases (17) no autopsy was performed, therefore it is not possible to derive any definitive trends.

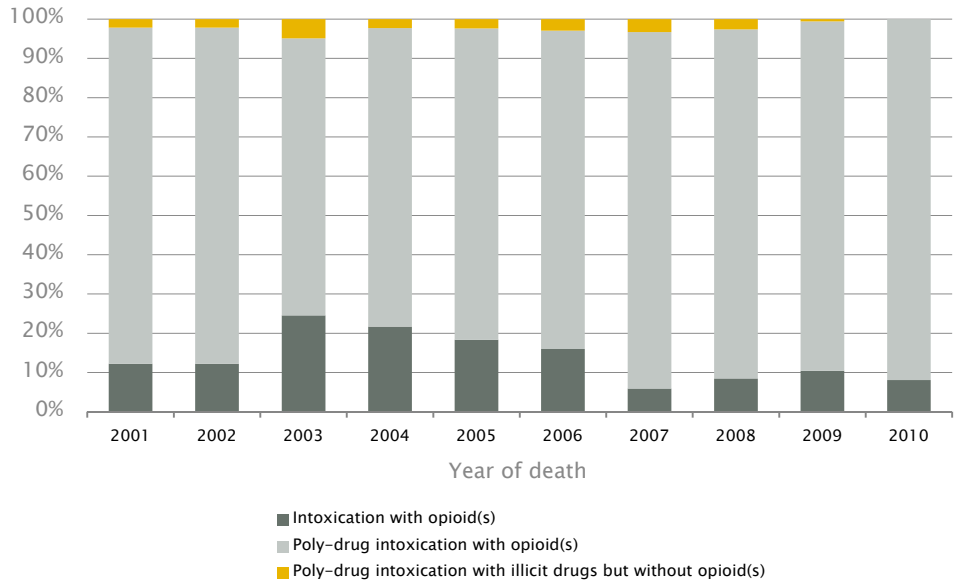
In 11% of cases of DRD, the toxicological analyses revealed only illicit substances (one drug or a combination of several drugs). In addition, psychoactive medicines were also found in 53% of cases, in 12% alcohol was detected as well, and in 24%, both substances, i.e., alcohol and psychoactive medicines, were found. As in previous years, fatal poisonings involving opioids clearly predominate (see Figure 6.2). The opioids most often found are morphine and heroin, followed by other opioids and methadone (GÖG/ÖBIG 2011b). Cocaine and amphetamines were detected in only 29% and 9% of cases, respectively. The share of persons who had exclusively taken opioids is 8%, which is in line with the long-term trend (2007: 6%; 2008: 8%; 2009: 11%). Patterns of

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In the case of indirectly drug-related deaths, the cause of death is not acute fatal poisoning involving narcotic drugs, but because of the patients' 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 available data cannot be assumed to be complete (see GÖG/ÖBIG 2007a).

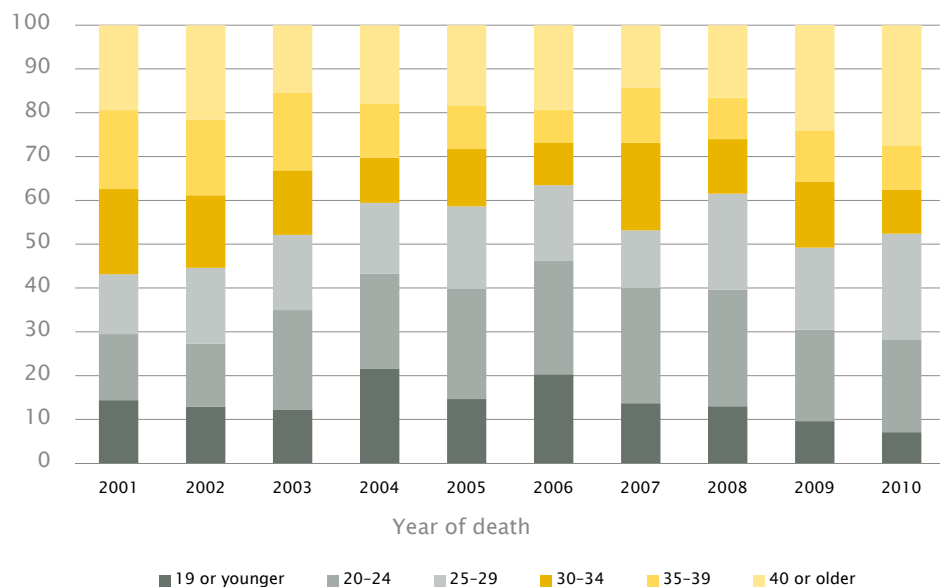
poly-drug use with opioids, where the effects of different substances may be potentiating and thus are difficult to control, continue to be widespread and constitute serious health risks (see Chapter 4).

Figure 6.2:
Share of directly drug-related deaths in Austria, by cause of death from 2001 to 2010



Source: GÖG/ÖBIG 2011b; representation by GÖG/ÖBIG

Figure 6.3:
Age distribution of directly drug-related deaths in Austria from 2001 to 2010
(percentages)



Source: GÖG/ÖBIG 2011b; representation by GÖG/ÖBIG

The grouped median⁴² of the age at death was 29.0 years in 2010, i.e., the age median of the reporting year is at a level similar to previous years, (2007: 28.3; 2008: 25.7; 2009: 29.2). The share of persons under 20 (7%) is lower than in the past few years and the lowest share of the past decade (2007: 14%; 2008: 13%; 2009: 10%; see Figure 6.2). At 18%, the share of women in directly drug-related deaths is in line with the long-term average.

Initial results are now available of the study on drug-related deaths conducted in Vienna⁴³. On the one hand, the study confirms conclusions drawn from the annual statistics on DRDs, i.e., that the main risk factors include multi-drug use, drug use in

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

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The study analysed a total of 198 forensic reports on drug-related deaths in Vienna and Lower Austria in the period from 2005 to 2007. The results obtained were related to data from drug advice and support centres in Vienna and Lower Austria. In addition, data sets from cooperation partners such as health authorities, ambulance services, courts and hospitals were analysed. Analysing the specific circumstances of the death in question will make it possible to draw up risk profiles as a basis for future prevention strategies.

private houses, poor state of health and organic damage due to long-term drug use (e.g., see GÖG/ÖBIG 2011b). On the other hand, a number of new aspects were found: release from prison turned out to be a relevant risk factor. One third out of a total of 74 former prisoners died within one month after their release, presumably because of an elevated risk of overdoses as their tolerance to opioids had massively gone down. An analysis of discharge diagnoses by the Vienna Ambulance Service and BADO data showed that many patients, in addition to addiction, also suffered from severe psychiatric diseases. In the majority of drug-related deaths that were examined, the person in question had not received drug-related advice or treatment services immediately before their death (SDW 2011a; see Chapters 7.1 and 11.3).

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. The available information and data primarily come from the annual reports of individual units and the Drug and Addiction Coordination Offices in the provinces.

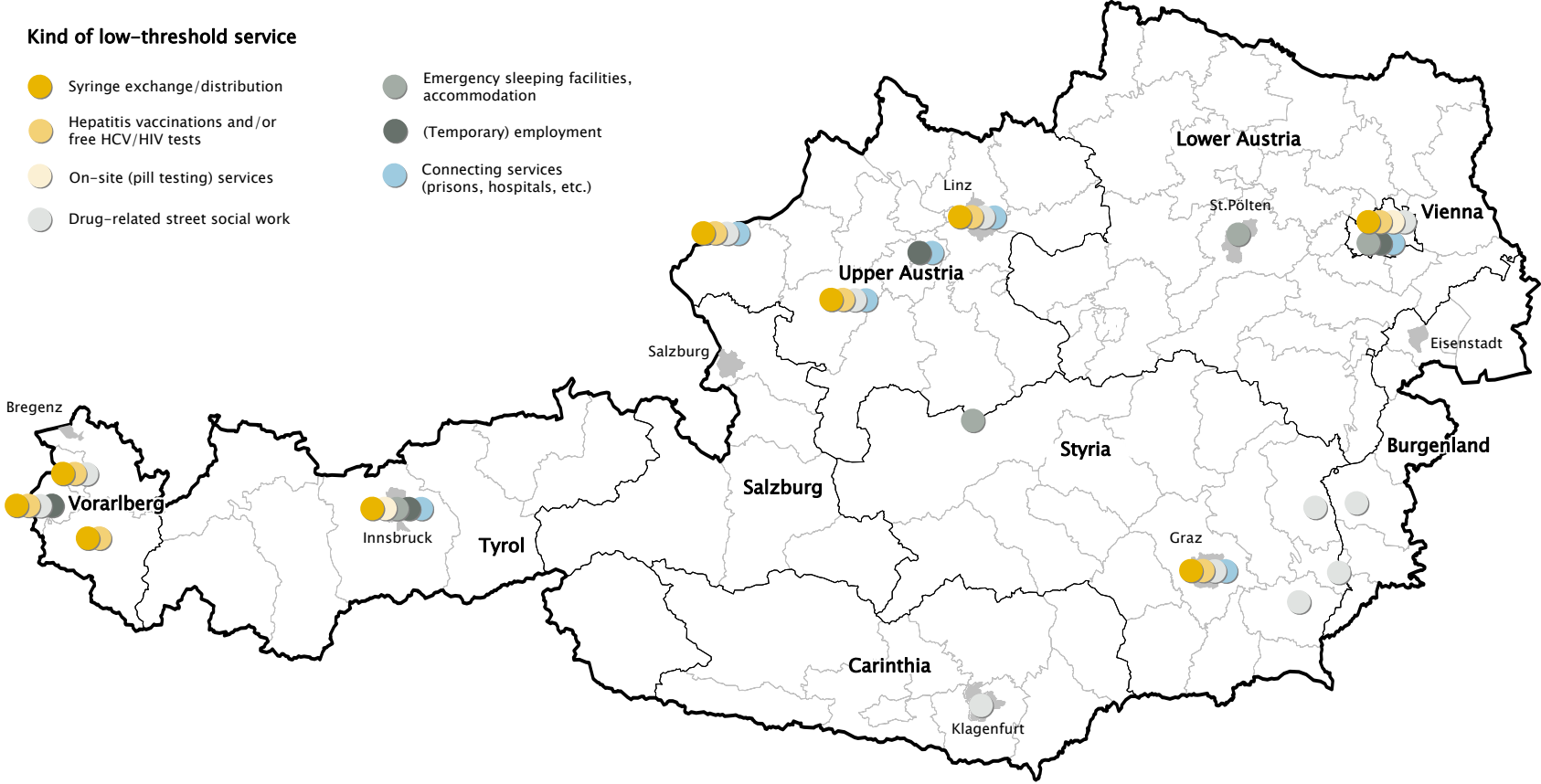
7.1 Prevention of drug-related emergencies and reduction of drug-related deaths

At federal level, interventions aimed at reducing drug-related deaths on the one hand and harm reduction on the other continue to be of great importance. A position paper on harm reduction (see GÖG/ÖBIG 2010a) drawn up by a steering group was adopted by the Drug Forum and will be integrated in the new national addiction strategy (see Chapter 1.2). The continuation of the Addiction Plan of Carinthia also includes the goal to implement the principle of harm reduction in all areas of drug-related services (Prehslauer, personal communication). In July 2010 a booklet on harm reduction in the context of Vienna's drug policy was drawn up, which also gives an overview of available harm reduction services (SDW 2010b).

Initiatives specifically focusing on drug-related emergencies and deaths are mainly pursued by low-threshold drug support centres, 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 great significance, e.g., crisis intervention and observation (VWS 2011b, VWS 2011c).

The study on drug-related deaths conducted in Vienna, which will form the basis for drawing up risk profiles relevant for prevention, has shown that release from prison is associated with a high risk of overdoses due to the users' reduced tolerance to opioids (see Chapter 6.3). Ex-prisoners have thus been defined as a target group.

Map 7.1: Specialised low-threshold providers of harm-reduction interventions for drug users in 2011



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

For an overview of the locations of specialised harm reduction centres for drug users in Austria, see Map 7.1.

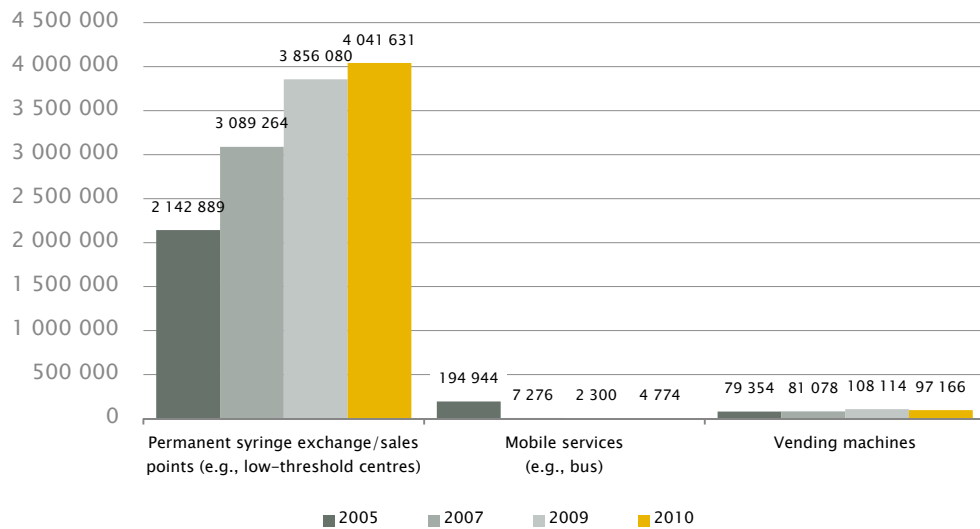
7.2 Prevention and treatment of drug-related infectious diseases

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.

The number of syringes exchanged in Vienna has remained at a level similar to past years (2009: 2 846 993; 2010: 2 817 160) even though the low-threshold support system of Vienna had to be restructured following reconstruction works at Karlsplatz square: the syringe exchange point run by *Streetwork* at Karlsplatz had to be closed, the room capacities of the *ganslwirt* centre were expanded and syringe exchange services were transferred to the temporary *TaBeNo-Süd* offices (for more details see GÖG/ÖBIG 2010a). Still, in 2010 the contacts to clients in the context of syringe exchange went down by 23% compared to 2009, i.e., clients tended to exchange more syringes at once. As contacts to clients are an important element of low-threshold work, the background of this development is analysed in the context of an evaluation study (VWS 2011a). In the third quarter of 2012, *ganslwirt* and *TaBeNo-Süd* will move to their new joint location at Gumpendorfer Gürtel, where a sociomedical drug care centre will be established (Lochner, personal communication).

Figure 7.1 illustrates that the total number of syringes returned or sold all over Austria has only seen a small further rise compared to the two previous years surveyed. In 2010, 4 138 797 syringes or needles were dispensed to drug users in Austria in permanent syringe sales and exchange points, which are primarily located in low-threshold centres (see Table A29 and ST10). By now, vending machines exist in five provinces. The total number of vending machines in Austria (15) has not changed compared to the previous year (see Table A29 and GÖG/ÖBIG 2010a).

Figure 7.1:
Syringe exchange and syringe sales in Austria in 2005, 2007, 2009 and 2010



Note: In Vorarlberg and Styria, for reasons of data administration, syringes provided in the context of street social work are registered as syringes provided by permanent exchange/sales points.

Source: ST 10; representation by GÖG/ÖBIG

The *Kontaktladen* contact point in Graz reports a massive increase in syringes exchanged, i.e., by 93 000 injection sets, to a total of 451 333 against the year before, which is attributed to excessive use of mephedrone, among other factors (see Chapter 4.2). In addition to the syringe exchange services, in 2010 *Kontaktladen*, in the context of a hepatitis prevention campaign, also implemented a spoon exchange programme. The campaign includes the communication of information by means of lectures, printed material, training of drug users to act as multipliers (peer education programmes), cooperation with prisons aimed at preventing infections and protecting staff, as well as a final evaluation. The project addresses staff of Styria's Drug Advice and treatment centres on the one hand and drug users on the other (Caritas, Diözese Graz-Seckau, 2011). While the programme as such met with much acceptance, it showed that users of mephedrone, because of their intensive patterns of use, tend to be 'confused' and cannot easily be addressed (Zotter, personal communication).

In July 2008 Caritas of Tyrol conducted a hepatitis survey in its three drug advice and care centres. The final report on the survey is now available⁴⁴: a share of 79% of interviewees had already been tested for HIV (results: 73% negative; 3.2% positive; 1.6% unknown result, 22.6% non-responders). 87% of clients had already undergone HCV testing (results: 23% negative; 55% positive; 8% unknown result; 16% non-responders). Nearly half of respondents said they had received hepatitis A/B vaccinations in the past, and 29% indicated needle sharing in the past month: here the share of women was significantly higher than the share of men. Approximately one out of two respondents indicated needle sharing the past year. The authors of the study thus conclude that safer use is still not practised as an everyday routine, that hepatitis A/B vaccination programmes for all IDUs would be required and that sterile syringes should more easily be available to drug users, in particular in rural areas (vending machines), and finally, harm reduction interventions should more specifically be oriented towards gender aspects (Dietmann et al. 2010).

Many opioid users tend to snort heroin over quite a long period before they switch to injecting use (Busch and Eggerth 2010; see Chapter 5.3). This fact might be important for low-threshold interventions in order to prevent users from changing to injecting drug use.

Hepatitis vaccination programmes are another essential intervention with regard to preventing and treating drug-related infectious diseases. However, such programmes are available in a small number of drug support centres only. The vaccination services are usually combined with free HIV and viral hepatitis testing. For instance from 1995 to 2010, the *ganslwirt* centre in Vienna carried out serological tests on a total of 1 341 injecting drug users in order to assess their need for hepatitis A/B vaccinations: in the case of 1 027 clients this was found to be advisable. A share of 77% out of this group started the vaccination schedule, and 45.5% received all three injections (Haltmayer and Schütz, personal communication).

Treatment of infectious diseases in drug users has become a focal issue all over Austria. In order for treatment to be effective, multiprofessional networks are needed that link drug advice centres and medical care institutions. For instance, drug users

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For the hepatitis survey, a total of 62 persons (41 men; average age: 33.6 years; and 21 women, average age: 29.8 years) were interviewed on the basis of a questionnaire on safer use and infectious diseases. All respondents were IDUs: 34% of them indicated injecting drug use several times a day, 26% injected drugs daily, 18% between two and six times a week, and, 9.8% less often than once a week. A share of 11.5% indicated that they had not used drugs in the past four weeks. The respondents remained anonymous but in order to prevent multiple interviews of one person, their initials and births of date were entered in the questionnaire. This might be one of the reasons for the high non-response rates.

suffering from hepatitis B or C are routinely treated in all gastroenterology outpatient departments of hospitals in Vienna.

Since early in 2011, Vienna's *ganslwirt* low-threshold centre has cooperated with the immunology outpatient department of Otto Wagner Hospital to provide new services for HIV-positive patients who are unable to keep regular appointments scheduled at the specialised clinics of General Hospital Vienna or Otto Wagner Hospital. Care interventions such as taking blood samples as well as their subsequent analysis and interpretation of findings take place at *ganslwirt* (with consultation of the specialists of Otto Wagner Hospital). After obtaining initial test results, follow-up tests may be made every three or six months. In addition, *ganslwirt's* testing services have been expanded and now also include rapid antibody HIV tests (Haltmayer and Schütz, personal communication).

In May 2011 Heino Stöver, a harm reduction expert, delivered a paper in Vienna which provided an overview of, and experience with, drug consumption rooms in Germany and Europe, in order to initiate a public discussion among experts on this issue in Vienna (APA 2011).

7.3 Responses to other health correlates among drug users

The activities of drug-related support and advice centres continue to include interventions with regard to **psychiatric comorbidity**. The corresponding services hardly differ from those reported in previous years (see GÖG/ÖBIG 2009b and 2010a).

Interventions and activities 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 the services of low-threshold centres also include dressing of wounds, health information, hygiene routines, etc.

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 services provided include advice and support regarding problems that specifically concern women (e.g. working in prostitution to finance drug use, experience of violence), which usually take place in specific settings.

Interviews with senior drug users conducted in the context of the SDDCARE project have shown that this group tend to suffer from diseases to a great extent (acute or chronic diseases such as hepatitis or dental problems) but often do not receive profes-

sional treatment. According to the authors, these drug users are hardly integrated in treatment structures and because of their marginalisation may also be apprehensive about getting treatment. Only one out of three respondents is receiving treatment in a drug care centre, so adequate services for this target group are definitely needed (Eisenbach–Stangl and Spirig, 2010; see Chapter 4.2).

The existing **further training** programmes have been continued in the reporting period. In Styria, hepatologists and representatives of *Streetwork* cooperated to organise information events on infectious diseases and prevention of infection in prisons (Ederer personal communication; see Chapter 11.3) In Autumn 2011, a new training programme in nursing and addiction⁴⁵ will start at the Anton Proksch Institute.

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<http://www.api.or.at/typo3/news/2011-06-08.html> (8 August 2011); website in German with summary in English

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 and scientific publications. 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.

According to a survey conducted in 2006 among Austrian advice and treatment centres⁴⁶ (BAWO 2009), a total of around 37 000 people in Austria are homeless (multiple counts cannot be excluded): approximately 31 000 adults and around 6 000 young people had contacted the corresponding services in order to prevent eviction, receive outpatient care and accommodation or assistance because of housing problems. In 2010, approximately 190 000 people were unemployed (according to the international definition), which corresponds to an unemployment rate of 4.4%⁴⁷. In 2009 around 174 000 people had taken up welfare assistance⁴⁸.

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. Interventions in this field, some of them low-threshold in kind, are available after treatment or as a part of accepting drug assistance. Addicted people may also take

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In 2006 the National Platform of Social Services for Homeless People (BAWO 2009), on behalf of the Austrian Federal Ministry of Labour, Social Affairs and Consumer Protection, conducted a quantitative and qualitative survey among organisations providing services for homeless people and similar service providers such as advice and care centres for women.

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http://www.statistik.at/web_en/statistics/labour_market/index.html (7 October 2011)

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http://www.statistik.at/web_en/statistics/social_statistics/social_benefits_at_laender_level/social_assistance/index.html (7 October 2011)

part in a range of other services that focus on unemployment, homelessness and spare-time activities. Building links between drug care 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 2010 registered in the Austrian DOKLI system (see Chapter 5.3), the share of people with jobs continues to be smallest in the group undergoing in-patient treatment: 8% (2009: 9%). Here, the percentage of persons who indicate that they are unemployed is also highest (2010: 44%). 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%). Compared to the previous client year, the share of employed people among clients receiving low-thresholds services has considerably gone down (2009: 17%, 2010: 10%). Again, women indicated unemployment by far less frequently than men, but a larger share of women receive welfare assistance compared to men (see Table A24).

Around half of the clients receiving low-threshold services in 2009 said their housing situation was stable. In 2010, however, this only applied to slightly more than one third of these clients (36%), which is a considerable decline. Among the group of clients needing long-term services, around 90% indicated that they had a stable accommodation (see Table A26).

Regarding highest level of education completed and characteristics of clients receiving services by Wiener BerufsBörse (WBB; Vienna Job Exchange), no difference was found in 2010 compared to the figures given in the report of the year before (GÖG/ÖBIG 2010a; GÖG/ÖBIG 2011a). In 2010 one out of five WBB clients took part in training schemes while a share of 7% and 4%, respectively, found employment in the regular labour market or subsidised employment, and 3% had minor employment (Wiener BerufsBörse 2011).

The fact that the system of welfare assistance has been replaced by the means-tested minimum income scheme has had a great influence on the financial situation of clients. By now, all provinces except Upper Austria have adopted the new scheme (see Chapter

1.2). As the new system has been in force for a short time only, its effects cannot yet be assessed.

8.2 Social reintegration

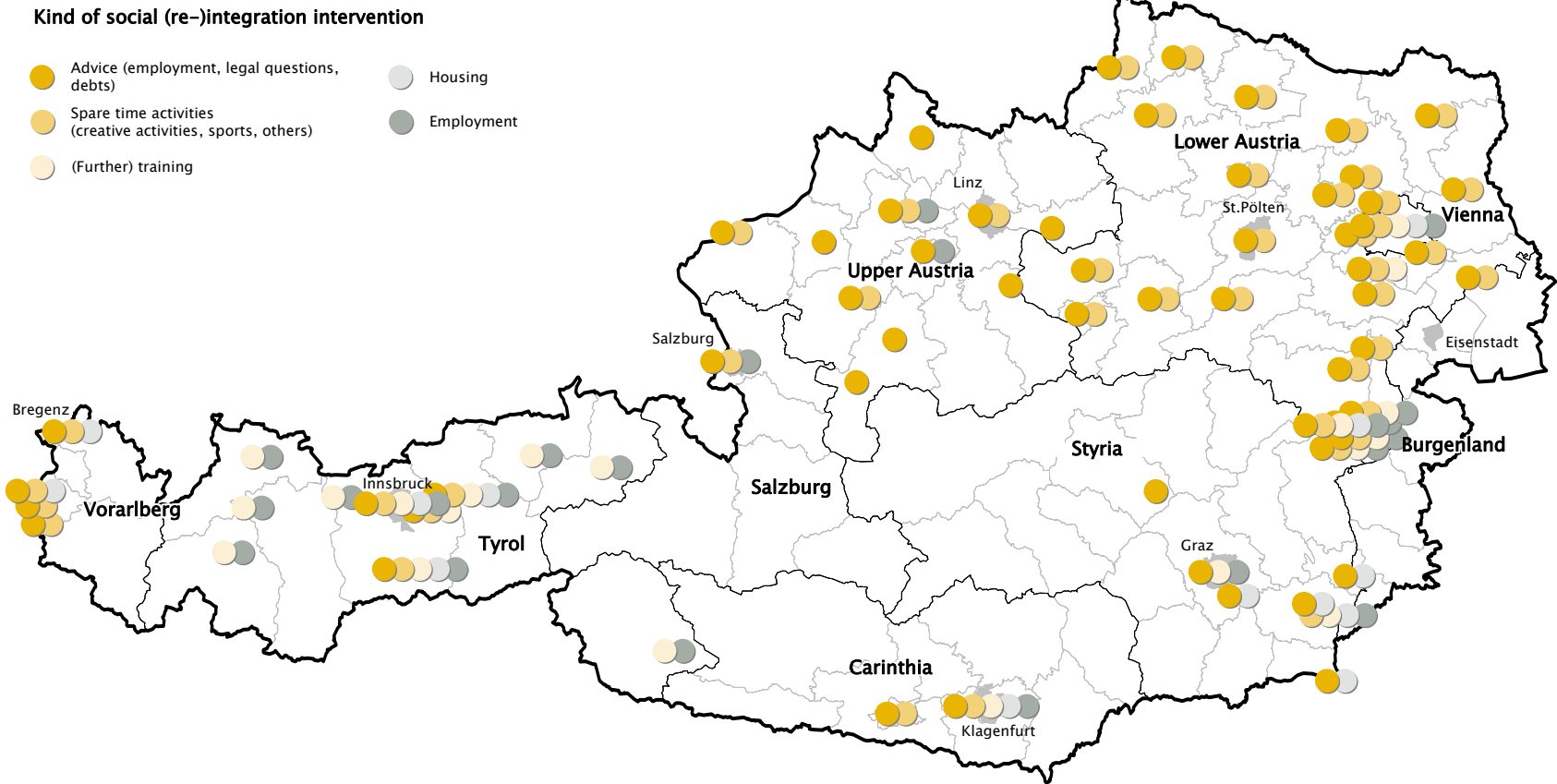
Services aimed at social (re)integration are delivered in the areas of employment and training, housing and spare-time activities (see also Map 8.1). Regarding **employment**, the corresponding interventions are oriented towards low-threshold access to occupation on a per-day basis as well as for a longer period. No information on new services in the field of training has been available. The majority of social (re)integration services described last year (GÖG/ÖBIG 2010a) has been continued or replaced by follow-up projects (e.g., *Standfest II*). Below, further information on expansion of existing, or establishment of new, services in this area is given.

Lower Austria's new Addiction Plan 2011–15 also includes a chapter on social integration (see Chapter 1.2), which specifies that integration is understood as social inclusion, and specific structures should be created in order to ensure that inclusion is an integral part of addiction-related services provided in Lower Austria, especially with regard to education and employment, housing and spare-time activities as well as general support and assistance (Fachstelle für Suchtprävention NÖ 2010).

In 2010 a pilot project was started in the context of *Dialog's* addiction and employment project (see GÖG/ÖBIG 2010a): the initial talks in order to assess clients' fitness for work now take place at the regional offices of the Public Employment Service of Lower Austria. This makes it easier to access clients and reduces their apprehension about turning to an addiction support service (Verein Dialog 2011).

On behalf of the Public Employment Service of Lower Austria, in autumn 2010 the LIMES vocational orientation programme was started which specifically addresses young people with addiction problems: LIMES aims at defining and implementing the daily structures and procedures that are to be adhered to during the course period. In order to prepare the clients for reentering the labour market, they are encouraged to examine possible prospects for their future. LIMES also includes the option of 'trial therapy'. If clients then decide to undergo treatment, they have the advantage of a sped-up, easier admission procedure for inpatient treatment, and they can start outpatient treatment immediately (Grüner Kreis 2010).

Map 8.1 : Specialised providers of inpatient and outpatient drug support services focusing on social (re)integration in 2011



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

The *Standfest I* employment project (see GÖG/ÖBIG 2010a), which had been phased out in 2009, was replaced by *Standfest II*, which addresses people who are temporarily unfit for work. Other clients are people who, after a period of unemployment, are ready to reenter the labour market or have been referred by the Vienna Job Exchange (WBB) and need additional support. The Institute for Addiction Diagnostics (ISD), in the context of assessing a client's fitness for work, may also refer people to *Standfest II*. An important aspect of this project is its close cooperation with other specialised labour market services oriented towards addiction problems. For participants who have not been gainfully employed for a longer period, job training schemes are available in the socioeconomic enterprises *gabarage* or *fix und fertig* as part of the *Standfest II* training.

In 2010 *fix und fertig* saw a major restructuring of its financing structure: now funding primarily comes from the Addiction and Drug Coordination Office of Vienna, while the Public Employment Service only contributes to wage costs for the transitional workers. The new structure has made it possible to increase the period clients may work in the enterprise, from nine to 12 months, which has had positive effects on the entire team (team building, less fluctuation, etc.; VWS 2011f).

In Graz the project *Offline* provides employment as well as low-threshold work and qualification services for people addicted to alcohol or illicit substances. The work hours are defined in line with the clients' patterns of use, and there is no age limit. Occasional or regular minor employment at *Offline* is possible for a maximum period of nine months. The project is funded by the Santner private foundation of the Anton Paar enterprise and implemented by Caritas of the Graz-Seckau Diocese (Styria)⁴⁹ (Ederer, personal communication).

The *VIVA* therapy garden project of Klagenfurt, Carinthia, aims at person-centred health promotion through activities such as gardening in order to aid addicted patients' recovery in the best possible way. The Sisters of St. Elizabeth provide the garden for free, and from April to October the participants in the project, i.e., clients of the *VIVA* drug support centre and the addiction clinic of Klagenfurt, do gardening work there twice a week. This type of occupational project offers a structured day programme, which considerably contributes to their psychosocial stability. The clients are paid a small wage of 5 euros per hour and they may take home the vegetables they have grown. Each Thursday lunch is cooked with goods from the garden for all clients. On open day, the dried herbs are sold. Some clients use the *VIVA* garden for the entire summer, others come occasionally for short-time employment. From April to October

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http://www.caritas-steiermark.at/fileadmin/user/steiermark/fotos__pdf__medien/Hilfe_und_Einrichtungen-/fuer_Menschen_in_Not/Arbeit/OFFline/Flyer_Projektinfo2011.pdf (7 July 2011); website in German

2010, a total of 14 clients, in groups of two to four persons, worked in the VIVA garden twice a week (Drogenberatung VIVA 2010; Kulterer, personal communication).

Eisenbach–Stangl and Spirig (2010), in the recommendations section⁵⁰ of their publication, point to older drug users' need for financial security and recommend activities to promote their (re)integration in the labour market. If this is not possible any more, non-discriminating occupation in day centres or neighbourhood assistance centres should be offered in order to provide day structure and a small source of income. Both (re)integration in employed ways of life and occupational projects could be combined with debt advice services.

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 situation⁵¹, which gives **housing** programmes special significance.

In Vienna, the temporary *TabeNo-Süd* office at Wiedner Gürtel provides basic, emergency and crisis intervention services for addicted clients, who may spend time in the day centre and use the emergency sleeping facility (monthly average in 2010: 20 clients a day) or the emergency outpatient department (monthly average from November to December 2010: 20 patients a day; one third of them women). Around half of clients face an unstable housing situation, and consequently, the problem of accommodation was addressed as a pressing issue in approximately 80% of advice and counselling talks at *TabeNo-Süd* and *ganslwirt*, followed by the issues of drug use,

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The publication by Eisenbach–Stangl and Spirig (2010) documents the European research project Senior Drug Dependents and Care Structures (SDDCare), which had been financially supported by the European Union and was implemented in four countries (Austria, Germany, Poland and Scotland) between 2008 and 2010. The project aimed at building a knowledge base on the situation in life and the health of senior women and men addicted to drugs and investigating their demands regarding care and support. The project consisted of five substudies which were loosely connected and for which interviews with senior drug users as well as experts were conducted.

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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).

health and financial problems (around 30% each; VWS 2011b, VWS 2011k; see also GÖG/ÖBIG 2010a and Chapter 6.2).

The day centre for unstable and homeless people run by Caritas Carinthia provides support and assistance to homeless people or people in danger of homelessness. The majority of clients is men (share of women: 15%), who often suffer from psychosocial problems or addiction. The share of young homeless people aged between 18 and 30 has been found to increase (Kärntner Caritasverband 2011).

Caritas of the Diocese of Graz Seckau plans to expand its existing accommodation services, i.e., provision of rented flats for homeless people, to include addicted people as well. Between 320 and 340 people in Graz are estimated to need places in the flats (Ederer, personal communication).

In a cooperation of the Fund for Social Services in Vienna (FSW) and old age and nursing services, new extramural housing structures (shared housing and assisted housing) will be established for senior (former) drug users. 50 beds will be available, which should be sufficient to meet the corresponding demand. The criteria for admission and the house rules will pursue a low-threshold approach (Spirig et al. 2010a)⁵².

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 main focus is on sports, art as well as cultural and creative activities and sharing of experience. In this context artistic and cultural activities, and recently also creative work, have played an increasingly important role. The majority of activities is not open to all, however, but only to clients of the corresponding centre, often in the context of therapy.

For instance, in 2010 *ganslwirt* held a monthly painting and creativity workshop in order to offer clients a satisfying spare-time activity and help them explore their creative potential. In the reporting year 78 people took part in 11 workshops (VWS 2011b).

Kontaktladen and *Streetwork* Graz again organised monthly spare-time events in order to motivate (former) drug users to try sports and exercise as a healthy way of life. In this context 32 people took part in 10 activities (cinema, volleyball, football, skiing, archery; Caritas Diözese Graz-Seckau 2011).

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In the context of a publication by Eisenbach-Stangl and Spirig (2010; see also Chapter 11.1), Spirig et al. (2010a) conducted 11 interviews with field experts in inpatient and outpatient drug treatment centres, low-threshold services, prisons and providers of social services for drug users. In addition, staff in the field of old-age services as well as care and nursing and at administration level were interviewed.

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 judicial 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 Coordination 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 (see also Chapter 11). 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 2011), 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.

In 2010 the number of reports to the police relating to violations of the Narcotic Substances Act (SMG) has seen a rise compared to the previous two years and is now near the level of 2006. SMG-related convictions because of misdemeanours (Section 27), after a decline from 2006 to 2009, have gone up again.

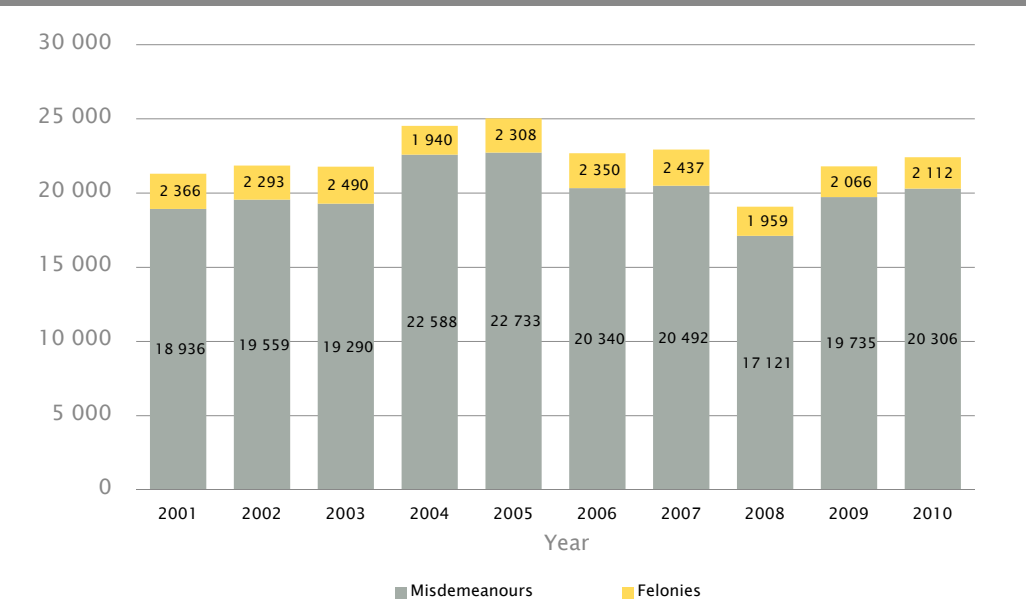
A similar trend is found regarding convictions because of felonies (Section 28 of the SMG). From 2006 to 2009, the annual figures went down by roughly 5%, but from 2009 to 2010 a rise by 14% was registered. In this context it should be noted that in the present report, the term felony is used for all 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 2010 a total of 23 853 violations of the Narcotic Substances Act (SMG) were reported to the police (2009: 22 729; see also Table A9), which is a higher figure than in the last two years. Of this figure, 22 418 reports relate to narcotic drugs (2009: 21 801) and the rest to psychotropic substances. Regarding type of report (see Figure

9.1), 2010 saw another rise in reports because of both misdemeanours (illicit handling of drugs – SMG Section 27) and felonies (preparation for drug trafficking – SMG Section 28, or drug trafficking – SMG Section 28a). Compared to 2009 this is an increase by approximately 2% of the number of reports relating to felonies, and around 3% regarding misdemeanours.

Figure 9.1:
Development of reports relating to violations of the Narcotic Substances Act, by misdemeanours and felonies in Austria from 2001 to 2010



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 and Figure 9.2), declines as against the figures of the past year show for all substances except heroin and opioids, medicines containing narcotic drugs as well as psychotropic substances or medicines⁵³. While reports relating to medicines containing narcotic drugs have remained at fairly constant levels since 2006 – with the exception of 2008 – from 2009 to 2010 a rise by 16% has shown, paralleled by a rise in reports because of psychotropic medicines. This is in line with information according to which (ab)use of benzodiazepines has massively risen in the last few years. A strong increase is also found regarding (ab)use of medicines (stimulants, amphetamines, antidementia medicines and antidepressants) which

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Psychotropic medicines are pharmaceutical products with effects on a person's mental state.

are used as uppers (SDW 2011a; Österreichische Apothekerkammer 2011). A noticeable decline, to 40% of the 2009 figure, shows with regard to ecstasy, which is partly offset by a rise in mephedrone-related reports. It should be noted that this report is the first to include separate figures for mephedrone (MMC). MMC was a legal substance until August 2010, when it was included in the substances prohibited under the SMG (see Chapters 4.1, 5.1, 10.1 and 10.2).

At provincial level, the number of reports shows a similar trend compared to 2009 as the federal figures, but differences do show according to province: for instance, rising trends, in part to massive degrees, of reports relating to heroin and opiates are found in Carinthia (+120%), Upper Austria (+40%), Vienna (+26%) and Vorarlberg (+17%), while the other provinces have registered similar levels as in 2009 (Salzburg) or even declines (Burgenland, Lower Austria, Styria, Tyrol). In Carinthia and Vienna, the number of reports relating to medicines containing narcotic drugs has strongly risen, while a marked decline shows in Lower Austria. Almost all provinces saw a rising, or even strongly rising, trend in reports because of psychotropic medicines. In all provinces except Vorarlberg declines to varying degrees show with regard to ecstasy. In this report, separate mephedrone figures are given for the first time: here high levels are reported particularly by Lower Austria, Styria and Vienna. One has to bear in mind that all reports concerning mephedrone were filed in the short period from August to December 2010 (see Table A12).

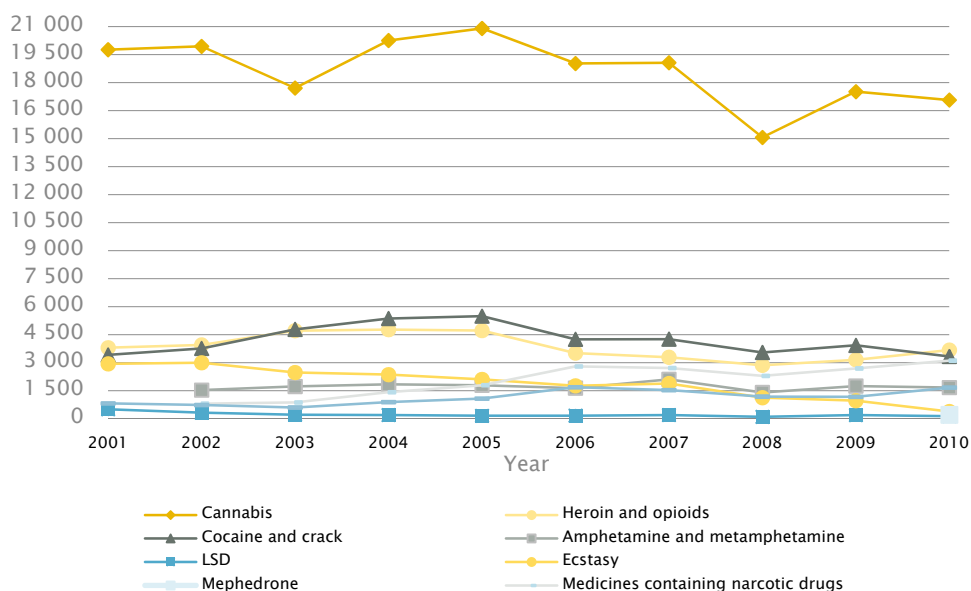
In 2010, a total of 23 853 reports to the police led to 2 075 arrests (2009: 2 775) in connection with drug-related investigations. However, regarding arrests, no further analyses (type of offence, substances involved, etc.) can be given.

For more detailed statistics on convictions, please consult Selected Issues Chapter 11.1 of this report as well as 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.

Figure 9.2:
Development of reports relating to violation of the Narcotic Substances Act in Austria
by type of substance, 2001 to 2010



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

9.2 Prevention of drug-related crime

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

The activities that the Addiction and Drug Coordination Office of Vienna has started in the area of public space and security aim at improving access to advisory and support services of socially marginalised people. Other objectives include promoting socially acceptable patterns of behaviour of this group in the public space and raising the subjective feeling of security among the public (SDW 2011a). In Vienna the *Help U* team around Karlsplatz square and the three *SAM* teams have continued their activities (see GÖG/ÖBIG 2010a).

Community-oriented social work structures were established in order to improve the acceptance of the *ganslwirt* and *TaBeNo-Süd* day centres (see GÖG/ÖBIG 2010a), to address addicted people in the vicinity of the centres and find quick, practical solutions in the case of problems or conflicts around the centres. Since spring 2010, the staff of the centres walk through the parks and streets around the centres once or

twice a day in order to establish contacts to clients and to residents living in the neighbourhood (VWS 2011b, VWS 2011k).

In order to enhance road safety, new preliminary drug testing devices are available which might be used in the context of traffic stops. In Vienna, trials are currently performed to test whether Frenzel goggles⁵⁴ might be suitable instruments for DUI checking by the police. In spring 2011, the Austrian Road Safety Board conducted a traffic survey on tests of the Frenzel goggles (Pilgerstorfer, personal communication).

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 treatment instead of punishment, is regulated by law.

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 11.1), data regarding temporary (probationary) waivers of reports (SMG Section 35), proceedings dismissed (SMG Section 37 SMG) and sentences suspended (SMG Section 39) are presented in Figure 9.3 and in Table A16.

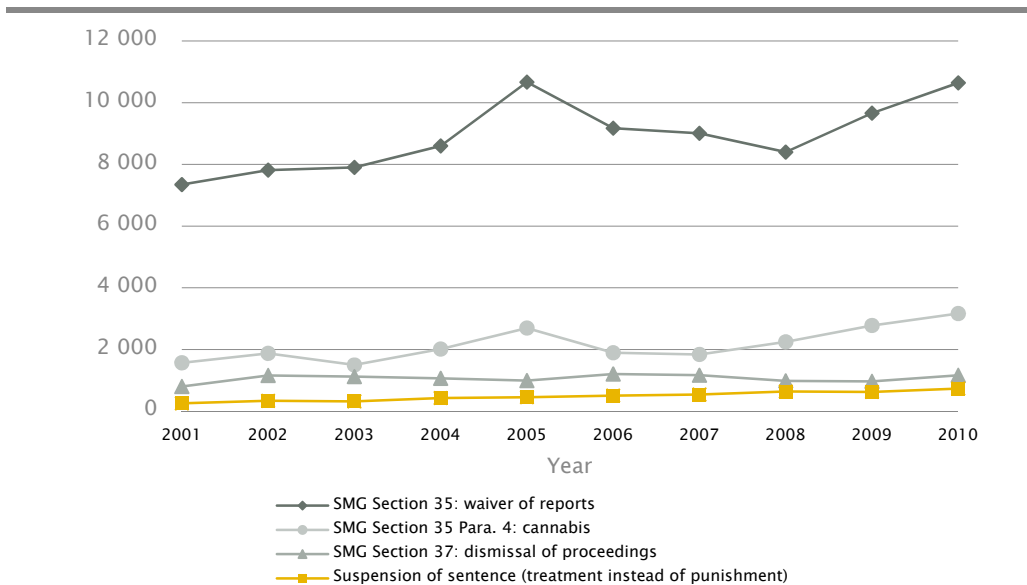
Figure 9.3 shows a decline in waivers of reports from 2005 to 2008, and as of 2006, also of dismissals of proceedings. Since 2008, however, the number of reports waived has increased considerably, also regarding cannabis-related reports. Further information on final convictions because of violation of the SMG, by reason for conviction, gender and age group, is provided in Table A14.

This year, data on suspension of sentence according to the principle of treatment instead of punishment (SMG Section 39) are available for the first time. Figure 9.3 and Table A16 show a continuous rise in cases where alternatives to punishment have been applied. This increase over several years is one of the reasons why the costs of medical treatment and counselling services delivered to addicted people have steadily gone up as well. However, it cannot yet be assessed which effects the Act Accompanying the Budget (BBG, BGBl I 2010/111 v. 30. 12. 2010) will have in this respect: e.g., this Act includes a restriction of cost coverage for inpatient treatment to a maximum period of six months (see Chapter 1.1).

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Frenzel goggles are a medical device consisting of spectacles with convex lenses (usually 18 dioptres) and an illumination system. The illumination and enlargement of the eyes through the lens makes it easier to detect changes in the pupil and involuntary eye movements.

Figure 9.3:
Development of statutory alternatives to punishment applied in Austria from 2001 to 2010

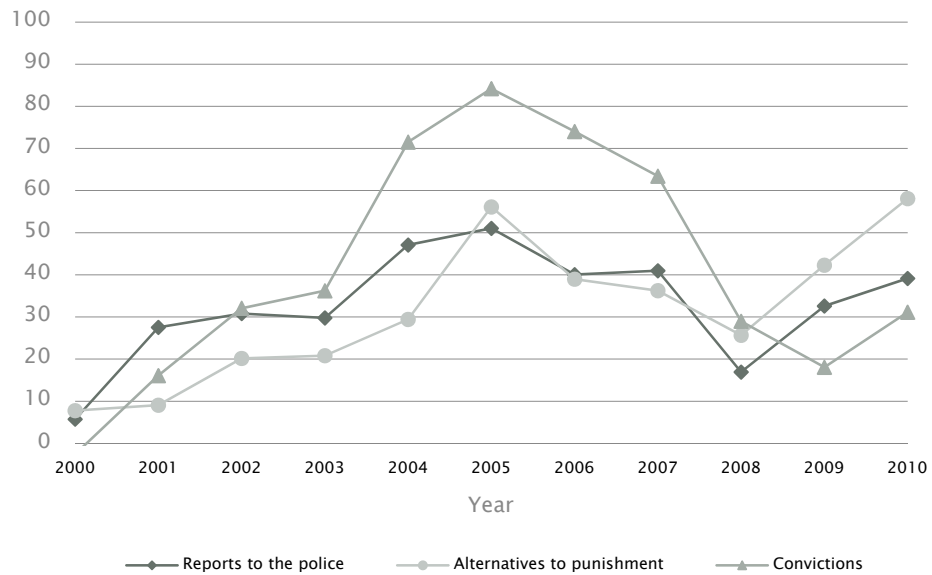


Until 2007: SMG Section 35 = temporary waiving of reports by the public prosecutors.
As of 2008: SMG Section 35 = temporary discontinuation of penal action by the public prosecutors.
The data regarding SMS Sections 35 and 37 were communicated to the Federal Ministry of Health by the public prosecutors and the courts.

Source: BMG; calculation and representation by GÖG/ÖBIG

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 9.4 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 gone down to similar degrees, but a smaller decline shows regarding alternatives to punishment. Since 2008 the shares both of reports to the police and cases where alternatives to punishment are applied have risen to similar degrees. As far as convictions are concerned, this rising trend does not show before 2009, however.

Figure 9.4:
Comparison of the index-related development of reported drug offences, convictions
and application of statutory alternatives to punishment in Austria from 2001 to 2010



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

Information on drug use in prisons is given in Chapter 11. For further details please consult the Selected Issues chapter on drug use in prison of the 2001 report (ÖBIG 2001).

9.5 Responses to drug-related health issues in prisons

Interventions regarding drug-related health issues in prison are discussed in Chapter 11.

9.6 Reintegration of drug users after release from prison

The majority of reintegration measures for drug users is also open to former prisoners. For further information on interventions aimed at reintegration after release from prison please consult Chapter 11.

10 Drug Markets

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 *ChEck iT!*⁵⁵ as well as BMI/.BK (see ST13, ST14 and ST15) and AGES⁵⁶. The data on availability are from Flash Eurobarometer and the analysis on addiction patterns of behaviour among young people in Lower Austria.

10.1 Availability and supply

While more than 95% of young people interviewed for Eurobarometer (Gallup Organization 2011; see also Chapter 2.2) said it was fairly easy or very easy to obtain alcohol and/or cigarettes within 24 hours, the shares indicated for obtaining illicit drugs are much lower: cannabis: 48.2%; ecstasy: 16.1%; cocaine: 11.7%. According to the survey, young people in Austria think that illicit drugs are less easily available than the European average.

The study on addiction patterns of behaviour among young people in Lower Austria (Bittner et al. 2010; see also Chapter 2.2), similar to the Eurobarometer survey, also shows that indications of easy access to both legal and illicit drugs go up parallel to the age of respondents. In the age group from 16 to 18, around 80% thought that it was easy to get alcohol and cigarettes, and 48.4% of girls and 38.4% of boys said it was fairly easy or very easy to obtain cannabis. As a rule, greater percentages of girls than boys indicated easy availability of each type of drug.

In both studies, the figures relating to availability of illicit substances are below those of the latest ESPAD survey (Strizek et al. 2007; see also GÖG/ÖBIG 2010a).

Following intensive media coverage of mephedrone use in the first half of 2010, experts and the media have been discussing the problem of easy access to **research chemicals** (see Chapters 1.1, 4.2 and 10.3), i.e., new synthetic psychoactive substances

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ChEck iT! is a cooperation project of the Vienna Social Projects Association (VWS) and the Institute of Medical and Chemical Laboratory Diagnostics of the Medical University of Vienna. *ChEck iT!* offers lab analyses of psychoactive substances at music events (parties, raves ...).

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The Austrian Agency for Health and Food Safety (AGES), on behalf of the Ministry of Health, regularly analyses products sold in head shops.

also known as **legal highs** that are sold in head shops⁵⁷ or on the Internet and also in the street, in colourful packaging and under fancy names such as Miaow, Blow or NRG, purportedly as bath salt or fertilizer. However, these substances may also be obtained online in bulk form and under their chemical names, as they are (officially) sold for research purposes, i.e., as research chemicals in the true sense of the word. So far, the Austrian media have primarily focused on mephedrone (MCC), which was included in the list of illicit substances under the SMG in August 2010 (see Chapter 9.1). Many research chemicals are in the phenethylamine family (3-fluoromethamphetamine, 2- or 3-fluoroamphetamine, etc.) or the cathinone subgroup (mephedrone, butylone, etc.). Another relevant group of substances is synthetic cannabinoids. The latter are found as ingredients of incense blends (herbal smoking blends) and seem to have replaced Spice.

In 2010 alone, the EMCDDA registered 41 new substances. They all come from Asia (typically China), where the majority of them is produced in large quantities, and little, or virtually nothing, is known of their possible effects and risks. Therefore research chemicals are a great challenge for both prevention and legislation, in particular as producers may easily exchange substances that have been banned and use other legal substances instead. There is concern that in this way, also very dangerous substances (of great toxicity and high potential for addiction) may enter the market. Because of the manifold variations of available substances, this issue is likely to remain on the agenda also in future years.

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. As of 2009, ecstasy pills have tended to be replaced by significant quantities of synthetic cathinone derivatives, the majority of which is not covered by the existing drug legislation. Amphetamine and methamphetamine are primarily imported from Eastern Europe (BMI 2011).

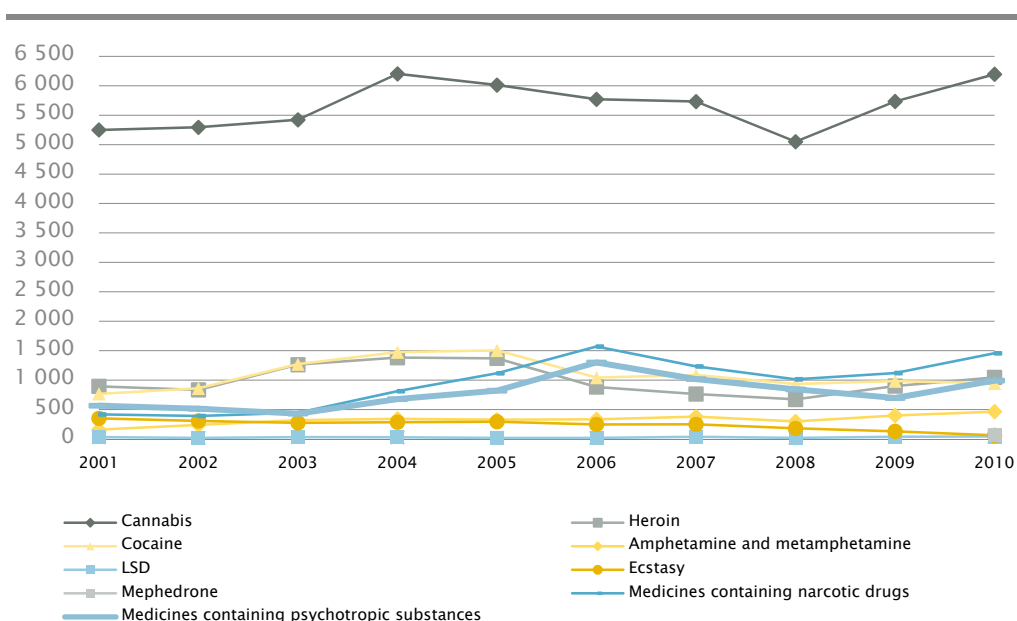
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Head shops are small shops selling hookahs and other smoking paraphernalia as well as books and legal (mildly) psychoactive natural products.

Compared to 2009 the quantities seized have remained at the same level or slightly risen for the majority of substances. What is remarkable is the decline in ecstasy seizures, which might confirm the assumption that ecstasy has partly been replaced by mephedrone (see Figure 10.1, Table A17 and Chapter. 9.1).

The quantities of drugs seized have shown considerable variations in the course of time (see Table A18). One has to bear in mind here that individual seizures of large amounts which often are not intended for Austria (transit) distort the general picture.

Figure 10.1:
Number of seizures of narcotic drugs and medicines with psychotropic ingredients in Austria from 2001 to 2010



Note *: Psychotropic medicines are pharmaceutical products with effects on a person's mental state.

Source: BMI/.BK 2011; representation by GÖG/ÖBIG

10.3 Price/purity

In the context of the *ChEck iT!* project (see Chapter 2.3) a total of 459 samples bought as psychoactive substances were analysed at 11 music events of the party and clubbing scenes in the provinces of Vienna, Lower Austria and Burgenland in 2010. Again, the increasing importance of research chemicals shows: in approximately 20% of all samples tested, substances of this group were detected. The analyses covered a total of 76 pills bought as ecstasy, 91 powder samples referred to as MDMA, 124 speed

samples, 58 cocaine samples and 52 powder samples bought as legal highs or research chemicals (VWS 2011d).

The share of substances bought under the name of ecstasy that did not contain pharmacologically active ingredients other than MDMA⁵⁸ (or MDE/MDA) was only 21% and, as in 2009, has thus again been small (in 2006 it was as high as 75%). On average, one tablet contained around 50 mg of MDMA. Almost half of all ecstasy pills analysed (47%) contained legal piperazine derivatives either as their only, or as an additional, ingredient (see Tables A19 and ST15). As in the year before, the piperazine derivative that was found most frequently was meta-chlorophenylpiperazine (mCPP). 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.

Another aspect worth mentioning is a rising share of powder or crystalline samples that were handed over for analysis: from 23 samples in 2009 to 91 in 2010 (see Table A20). This might result from the belief in the scene that MDMA powder is particularly pure. However, in 2010 only 52% of these samples contained only MDMA (or MDE/MDA) without any other pharmacologically active ingredient. The average content of MDMA was around 580 mg per gram, while 35% of powder or crystalline samples that were referred to as MDMA also contained research chemicals, mostly mephedrone. Great differences in the price of one gram of MDMA were found: between 30 and 140 euros.

Only 15% of the substances bought as speed and analysed by *ChEck iT!* contained only amphetamine as a pharmacologically active component. Around 60%, apart from amphetamine, also contained caffeine (see Table A20). At the end of January 2011, para-methoxyamphetamine (PMA) was detected in an ostensible speed sample. In past years PMA and PMMA, a substance related to PMA, have repeatedly led to the death of users in Europe. Therefore a warning was issued via the Austrian and European early warning system. As it turned out later, already early in January one person had died in Styria after using a speed sample that contained PMA.

Regarding products referred to as cocaine and analysed by *ChEck iT!*, just 14% actually contained only cocaine without any other pharmacologically active substance. In 50% of the cocaine samples, levamisole was detected, a phenomenon also showing in other European countries. The most dangerous possible side-effect of levamisole is a change in the blood composition and a weakened immune system, which in turn may cause

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3,4-methylenedioxy-N-methylamphetamine

potentially lethal infections. The second-most frequent additive was phenacetin (in 34% of samples). Phenacetin used to be administered as a pain killer and to bring down fever, but because of its carcinogenic risks and associated renal problems caused by combinations of phenacetin and other analgesics, this substance was withdrawn from the market.

A share of 79% in a total of 52 samples bought as research chemicals or legal highs, either as powders or as pills, actually contained research chemicals. The substance most frequently found was mephedrone, which had been legal until August 2010 in Austria.

The Austrian Agency for Health and Food Safety (AGES) analysed more than 50 herbal blends sold in Austrian head shops. The following (synthetic) cannabinoids were found: JWH-015; -018; -019; -073; -081; -122; -200; -210; -250; pravadoline; oleamide, RCS-4 and AM-694. Several of these substances have been included in the substances regulated under the Act on Pharmaceutical Products since 2009 already. A great variety of products and product names exist, and AGES tested a total of over 50 different products. Often, certain products were available only for a certain time. The results of the analyses indicate that, as a rule, products with identical names and identical packaging also contain identical substances. If one of the substances is prohibited in a number of countries, the corresponding products tend to disappear from the market and are replaced with other 'new' synthetic cannabinoids. One has to bear in mind, however, that this interpretation by GÖG has been based on a (still) small number of data.

Information by the Ministry of the Interior on the purity and prices of various drugs sold at street level is given in Table 10.1 (see also ST14 and ST16). As in previous years, a considerable variation of the potency of drugs sold at street level was noted.

Table 10.1:

Purity and price (EUR per gram*/pill**) of various drugs sold in the streets in 2010

		Herbal-cannabis*	Cannabis resin*	Brown heroin*	White heroin*	Cocaine*	Amphetamines*	Ecstasy**	LSD**
Purity	Minimum	0.3%	0.1%	0.1%	20.0%	0.1%	0.7%	6.9%	-
	Maximum	21.1%	55.0%	50.0%	77.0%	93.5%	27.3%	100%	-
	Median	6.8%	7.4%	11.5%	20.0%	23.2%	6.0%	9.6%	-
Price	Minimum	5	5	-	-	70	15	5	30
	Maximum	10	10	-	-	120	30	10	35
	Typical	8	8	-	-	80	20	8	30
	According to <i>ChEck iT!</i>					80-100	10-35	10	

Note: These data provided by the Ministry of the Interior are based on information by undercover police agents. For the individual drugs, between 3(!) and 440 purity analyses were carried out.

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

Part B

Selected Issues

11 Drug-related Health Policies and Services in Prison

Two aims of the EU Drugs Action Plan 2009–2012⁵⁹ include monitoring of drug abuse and high-risk behaviour as well as providing access to health care for drug users in prison. The EU Drugs Action Plan also underlines the need to develop and implement prevention, treatment, harm reduction and rehabilitation services for people in prison, equivalent to services available outside prison.

This Selected Issues chapter describes the Austrian prison system and prison population and in particular the availability of drug-related health care services in the prisons of Austria.

The information given in this chapter primarily comes from personal communication with Senior Public Prosecutor Karin Dotter-Schiller⁶⁰ and Andrea Moser-Riebniger of the Ministry of Justice (BMJ) as well as data collected by the Prisons Directorate of the BMJ. Other data have been provided by the judicial criminal statistics maintained by Statistics Austria as well as the *Neustart* association (probation assistance). Further sources include academic publications, internal decrees, national and European legislation, a publication by the Federal Ministry of Justice, annual reports of drug advisory and treatment services as well as Standard Questionnaires SQ27 and SQ23/29. In addition, the provincial Addiction and Drug Coordination Offices have provided relevant information.

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Please consult

http://europa.eu/legislation_summaries/justice_freedom_security/combating_drugs/jl0019_en.htm

(7 July 2011)

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We are especially indebted to Dr. Karin Dotter-Schiller and Mag.^a Andrea Moser-Riebniger of the Ministry of Justice. Their expertise has been a most essential contribution to this chapter.

11.1 Prison systems and prison population: Contextual information

Austria's **prison system** consists of 27 prisons (including one for female prisoners and one for young people) and the Vienna Juvenile Court Representatives' Office⁶¹. The Federal Ministry of Justice is the highest administrative and law enforcement authority and thus in charge of strategic planning. The Prison Directorate is an authority directly reporting to the BMJ and performing operative tasks.

Austria's prisons have capacities for 8 527 people. Table 11.1 below gives an overview of the numbers of prisoners at three selected dates of reference. The figures show that the share of women among the total number of prisoners is around 6%. Young people account for a share of around 2% in overall prison population, and approximately 22% are pre-trial detainees.

Table 11.1:
Inmates in Austrian prisons and detention or custody centres as at 1 December

Prison population	2008	2009	2010
Men	7 766	8 186	8 251
Women	482	522	562
Total	8 248	8 708	8 813
Of these:			
young people	184	172	193
people in pre-trial detention	1 785	1 994	1 909

Note: Pre-trial detainees (with a few exceptions) are detained at the court detention centres of the competent trial court (Hofinger, Pilgram, undated).

Source: Moser-Riebniger, personal communication; representation by GÖG/ÖBIG

Table 11.2 gives the monthly prison population of 2010. The figures show a pronounced rise from January to March 2010, and in December they are around 5% above the figures of January.

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<http://strafvollzug.justiz.gv.at/einrichtungen> (7 July 2011); text in German

The Vienna Juvenile court representatives provide specific assistance to juvenile offenders or offenders under age, they assist the guardianship court and deliver services in the context of criminal justice. The Vienna juvenile court representatives, as part of a comprehensive assistance and care network, deliver services to young people of either sex who are in pre-trial detention or in prison. They also provide assistance with regard to diversion programmes and provision of community services.

Table 11.2:
Number of inmates per month in 2010

	Jan.	Feb.	March	April	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
Number	8 365	8 629	8 719	8 775	8 671	8 663	8 664	8 592	8 597	8 567	8 640	8 813

Source: Moser-Riebinger, personal communication; representation by GÖG/ÖBIG

Table 11.3 gives an overview of the number of newly imprisoned people in Austria's prisons from 2001 to 2010. Again, the total number of new women prisoners is considerably lower than the number of men. Between 2001 and 2010 the shares of women in prison are between 9% and 11%, with a slight rise as of 2008.

Table 11.3:
Newly imprisoned people in Austrian prisons, by gender and age from 2001 to 2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Male younger youths	674	777	1 168	1 174	740	694	682	554	639	622
Male older youths	1 130	1 395	1 500	1 726	1 755	1 420	1 403	1 152	1 222	1 207
Male adults	9 526	10 544	10 634	11 024	10 724	10 177	10 206	8 902	9 249	9 172
Total (male)	11 330	12 716	13 302	13 924	13 219	12 291	12 291	10 608	11 110	11 001
Female younger youths	56	79	76	112	64	57	42	70	70	69
Female older youths	91	107	127	101	116	95	112	75	109	99
Female adults	886	1 001	1 040	1 014	980	958	960	888	906	1 030
Total (female)	1 033	1 187	1 243	1 227	1 160	1 110	1 114	1 033	1 085	1 198
Total (male+female)	12 363	13 903	14 545	15 151	14 379	13 401	13 405	11 641	12 195	12 199

Note: Younger youths = 14 to 18 years; older youths = over 18 to under 21 years.

Source: Moser-Riebinger, personal communication; representation by GÖG/ÖBIG

After this statistical description, the figures relating to annual **convictions** because of drug offences in Austria will be discussed. Figure 11.1 and Table A13 of the judicial criminal statistics show the trend regarding number of convictions because of violations of Sections 27 and 28 of the Narcotic Substances Act (SMG). Following a continuous decline in convictions under the SMG from 2006 to 2009, in 2010 a new rise has been registered (4 363 convictions as against 3 928 in 2009). The number of prison sentences without probation has gone up as well (n = 1 381). The share of convictions for violation of the SMG in the total number of convictions in Austria has also seen a rise by 1 percentage point (to 11.4%) compared to 2009. Again the number of misdemeanours (SMG Section 27)⁶² has been considerably higher than the number of

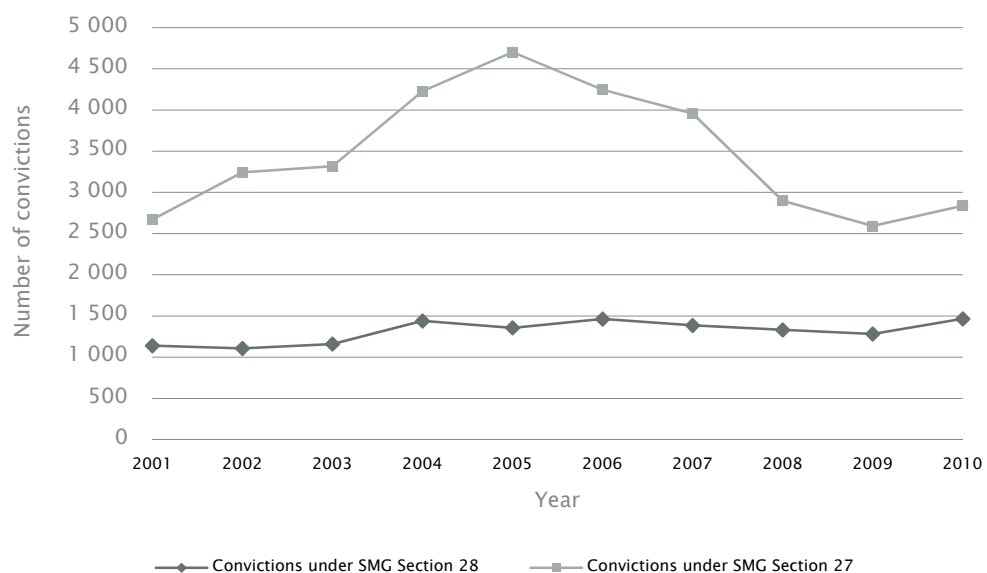
62

The term misdemeanours relates to a violation of Section 27 of the Narcotic Substances Act (SMG) i.e., illicit handling of narcotic substances.

felonies (SMG Section 28)⁶³: 2 838 v. 1 466. The share of felonies in convictions under the SMG was 34% in 2010 (2009: 33%).

Table A15 provides an overview of convictions broken down by age and reason for conviction. In 2010 a rise showed compared to 2009 regarding both young people and adults. This year also saw an increase in both people punished with a fine and people punished with imprisonment without probation. The number of young people convicted because of felonies was similar to past levels, while the corresponding number of adults had gone up. Convictions because of misdemeanours rose for both young people and adults.

Figure 11.1:
Convictions according to Sections 27 and 28 of the SMG in Austria from 2001 to 2010



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 (judicial criminal statistics); representation by GÖG/ÖBIG

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The term felonies relates to violations of Sections 28 and 28a of the Narcotic Substances Act (SMG), i.e., preparation for drug trafficking or drug trafficking.

As in 2009, 74% of convictions for violation of the SMG resulted in prison sentences (2008: 71%), with prisons sentences suspended on probation accounting for 38% of all prison sentences (2009: 42%). This is a further decline compared to previous years. The share of young people sentenced to imprisonment was 3.5% (2009: 3.7%), and for 2.1% the prison sentence was suspended on probation (2009: 2.4%), i.e., their shares are slightly smaller than in 2009 in both cases.

A detailed discussion of the statistics on convictions in Austria is also given in Chapter 11 of the 2008 report (GÖG/ÖBIG 2008c). For lack of data, the main offences described cannot be broken down into subgroups.

The *Neustart* association provided data on clients receiving release assistance⁶⁴ or probation assistance. Table 11.4 shows the number of new clients receiving release services in a specific year as well as the total number of clients and the share of women, which has been around 8% over the years. The share of clients convicted because of drug-related offences is around 20%.

Table 11.4:
Release assistance provided in Austria

Number of clients	2006	2007	2008	2009	2010
New clients in the respective year	4 256	5 444	4 441	4 035	3 850
Total number of clients	5 263	5 353	5 049	4 759	4 458
of these: women	–	403	404	346	350

Source: Hovorka, personal communication; representation by GÖG/ÖBIG

Table 11.5 lists people who have received probation assistance in the past five years. The share of young people (excluding cases of diversion) is around 30%, and the share of women (including diversion) is approximately 13.5%. Around 10% of clients receiving probation assistance were convicted because of violation of the SMG.

Table 11.5 also provides information on people who received probation services exclusively in the context of diversion. In this group the share of young people went down from almost 60% in 2007 to 50% in 2010. Regarding this type of service, the share of clients who committed SMG-related offences is 3.2%.

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Release assistance – different to probation assistance, which is compulsory – is an advice and support service that former prisoners may use voluntarily in the last six months before release and at the critical stage immediately afterwards. Release assistance focuses on integration (e.g., housing, employment) in addition to general advice and support.

Table 11.5:
Data on probation assistance in Austria

Number of clients	2006	2007	2008	2009	2010
New clients in the respective year (without diversion)	2 572	3 062	3 982	4 051	4 041
Clients as at 31 December (without diversion)	6 928	7 476	8 478	9 287	9 980
of these: young people	2 298	2 479	2 607	2 691	2 822
Clients as at 31 December (including diversion)	7 277	7 925	8 984	9 737	10 421
of these: women	1 055	1 121	1 210	1 210	1 350
New clients in the respective year (only diversion)	–	297	334	256	266
of these: young people	–	174	179	126	131
Clients by 31 December (only diversion)	349	449	506	450	441

Note: Diversion as an alternative to criminal charges is ordered by the public prosecutors. Charges may temporarily be suspended and, for instance, a probation period of one year may be defined during which probation assistance is mandatory.

Source: Hovorka, personal communication; representation by GÖG/ÖBIG

Information on **characteristics of prisoners** may be derived from current estimates of drug use during imprisonment. For instance, Spirig et al. (2010b)⁶⁵ indicate a share of 20% to 30% regarding injecting drug use (see Chapter 11.5). If use of other drugs (e.g., cannabis, abuse of medicines) is also taken into account, a share of up to 50% of prisoners are estimated to be regular drug users. This share goes up further if occasional drug use is also included.

Regarding training and employment situation of imprisoned drug users, Eisenbach–Stangl et al. (2010; see also Chapter 8.2)⁶⁶ state that all drug clients surveyed in Vienna had completed compulsory school and more than half of them had completed vocational training. Similarly, in his study⁶⁷ Lipphart–Kirchmeir (2008) also found that less than half of imprisoned drug users had not completed apprenticeship.

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For a study by Eisenbach–Stangl et al. (2010) qualitative interviews were conducted with 19 senior drug users (i.e., opioid users aged 35 or over) at the prison of Favoriten, Vienna, and the Schweizer Haus Hadersdorf inpatient treatment centre in Vienna.

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Ibidem

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In the context of his thesis on the current situation of drug use in prison and prospects for the future, Harald Lipphart–Kirchmeir studied 634 case files of prisoners from December 2005 to June 2006, and in addition, interviewed prisoners and staff at six prisons.

11.2 Organization of prison health policies and service delivery

The provision of general **health care** in prisons in Austria is regulated in the Act on Prisons (StVG; BGBl 1969/144 v. 26. 3. 1969) and the Narcotic Substances Act (SMG; BGBl I 1997/112 v. 5. 9. 1997), several internal decrees and the European Prison Rules (EPR). The delivery of general health care services in prisons is financed by public funding through the Federal Ministry of Justice (BMJ).

The principle of equivalence of care⁶⁸ as laid down, e.g., in the European Prison Rules, also applies in this case, and consequently, also prisoners have access to opioid substitution treatment even though this is not explicitly regulated in the Austrian Act on Prisons.

At present, the health care staff of Austria's prisons comprises 213 people (doctors, therapists and nurses), i.e., approximately 27 health care staff for every 1 000 prisoners. At present, the prison administration department employs additional 93 full-time equivalents (in terms of 38-hours weeks) recruited through the Judicial Support Agency (JBA)⁶⁹.

As no national drug strategy exists for Austria (see Chapter 1.1), no strategy papers for **drug-related health services in prison** have been drawn up either. In Chapter 11.3 the available drug-related health care services are described in more detail. In order to prevent or reduce misuse of substances to the greatest possible degree, strategies regarding imprisoned drug users have been adopted at both national and regional levels and for individual prisons. For instance, 2009 saw the update of a publication by the Federal Ministry of Justice on treatment of addicted prisoners during and after their stay in prison in Austria (BMJ 2009; see also GÖG/ÖBIG 2010a).

In this regard responses to substance abuse also deserve mention. If prisoners abuse alcohol, illegal substances or legal drugs that have not been prescribed, sanctions are imposed under the Act on Prisons. In the case of abuse of illicit substances, the incident is also reported to the public prosecutors. All forms of substance abuse

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According to the principle of equivalence of care, treatment services in prison shall be equivalent to services available outside prison.

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The Judicial Support Agency (JBA) is a public corporation which, against payment, supplies qualified staff to prisons and custody centres for mentally ill offenders. The JBA has a statutory obligation to operate and is fully owned by the Republic of Austria.

described above result in administrative penalty proceedings⁷⁰ and prisoners may lose any privileges previously granted.

In order to ensure the necessary cooperation of all actors in the health and social care sector, cooperation structures have been established between the prison administration and the relevant institutions and service providers, mostly at regional level. In addition, the provincial governments and district authorities are integrated in the cooperation network. Health care for prisoners is provided by health care and treatment services, often in cooperation with external organisation, e.g., Dialog (see Chapter 11.3).

11.3 Provision of drug-related health services in prison

In the prisons, a variety of **treatment** services are available depending on demand and the decision of individual prisons. The most frequent forms of treatment include maintenance treatment, withdrawal, abstinence-oriented care if desired as well as **prevention**, diagnosing and treatment of HIV, hepatitis C and other infectious diseases. Upon commencing a prison sentence, prisoners get care packages with condoms and leaflets on HIV, AIDS and hepatitis. In addition, **information** events are organised in a cooperation of the Aids Hilfe support association and prison doctors, psychologists and social workers. In the majority of prisons inmates have easy, unobserved access to condoms and disinfectants as a measure of **harm reduction** (Obrist and Werdenich 2007). Other harm reduction interventions include diagnosing and treatment of infections acquired in the context of injecting drug use. However, infection problems have hardly been registered in Austrian prisons. Therefore it is assumed in the Ministry of Justice that other forms of drug use seem to be practised, which is in contrast to the findings of Spirig et al. (2010b; see Chapter 11.5). Needle and syringe exchange is not possible in Austria's prisons.

In 2009 an expert meeting was held in Styria which focused on infectious diseases, medical treatment, OST, harm reduction (e.g., syringe exchange) as well as drug use among prisoners (Amt der Steiermärkischen Landesregierung 2010). An information booklet on preventing infection in prison was prepared, and social workers continue to make visits to the Jakomini Prison of Graz, based on an agreement previously concluded (Ederer, personal communication; see Chapter 7.3).

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Administrative penalty proceedings are instituted if a prisoner violates a provision of the Act on Prisons, e.g., in the case of unauthorised leave, escape, self-harm, etc. The corresponding offences are punishable by reprimand or loss of privileges, fines or segregation.

In order to assess the state of health of new prisoners and, if necessary, start treatment routines, upon commencing a prison sentence all prisoners are examined by a doctor who takes their blood pressure and weight and examines their skin and dental status. In addition, need for medicines and possible addiction to drugs is established. It is upon the doctor to decide which questions to ask regarding a possible period of former drug use. The prison of Favoriten⁷¹, Vienna, is the only prison where drug use in the past is among the standard questions that have to be asked. The treating doctor decides which method or clinical instrument is used for establishing drug misuse of the prisoner in question. Since 2010 the Institute for Addiction Diagnostics (ISD), on behalf of the Social Welfare and Public Health Law Department (MA 40) of the City of Vienna has examined inmates of the prisons of Simmering and Josefstadt in Vienna (Schmidhofer, personal communication).

Under the principle of equivalence of care, combined anti-retroviral therapy (cART) for the **treatment** of HIV infections is available also in prisons. **Drug-related treatment** in Austrian prisons also includes low-intensity cognitive behavioural therapy encouraging prisoners to talk about their drug abuse and activating the resources needed to stop drug use. However, it is not possible at present to provide detailed information on the number and characteristics of people who receive drug-related treatment during their stay in prison.

Since 1999 the Dialog association has provided social work services and medical treatment to detainees in the two police detention centres (PAZs)⁷² of Vienna (Schmidhofer, personal communication). In 2010, Dialog delivered services to a total of 1 749 detained clients in PAZs (2009: 1 533; +14%), which also include interventions specifically addressing women or men (Verein Dialog 2011). Vienna's *ganslwirt* low-threshold centre also provides services to prisoners (VWS 2011b). In Graz the prison of Karlau cooperates with *b.a.s.* so that 10 counselling slots are available to prisoners during the

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The prison of Favoriten is a treatment prison, i.e., in charge of treating offenders who have committed an offence related to narcotic substances and are then referred to Favoriten prison by the court. In addition, inmates of other prisoners who have applied for addiction treatment may also be transferred to Favoriten (<http://strafvollzug.justiz.gv.at/einrichtungen/justizanstalten/justizanstalt.php?id=1>; 13 July 2011); website in German

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Police detention centres (PAZ) are prisons whose management comes under the competence of the Federal Ministry of the Interior (BMI). Different to prisons, the inmates of PAZs are not detained because of a conviction following a criminal offence but rather because of detention to secure subsequent deportation or as a consequence of administrative offences. In sum, more people are detained in PAZs than in prisons, but the average duration of detention is fairly short (Hofinger, Pilgram, undated); http://www.bmi.gv.at/cms/BMI_Presse/_news/BMI.aspx?id=636545376547566B6F54593D&page=1&view=1; 28 July 2011); website in German

pre-release stage (b.a.s. 2011). Also in Styria, workers of *Kontaktladen* and *Streetwork* visit drug users in prison (2010: 115 prison visits) to provide psychosocial support and help inmates prepare for life after release (Caritas Diözese Graz-Seckau 2011).

In several prisons, substitution treatment may be combined with psychosocial support services by psychiatrists, psychologists or psychotherapists, e.g., group counselling, group therapy or individual sessions (Spirig et al. 2010b). People who have already been in substitution treatment before imprisonment may continue OST, and drug users may also enter OST in prison. In the prisons of Josefstadt (Vienna) and Innsbruck, the required dose of substitution medicine can be obtained from a dispenser (Meyer-Philippi, personal communication). As at 1 April 2011 a total of 880 prisoners were undergoing substitution treatment, i.e., approximately 10% of all inmates. According to the thesis by Harald Lipphart-Kirchmeir (2008; see Chapter 11.1), between 3.8% (prison of Graz-Karlau) and 11.5% (prison of Stein) of inmates were in substitution treatment.

The substitution substances most often prescribed are methadone (46% of prisoners undergoing OST), subtitol (31%) and Subutex/Suboxone (= buprenorphine; 18%; BMJ 2011): i.e., methadone is prescribed considerably more often in prisons than outside prisons (see Chapters 5.3 and 11.5). It should also be mentioned that Pont et al. (2005), in the substitution guidelines for prisons, recommend exclusive use of substitution medicines that show the desired effects for at least 24 hours and thus have to be administered only once a day (methadone, buprenorphine, slow-release morphine). From a scientific point of view and for reasons of costs, use of methadone is recommended. However, in the case of intolerance to methadone, prescription of another substitution medicine may be considered, and patients who have started OST before imprisonment should continue to use the medicine they were prescribed when entering treatment.

The above figures relating to the number of prisoners in substitution treatment do not include prisoners who are undergoing another type of drug treatment during imprisonment and are not included in OST programmes. An approximate share of 16% of inmates is estimated to receive some type of drug-related treatment (only OST or only another form of treatment, or OST and/or another form of treatment).

Apart from withdrawal supervised by a doctor or psychiatric or psychological staff, and treatment with substitution substances, a number of prisons, although only prisons for men, also have special drug-free zones (the prisons of Garsten, Hirtenberg, Salzburg, St. Pölten, Sonnberg, Suben and Vienna Simmering; Obrist, Werdenich 2007) where inmates do not use any drugs, alcohol or pharmaceuticals (including substitution medicines). On the one hand, these zones are intended for prisoners who are not addicted to drugs and who want to live in a drug-free environment also in prison, and on the other, they are an opportunity for prisoners who are no longer (physically)

dependent on drugs to move away from the drug scene. According to Eisenbach-Stangl et al. (2010), some inmates see prison also as a safe place where they have the chance to stay clean at least for a certain period. However, the effects that a consistent separation of drug-free zones from other zones actually has on the prison system have not yet been critically assessed.

Numerous services are available that aim at improving the health and social conditions for drug users in prison, depending on the prison, type of imprisonment and individual inmate. For instance, the providers of social services may cooperate with debt advice centres in Vienna or with the Public Employment Service to organise workshops on debt advice, job coaching, employment programmes and AIDS for prisoners at the pre-release stage. All prisons run education and training programmes as well as qualification schemes (apprenticeship, intensive skilled work training, forklift operation training, German language courses and general education courses).

Intensive **rehabilitation** programmes are run to promote social reintegration. They include both substitution treatment and support through therapeutic communities, although the latter are only available either to inmates who are granted prison leave or after release (see SQ27 and also Chapter 11.2). In 2010, 22% of job applicants to *fix und fertig*, a socioeconomic enterprise, were referred by their probation officer or a social service provider of the prison, in order to get a transitional employment after their stay in prison (VWS 2011f).

When a prisoner is released they receive one half of their income earned during imprisonment in order to get them started (the other half is disbursed monthly during imprisonment). Inmates who have worked during the term of imprisonment or who have no employment through no fault of their own have the same rights and duties as people employed in the regular labour market. Therefore, after release the majority of ex-prisoners is entitled to unemployment benefits (Spirig et al. 2010b).

A cooperation network exists with established doctors and psychiatrists in order to assist in the inmates' preparation for release and to ensure a continuity of care services also after release. Regional support centres are also integrated in service provision, and if necessary, the client in question may be admitted to inpatient treatment after imprisonment (see also Chapter 11.2). These services essentially contribute to preventing drug-related deaths after release from prison. A research project by the Addiction and Drug Coordination Office of Vienna (SDW) has shown that between 2005 and 2007, 74 out of 198 people whose deaths were directly related to use of illicit substances had been former prisoners. One third of them died within one month after release from prison: ex-prisoners face a greatly elevated risk of overdoses because after the stay in prison they have a very low tolerance to opioids (SDW 2011a; see Chapter 6.3). In order to respond to this situation, the issue of the high risk of overdoses should proactively be addressed in the context of release assistance. The health

promotion services in prison are rather oriented towards concomitant diseases and responses to overdoses during imprisonment than towards the (risk) situation after release. Obviously, there is need for qualification activities in this field (Amt der Steiermärkischen Landesregierung 2010).

Prisoners are obliged to undergo **drug tests**, and it is upon the prison to decide when tests will be carried out. For instance, prisoners may be tested before they are granted day release or leave to go to work outside prison, if drug abuse is suspected or in the context of withdrawal treatment. Usually, rapid tests with test strips are carried out. Upon request of the inmate, a B-sample may be sent to a laboratory for analysis. The test results are recorded in the plan of imprisonment goals for the inmate in question.

11.4 Service quality

In the context of **quality assurance** of drug-related services in prison, non-standardised reports are submitted to the Prisons Directorate, an authority directly reporting to the Ministry of Justice. The available data do not permit standardised quality assurance routines and no such routines are thus performed.

At present, standards are under preparation in line with those described in Section 21 of the Act on Prisons, and they will cover the provisions of Section 22 (treatment of prisoners) and Section 68a (withdrawal treatment of prisoners) of the Act on Prisons. An updated publication by the Federal Ministry of Justice (BMJ 2009; see also GÖG/ÖBIG 2010a) includes practical guidelines for the treatment of addicted prisoners during and after imprisonment.

In accordance with an internal decree by the Ministry of Justice, opioid substitution treatment in prisons is delivered on the basis of the substitution **guidelines** for prisoners⁷³ (Pont et al. 2005), which include a separate chapter on specific aspects of OST during imprisonment (indication, supervision, etc.; see Chapter 11.3).

Drug abuse in prison is a particular challenge for the providers of health care services discussed in Chapter 11.2. A revision of the existing drugs guidelines is planned, which is expected to bring about defined quality standards and to promote professional service delivery.

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Internal decree by the Federal Ministry of Justice of 26 January 2006, JMZ 52203/0001-V1/05

Regular **training** programmes for prison staff are needed in order to communicate the knowhow they need with regard to prevention, risk awareness and harm reduction, and thus to ensure adequate interactions with inmates and adequate use of their own resources. Such training takes place intermittently in the context of in-house courses that consist of individual modules on management, information technology, social skills and health as well as legal matters and administration. For instance, the module on inmates included crisis intervention and prevention of suicide as well as interactions with specific groups of prisoners and imprisonment under eased conditions. The issues of drugs and immigrant prisoners were also addressed.

Following a pilot project implemented in Berlin in 2003, which provided evidence of the fact that the antagonist drug of naloxone could sensibly be dispensed to specially instructed drug users for self-administration, a first-aid training course including naloxone administration was held in Styria in cooperation with doctors providing substitution treatment. At the course two instructional films were shown, and services provided in prison were also included (Amt der Steiermärkischen Landesregierung 2010).

11.5 Discussion, methodological limitations and information gaps

In Austria, drug-related health policy and the institutions and organisations delivering health care generally aim at ensuring equality of treatment both in prisons and outside, in line with the corresponding legislation. However, it has not always been possible to meet this goal in both respects. For instance, outside prison, regional differences do exist with regard to availability of substitution treatment by established doctors (see Chapter 5 and Map 5.1), and in prison, the types of substitution medicines most frequently administered to inmates differ from those dispensed to patients outside prison (see Chapters 5 and 11.3).

Although substitution treatment is available in every Austrian prison, considerable differences are found regarding quality of implementation. For instance, prisoners in OST often face restrictions or discrimination such as exclusion from certain types of work or refusal of eased conditions, which is in fact contrary to the purpose of substitution treatment and against the principle of equivalence of care (Spirig et al. 2010b). The study⁷⁴ by Gegenhuber et al. (2008) also reports instances of restrictions or

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From 2005 to 2007 a research project took place at European level which also included three Austrian prisons. This project was followed by a survey on behalf of the Austrian Federal Ministry of Justice conducted from November 2007 to January 2008. In this context 123 staff (approx. one third of them women) and 183 male inmates of additional 13 prisons were interviewed (Gegenhuber et al. 2008; see GÖG/ÖBIG 2009b).

discrimination. In eight out of the total of 16 prisons included in the survey it was not possible for inmates in substitution treatment to be transferred to a department with open prison⁷⁵ conditions. In six of the prisons surveyed, these prisoners were not granted day release or prison leave in order to go to work outside the prison. According to Gegenhuber et al. (2008), the majority of prisoners interviewed (83.5%) said that in their latest OST before imprisonment they had a say in the choice of substitution medicine. This applies to only half of respondents undergoing substitution treatment in prison (44.3%).

Outside prison it is not always possible either to choose among treatment centres, and access to treatment may also be restricted, especially in a situation of increasingly tight budgets (see Chapters 1.1 and 11.2). Although outside prison, (free) exchange of needles and syringes is not equally available all over Austria, such services do exist, but in prison, needle exchange is not possible at all. This shortcoming should be discussed at political level, and needle and syringe exchange services should be established in prisons as soon as possible.

After a recent change in the relevant legislation, the Federal Ministry of Justice will take over the cost of inpatient treatment for a maximum of six months only, and if no other cost-coverage option is possible, patients might be refused further treatment even though they would need it. This could result in larger numbers of patients having to terminate the current treatment too early and thus having to spend time in prison because treatment as an alternative to punishment is no longer available. Possible problems in this regard should be studied in more detail.

In this context, the issue of incomplete data also deserves mentioning: data on drug-related treatment of prisoners are not entered in the DOKLI database of clients receiving drug treatment and care services (see Chapter 5). Therefore it is impossible to compare drug-related treatment in prison and outside, or differences in drug treatment between prisons. A nationwide standardised uniform documentation system of examinations and treatment in prison would indeed be needed. At present, an essential basis for quality assurance is thus lacking and documentation requirements vis-à-vis the European Union cannot be met, therefore activities in this regard are urgently needed, as is gathering (at least by spot-checking) of substance-related data according to ST 12 (prevalence and forms of drug use, etc.).

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Open prison means that there are no, or only few, safeguards against escape. Prisoners who strictly obey certain rules (e.g., prohibition of alcohol and obligation to return in time) are allowed to leave the prison in the morning to go to work.

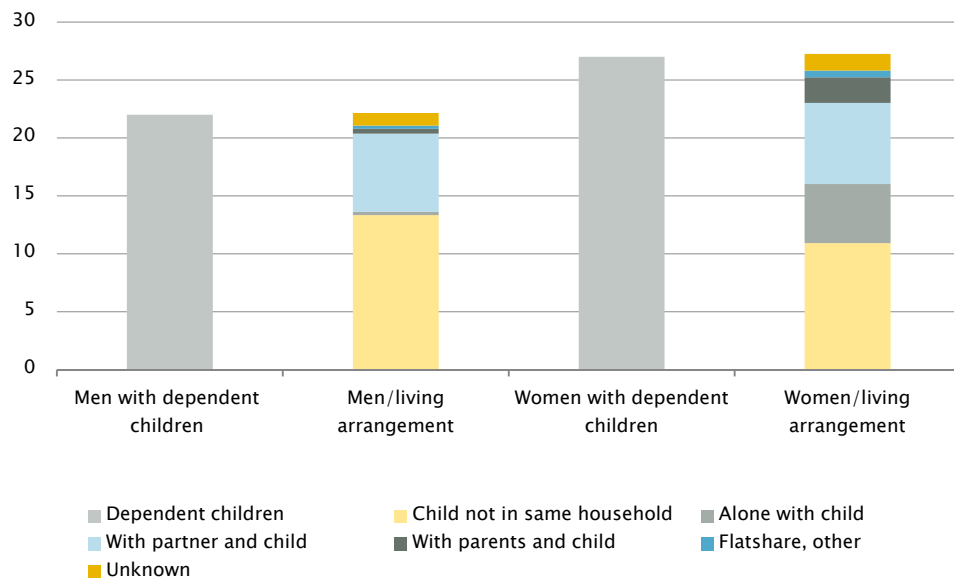
As has already been discussed in Chapter 11.4, reports relating to a possible drug addiction are communicated to the Prisons Directorate in a non-standardised way. The Prisons Directorate is aware of the necessity of conducting surveys and studies on drug issues in prison. The planned revision of the existing drug guidelines and preparation of quality standards could improve the situation.

12 Drug Users with Children

Drug-using parents and their children are often facing numerous problems and in recent years have been identified as a target group for whom specific, and often complex, services are required. The corresponding interventions are taken at several levels and usually pursue several goals at once. It is particularly important to have a network in which different services and areas of service provision are linked. The data sources used in order to assess the situation in Austria include the DOKLI and BADO documentation systems (see Chapter 5), the AIDS statistics (see Chapter 6) as well as studies, comments and reports by experts as well as the Addiction and Drug Coordination Offices of the provinces and the Addiction Prevention Units.

12.1 Size of the problem

Figure 12.1:
People starting long-term drug-related treatment in 2010, by indications of dependent children they have to support (percentages)

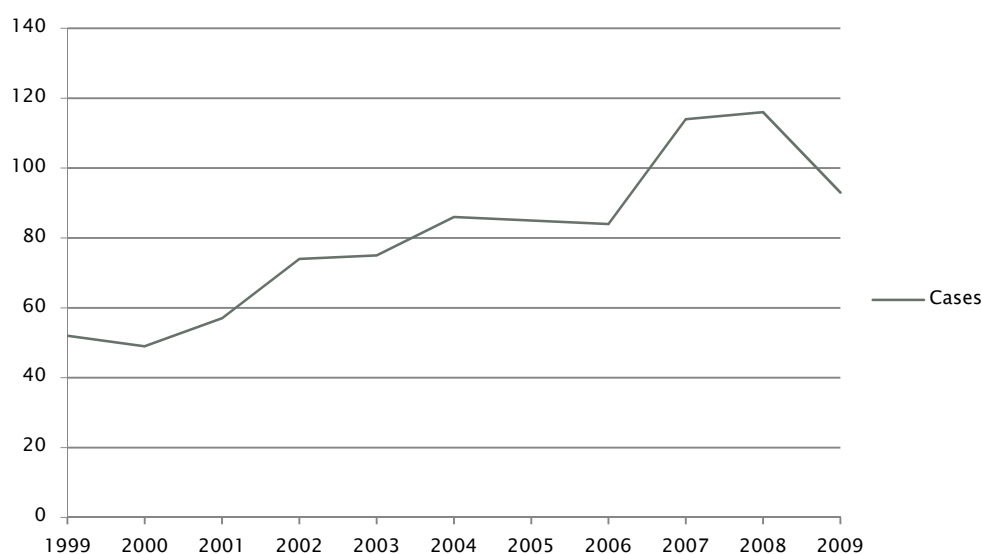


Source: DOKLI analysis of client year 2010; representation by GÖG/ÖBIG

An analysis of DOKLI data (see Chapter 5.3 and Tables A23 to A28) shows that 26% of women and 21% of men in long-term drug treatment have dependent children (see Figure 12.1). A share of 12% of women and 3% of men whose children are living with

them are single parents. 40% of women and 66% of men are living in a household with their children and their partners. These figures are confirmed by other reports (e.g. de Cordoba et al. 2004), according to which around 60% of pregnant women addicted to opioids have a partner who is also dependent on drugs, and around 40% of them are living with their partners. The DOKLI data do not indicate relevant differences between women or men with children and without children. The 2009 analysis of the BADO documentation of clients of drug treatment and care centres in Vienna gives a slightly higher share of women than of men with children (33% v. 25%).

Figure 12.2:
Number of newborns with NAS according to ICD 10 from 1999 to 2009



Source: BMG-DLD 1999-2009; representation by GÖG/ÖBIG

The ICD-10 diagnoses for Austria may also provide relevant information. From 2000 to 2009, a rise in the number of newborns with neonatal abstinence syndrome has shown (see Figure 12.2), which corresponds to reports by various sources on an increase in births by women addicted to narcotic drugs. The addiction clinic of General Hospital Vienna registered a rise in births from 15 in 1995 to between 50 and 60 in 2007/08 (BMG 2009). From 1995 to January 2008, a total of 478 pregnant drug users received treatment in the addiction clinic. According to the Addiction and Drug Coordination Office of Vienna (SDW 2011b), Vienna has seen an increase from 30 addicted mothers giving birth in 1994 to 87 in 2010. The largest number of births (112) was registered in 2008.

Children of addicted parents are facing **numerous problems**. For instance, drug use during pregnancy may result in organic or physical damage (tendency to premature birth, adverse effects on child development, etc.) as well as neonatal abstinence syndrome among new-born babies. The addiction of parents also has massive psychosocial consequences for the child such as delayed development and behavioural disorders or problems because of neglect. The situation of families with addiction problems is characterised by playing down the problem and by denial, blaming of others as well as helplessness and stress.

Hardly any specific data on the situation of addicted parents and their children are available in Austria. Apart from the data on NAS mentioned above, the AIDS statistics (BMG 2011; see Chapter 6) are a relevant source of information: since 1983, 14 cases of AIDS and 10 AIDS deaths have been registered among children who were under 13 when the infection was diagnosed and whose mothers had indicated injecting drug use as the mode of transmission. The majority of other studies in this field focus on measures to reduce the risk of adverse health consequences for new-born babies. In this context, the project on drug addiction and pregnancy started in 1994 at the Vienna Psychiatric University Hospital plays an important role, as does the Comprehensive Care Project initiated as a consequence of the former project, which focuses on drug-using pregnant women and their children (see Chapter 12.3 and EDDRA). Several publications (e.g., de Cordoba et al. 2004) underline the good results of interventions in this context, e.g., the reduction from 20 days in 1995 to 5 days in 2008 of the average withdrawal stage of babies, the good retention rate of patients (89%) and the high share (nearly 80%) of neonates who were discharged from hospital with their mothers (see Fischer 2009).

A number of research studies on opioid-using mothers and their children have been carried out and published. Below, an overview of the most relevant publications and results is given. First, studies on treatment during pregnancy and its effects on NAS are discussed, followed by results relating to the later development of the children.

In 2000 the results of one of the first controlled prospective studies⁷⁶ on buprenorphine treatment of pregnant women were published. Until then, pregnant drug users had exclusively been treated with methadone. Buprenorphine turned out to be well tolerated by the patients (Fischer et al. 1998). Eight of the neonates did not show any NAS symptoms, and another four did show symptoms but did not have to be treated, and the rest of babies (three) had to be treated for neonatal abstinence syndrome.

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This pilot study was conducted as an open study and included 15 women who were administered buprenorphine after the first trimester.

Comparative studies were then carried out, e.g. by Fischer et al (2006)⁷⁷, in which 18 women were treated with either methadone or buprenorphine from the 24th to 29th weeks of pregnancy. The retention rate was slightly higher among the mothers in the buprenorphine group while use of additional drugs was significantly less frequent among those in the methadone group. Eight neonates showed NAS symptoms, and those in the methadone group slightly earlier than those of the other group. In both groups, the subsequent NAS treatment of the babies was shorter than in other studies, which the authors attribute to the standardised morphine treatment of the women.

In another comparative study (Ebner et al. 2007)⁷⁸, pregnant users of opioids received oral methadone, buprenorphine or slow-release morphine: 40% of the new-born babies did not require NAS treatment (they showed no, or only mild, symptoms). In this regard, the advantage of buprenorphine was obvious: as many as 79% of the neonates in this group did not need treatment, compared to only 32% in the methadone group and 18% in the morphine group. A share of 60% of new-born babies suffered from symptoms that required treatment, but no severe NAS complications showed. The babies with NAS were treated with morphine hydrochloride or phenobarbital, with significant differences as to the necessary duration of treatment: on average, morphine hydrochloride had to be administered for 10 days only, compared to 18 days in the case of phenobarbital.

In the MOTHER study⁷⁹ at eight sites in the U.S., Canada and Austria (Vienna Medical University, Department of Psychiatry and Psychotherapy), pregnant women addicted to opioids were treated with either methadone or buprenorphine. According to Jones et al. (2010), 18% and 33%, respectively of the women, discontinued treatment. The babies of mothers in the buprenorphine group had a significantly shorter hospital stay

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From 2000 to 2002, 146 pregnant women addicted to opioids were examined, but the majority of them could not be included in the study because of poly-drug addiction, current methadone treatment or other reasons. The women were randomly assigned to the two treatment groups of nine members each.

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A total of 53 out of 86 women examined were eligible for the study. 22 of them were administered methadone, 17 took morphine and 14 women, buprenorphine. The women were not randomly assigned to the different groups, however. Additional use of cocaine and benzodiazepines could be stopped in the course of the last trimester. Additional use of cannabis or nicotine was no criterion for exclusion. The new-born babies who needed NAS treatment were non-randomly assigned to a morphine hydrochloride group (17) or a phenobarbital group (15).

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The MOTHER study was funded by the U.S. National Institute on Drug Abuse. From a total of 1 074 pregnant opioid-dependent women, 175 were selected for participation in the study. They were admitted as inpatients and received rapid-action morphine sulphate, then they were randomly assigned to a group treated with buprenorphine (86) or methadone (89). The treatment was started in an inpatient setting.

and a significantly shorter duration of treatment for the neonatal abstinence syndrome with significantly smaller doses of morphine. However, no significant differences showed with regard to indicators such as number of neonates who required treatment for neonatal abstinence syndrome, or severity of NAS, but mothers receiving buprenorphine were more likely to discontinue treatment during pregnancy. This difference has also shown in studies of non-pregnant opioid users. Because of its advantages regarding neonatal abstinence syndrome, buprenorphine is recommended as the medicine of choice for pregnant opioid users while taking into account its possible negative aspects. The results of screening for eligibility for the MOTHER study also reflect characteristics of pregnant opioid-addicted women in the individual countries (Unger et al. 2010). The differences found, some of which are pronounced, seem to result from differences in treatment procedures, availability of treatment as well as treatment structures and legal conditions. From the data obtained, the authors conclude that opioid-using women in Austria show less severe problem patterns of addiction and that their situation in life is less precarious in particular compared to women in urban areas of the U.S. The high rates of benzodiazepine addiction found in all countries have given rise to concern, as the interaction of benzodiazepines with opioids may have severe consequences.

Berger et al. (2007) published experience⁸⁰ gathered in the context of the *Comprehensive Care Project* for opioid-addicted mothers and their babies, from the point of view of the specialised developmental risks outpatient clinic of the child and youth neuropsychiatry department at Rosenhügel Hospital in Vienna. Regarding biological risks and effects, a reduction of prematurity and duration of NAS was found. Prenatal dystrophy and microcephaly showed in 20.9% and 13.7% of infants, respectively, which may indicate problems of prenatal development. A small number of babies showed anomaly in spontaneous movements, and a very small share (5.3%) showed delayed statomotor development during the first year of life. In part of the children microcephaly was permanent, resulting in mild cognitive impairment.

Regarding psychosocial risks and consequences, distinctive interaction deficits (26% of children) and impaired relationships (another 45%) were found. Here, differences showed between children who lived with their biological mothers (relationships affected more often) and those living with foster mothers. Regarding cognitive development of children of drug-addicted mothers, small negative deviations have been

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Based on an evaluation carried out in cooperation with the University Hospital of Child and Youth Neuropsychiatry from 1999 to 2001. The results relate to 95 children born between March 1995 and October 1999 who had been referred to the developmental risks outpatient department. The children were to be monitored from the age of 6 weeks to 6 years. Compliance with appointment-keeping for follow-up examinations was good (59%). 38 children could not be included in the aftercare project in spite of referral to the clinic.

reported in almost all areas. However, because of the complex situation with multifactor interactions, it is difficult to derive any correlations. However, an attempt has been made to describe typical courses of development.

At pre-school age or at age six, signs of development disorders were found in 32% of children. One third of the children had psychopathological symptoms (primarily emotional disorders but also behavioural disorders). In another 14%, symptoms of attention deficit disorder (without increased impulsivity) were found. Intelligence tests (K-ABC) revealed a statistically significant negative deviation across all areas. For 33% of children examined, possible problems at school because of conduct disorders are expected, 32% are assumed to show developmental disorders, and another share, which cannot be quantified, may face cognitive and executive dysfunction. A catamnesic telephone survey seems to corroborate this assumption.

The study also showed that around one out of three children was moved to foster parents at a very early stage, another third remained with their mothers at first and were transferred to another caregiver within the first few years of infancy, and the remaining third of children stayed with their mothers and the situation eventually stabilised. If the child is transferred to foster care during infancy, this typically constitutes a medium psychosocial risk, while in the case of an elevated psychosocial risk, adequate interventions and advice may help achieve a certain stabilisation. A correlation also shows between additional poly-drug use (especially benzodiazepines) during pregnancy and need for foster care in infancy. While living with foster parents seems to be favourable for the positive development of children, one should also consider a possible stabilisation of the situation in the biological family through adequate support. Any decision on transfer to foster care should be based on observation during frequent visits within short intervals, taking into account both additional drug use and the quality of mother-and-child interaction.

The final conclusion from the project results is that the biological risk is small in the case of consistent substitution treatment, while the psychosocial risk is generally greater, but use of additional drugs (alcohol, nicotine, and benzodiazepines) increases both types of risk.

According to reports from Vienna, the Youth and Family Office is involved after almost every birth given by a drug-using mother or a mother in OST. As the drug support centres and the Youth and Family Offices are oriented towards different focuses and as no standards for cooperation across all agencies in Vienna have been established, this has brought about insecurity in some cases or decisions on foster care do not seem to be consistent. Analyses of the BADO documentation show that 18% of children of clients of drug support centres in Vienna are transferred to foster care (SDW 2011b).

12.2 Policy and legal framework

The **political framework** is defined by the addiction or drug policy papers of the individual provinces. In four provinces, the children of addicted parents are explicitly mentioned in the corresponding paper. The new Addiction Plan 2011–15 of Lower Austria (see Chapter 1) lists care for children in families with addiction problems among the support services for relatives that should be undertaken. It is relevant in this context that ENCARE Lower Austria⁸¹ has lobbying functions and is to promote an exchange of experience in this field. The set of measures for the period from 2011 to 2015 includes building and expanding services for relatives (which also includes children) across the province and for taking into account the age of target groups. The continuation of the Provincial Addiction Plan of Carinthia (see Chapter 1.2) includes a focus of activities on developing and implementing prevention and treatment services for families with addiction problems including their children (Prehslauer, personal communication). The Drug Policy Programme of Vorarlberg (Amt der Vorarlberger Landesregierung 2002) mentions children of drug users as a target group of the *Clean Bregenz* advisory centre. Vienna's Drug Policy Programme of 1999 points to the good results regarding care and support for pregnant drug users and their children brought about by the interdisciplinary cooperation structures and coordination by the *CONTACT* hospital connection service.

The **legal framework** addressing the issue of children of addicted parents is provided by the Youth Welfare Act (BGBl 1989/161 v. 28. 4. 2011).

12.3 Specific responses for drug users with children

Interventions and services are found at several levels and typically they pursue several goals at once. On the one hand, they address pregnant women in order to improve their state of health and reduce or prevent negative health effects first on the foetus then on the baby, child and eventually adult human being. In fact, pregnancy often motivates drug-using or drug-dependent women to change their patterns of life and to enter treatment. On the other hand, children (also adult children) are addressed as they face an elevated risk of developing addiction themselves, and it is essential to identify problems at the earliest possible stage, to find problem-solving strategies and offer appropriate interventions.

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ENCARE Lower Austria is one of the provincial networks that were established in the context of the ENCARE project of the European Union (see Chapter 12.3).

In the context of care services for pregnant women, birth control may also be discussed in order to prevent a further pregnancy at an inconveniently early time. In Graz, the Social Welfare Department and Kontaktladen/Streetwork have concluded an agreement under which the City of Graz takes over the cost of intrauterine devices for clients of Kontaktladen/Streetwork (Zeder, personal communication). This is deemed sensible as women who use benzodiazepines as an additional drug tend to have problems with the contraceptive pill regimen.

Addicted pregnant women may turn to all addiction support centres for care and treatment, the same as any other addicted person. Because drug users face special pregnancy risks, they should be treated at specialised centres where different departments may collaborate (Fischer, personal communication), for instance, at the addiction clinic of the Vienna University Hospital of Psychiatry, a clinic of international renown which has specialised in services for addicted pregnant women since 1994. As it is located near the University Hospitals of Gynaecology and of Paediatrics, close cooperation with these two specialised hospitals is possible. In the context of the project on drug addiction and pregnancy and the *Comprehensive Care Project*, multi-professional, interdisciplinary care structures were built in order to reduce the risk of developmental disorders in children by means of comprehensive pre-, peri- and postnatal care services (see Chapter 12.1). These care structures have continually been advanced as a response to studies in this field and many years of practical experience. The care model pursued mainly follows the recommendations by Winklbaaur et al. (2008) as well as Metz and Fischer (2010). The corresponding services are provided by the relevant medical departments of General Hospital Vienna (including laboratories) and the Department of Child and Youth Neuropsychiatry of Rosenhügel Hospital, Vienna, as well as a wide range of other institutions and services such as the *DSA im AKH* social work service, the *CONTACT* hospital connection service and the Youth and Family Welfare Office of the City of Vienna, the Vienna Community Mental Health Centres (PSD) and external addiction treatment centres. Provision of comprehensive psychosocial care is of great importance, and in this respect, the performance of General Hospital Vienna, because of its good structures (in particular also with regard to nursing) has been excellent compared to the corresponding treatment and care centres in the U.S. As a rising number of pregnant women and their children have needed treatment and care in the context of this network, the delivery of obstetric and neonatology services has now been dispersed among several hospital departments in Vienna. A number of training courses were organised in order to improve and professionalise interdisciplinary cooperation. In addition, from 2007 to 2010 a project aimed at optimising inpatient treatment of neonates of drug-addicted mothers was run at Preyer's Paediatric Hospital in Vienna in order to improve and shorten the withdrawal period of babies and to improve care services delivered to mothers during that time. Now intensive aftercare is provided at a child neuropsychiatry clinic where a multiprofessional team is available.

Also outside Vienna, several cities and provinces have taken steps to improve care services for pregnant addicted women in order to reduce adverse effects on the foetus and the neonate. For instance, in 2010 a care programme for pregnant women in OST was initiated as a module of the *Wir werden Eltern* [Becoming Parents] project in Tyrol (Kern, personal communication; GÖG/ÖBIG 2010a). Every pregnant client of the addiction clinic at the University Hospital of Psychiatry in Innsbruck is assisted by a midwife as of the second pre-natal examination scheduled between the 17th and 20th weeks of pregnancy, in order to have access to expert care and advice. The mother-to-be is encouraged to become aware of her health and physical needs and at least to control her drug use. In addition to provision of health care at the high-risk clinic of the Innsbruck University Hospital and preparation for birth, the women are also helped prepare for life with a baby. In the first year of the project, the above services were delivered to three women, whose feedback was very positive. The care network also permits close monitoring and thus is a good basis for making decisions regarding the time after birth. Therefore the criteria for admission were modified and now the programme is also available to pregnant women whose opioid substitution treatment is provided by an established doctor and who agree to additional services by the addiction clinic.

In Lower Austria a pilot project was started in the district of Mödling as part of the DESK project, which focuses on drugs and addiction, parents and children. The pilot project aims at improving psychosocial and health care services for pregnant women who are addicted to alcohol, illicit drugs or medicines (Hörhan, personal communication). In 2012 the project will be expanded to include the districts of Wiener Neustadt, Baden and Neunkirchen. Guidelines for action were drawn up, which have been tested and evaluated since autumn 2010. The province of Styria also saw the preparation of a programme for action.

In order to support pregnant women who are addicted to opioids and to raise their awareness of possible consequences of their addiction a wide range of services exist. In addition to provision of health care, booklets are available on advice and care as well as financial support and other services, and also on specific aspects related to addiction, e.g., the effects that illicit drugs and substitution medicines have on the foetus, breastfeeding during substitution treatment, etc. The booklets have been drawn up in consultation with experts in various fields and directly address the women concerned. The booklet on pregnancy and drugs⁸² (see GÖG/ÖBIG 2010a) is a good example. In addition, information material specifically addressing experts has been, or will be, drawn up (e.g., in the context of the cooperation project of Vienna and Lower Austria).

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For downloading the booklet (in German) please visit
<http://www.suchtvorbeugung.at/suchtkoordination/index.php?kap=21&id=56> (7 September 2011)

In Tyrol it showed that proactive approaches and continuous motivation by multipliers are needed in order to encourage pregnant drug users to take up the available support services (kontakt+co 2011).

In recent years, it has been an explicit goal for the time following birth that children should live with their own parents whenever possible, with the youth welfare departments providing assistance to ensure the well-being of the child, and the addicted parents receive support by addiction services. Essential aspects here include a definitely positive approach, an atmosphere of trust and appropriate support services for the families (Hutter et al. 2006). In recent years, awareness-raising among providers of services has thus been an essential concern, combined with the improvement of existing care networks and cooperation. Several provinces have consequently established standards for cooperation with youth welfare departments and addiction care services. Other policy papers (e.g., the standards for Carinthia) are concise and only list the most relevant competencies, interventions and procedures. Some papers (e.g., the standards for Lower Austria) also include a more detailed description of the problem, define basic criteria as minimum requirements for a good development of children and list available structures and services (e.g., conferences of service providers), the limits of cooperation and issues of data protection. Generally, all actors relevant at a certain phase (pregnancy, birth, parenthood after birth), and also the parents, should fully be integrated in the care network as early as possible. If necessary, written agreements should be made. In Vorarlberg, the cooperation standards drawn up in 2008 are currently being evaluated (Neubacher, personal communication). According to the annual report by the Maria Ebene Foundation, Vorarlberg (Stiftung Maria Ebene 2011), the interdisciplinary cooperation network that was built for this purpose has had very positive effects on care services but in individual cases, legal and institutional obstacles continue to exist (e.g., non-disclosure obligations, data protection, lack of staff). In other provinces (e.g., Salzburg) such guidelines for cooperation are still at the preparatory stage. According to Fischer (personal communication), Vienna has need for additional shared flats provided by the Youth Welfare Department to assist women for whom it is difficult immediately after giving birth to cope with the new situation and to look after their babies.

The Addiction and Drug Coordination Office of Vienna defined children of drug-addicted mothers as a focal theme of the year 2010 (SDW 2011b). The corresponding activities also integrated individual initiatives some of which had existed for several years already, e.g., the working group of drug support services in Vienna on children in families with addiction problems, or the KISAM coordination conference of the Youth and Family Welfare Office of the City of Vienna. In addition to awareness-raising among staff, uniform standards and specialised services in line with individual needs are under preparation. It has shown, however, that so far no services exist for the target group of addicted parents with older children.

In the area of prevention, the European ENCARE project started in May 2004 and phased out in 2010 was an important impulse for an intensified discussion of the situation of addicted parents and their children and for initiating specific interventions for this group. In the context of ENCARE, the Ludwig Boltzmann Institute of Addiction Research carried out a study (Puhm et al. 2008a) of children in families with addiction problems, which focused on alcohol problems, however. In addition, the existing explicit and implicit services for addicted parents were researched (Puhm et al. 2008b). Another ENCARE activity was to establish an Austrian network coordinated by the Addiction Prevention Institute of Upper Austria. In the following years, the Addiction Prevention Units built provincial networks focusing on children in families with addiction problems, and a website⁸³ was designed for an interregional exchange of information (GÖG/ÖBIG 2007b). The regional ENCARE networks organise training courses and expert meetings and promote network-building, which has considerably contributed to raising awareness among the public and experts of the situation that children of addicted parents are facing. The above activities particularly address people who work with children and young people, such as (kindergarten) teachers or child care workers, in order to raise their awareness and communicate knowhow to help them detect problems at an early stage and find good ways to interact with the children concerned. In addition, demand was identified for specific, sustainable, free services for adults (in order to promote parenting skills) and children (to support and help them open up fresh perspectives and find confidence in their own resources). As a result, services for children were initiated, e.g., the *Kasulino* project in Vorarlberg (GÖG/ÖBIG 2006), the *KiJA on Tour!* project in Upper Austria (GÖG/ÖBIG 2008c) and in Tyrol, the INTERREG project⁸⁴ *Kinderleicht – Zukunft. Von Anfang an* [Child's play: having a future, right from the start] (GÖG/ÖBIG 2010a). While the project in Upper Austria focuses on communicating information to children and young people, the other projects are oriented towards individual and group services. The *Kinderleicht* project aims at drawing on and promoting the existing resources of children and families. In summer 2010 standards for advice and counselling services for individual and group settings were drawn up and the project was coordinated with main stakeholders. As of autumn 2010, free services for families have been available (individual counselling for children and young people aged between 4 and 18, group services for children from 7 to 12 and counselling for parents); any information shared is treated with confidentiality (Caritas Tirol 2011). Families are referred to the services by drug support centres, kindergartens, schools as well as clubs or other spare-time organisations. In Salzburg, the *AhA!* association for relatives of mentally ill people runs the project *JoJo – Kindheit*

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<http://www.encare.at/> (website in German)

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

im Schatten [Yoyo – an overshadowed childhood]⁸⁵ which provides services specifically targeting children of parents with psychiatric diseases. For a time of up to six months, the children receive support in individual sessions or small groups where they may deal with problems by creative means appropriate for their age. In Lower Austria, the new KIPKE project provides similar services for children of psychiatrically ill parents, and also advisory services for parents including house calls (PSZ and Caritas St. Pölten 2011).

Apart from a few projects aimed at preventing addiction and specific services for children whose parents suffer from psychiatric diseases, which are also open to children of addicted parents, the majority of services for families with addiction problems are provided by specialised addiction support centres. Further information on these services are provided by Suchthilfekompass⁸⁶ [Addiction Help Compass]: 19 inpatient and 61 outpatient addiction-related services indicate children as one of their target groups but do not explicitly state in which context they address children and what type of service they provide. 14 inpatient and 49 outpatient services mention children as relatives. One outpatient and five inpatient services provide play therapy for children of clients. It cannot be specified how many of these services integrate children of clients in the context of family therapy or provide psychotherapy specifically for the children. In this respect, other sources of information have to be consulted, e.g., websites and annual reports of service providers.

Hutter et al. (2006) point out that addiction support and advice centres are undoubtedly qualified for working with addicted parents and their children as they have gathered much experience with compulsory treatment contexts, resistance and denial on the part of clients, but so far, children have hardly been regarded as their target group. It would be helpful to have services and structures in which parents and children were proactively contacted jointly and which included support and care appropriate for children. The existing addiction-related services are primarily oriented towards adults (addicted people and their relatives), e.g., API's closed-group psychotherapy for adults with addicted parents. However, meanwhile a few services have defined children as a specific target group, e.g., the *Auftrieb* centre of Wiener Neustadt, Lower Austria, and API, in the context of its support network for relatives. According to the Dialog association, young relatives very rarely receive support services (Verein Dialog 2011). In 2010 the Drug Advice Centre of the Province of Styria (Drogenberatung des Landes Steiermark 2011) organised two open groups for children

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For further information please consult <http://www.aha-salzburg.at/> (website in German)

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The corresponding data relate to the year 2009.

from 9 to 13 with addicted parents. The main focus of the groups was to help children cope with their emotions.

In the addiction treatment sector, the parents-and-child-house of Grüner Kreis provides an 18-month inpatient treatment programme which specifically addresses parents addicted to opioids and their child(ren). Other treatment centres also admit parents with children if necessary, e.g., the KIT association of Tyrol. However, in the majority of cases, childcare has to be organised before parents may enter inpatient treatment.

As Austria has no national **treatment guidelines** for the treatment of addiction, (see GÖG/ÖBIG 2010a), no guidelines for the treatment of addicted parents and/or their children exist either. However, there are recommendations based on existing literature and practical experience gathered over many years. According to Winklbaaur et al. (2008)⁸⁷, the coordination of support services for addicted pregnant women and their families by means of case management as well as intensive support and care during pregnancy are essential approaches. The recommendations that the authors have drawn up include the following:

- » As a rule, substitution treatment is preferable to withdrawal. If the patient's condition is stable and if she explicitly wants to become abstinent, withdrawal should not take place after the 32nd week of pregnancy. The dose for maintenance treatment should be adequate to prevent additional drug use and doctors should take into account the patient's individual situation, and the decision for a substitution medicine should be evidence-based. Any withdrawal from benzodiazepines should be carried out slowly.
- » At the start of care provision, comprehensive medical and psychosocial examinations are needed in order to know the entire range of problems that have to be considered, and the woman's partner should be addressed as well. If the partner is addicted to opioids, he should also enter substitution treatment, and if possible should be prescribed the same medicine. Possible psychiatric comorbidity should be taken into account and treated accordingly.
- » Mild depression should not be treated pharmacologically whenever possible. However, in case of severe depression and risk of suicide, inpatient care or treatment with psychopharmaceuticals is indicated. If the patient is administered antidepressants, possible interactions with other medicines have to be taken into account.

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In the context of a literature review, PubMed studies (going back as far as 1998) were researched and analysed. The results of this study as well as the experience of the authors were integrated in the recommendations.

- » The obstetrician has to be informed about the type of treatment delivered as this has to be considered when analgesics have to be administered during birth.
- » After birth, the mother should remain in hospital for five to eight days, while the neonate is monitored for signs of NAS. Any separation of mothers and babies should be as short as possible in order to avoid negative effects on child bonding.
- » NAS in the baby should be treated with morphine. However, in the case of poly-drug use during pregnancy, administration of phenobarbital is recommended.

In another literature review⁸⁸ by Metz and Fischer (2010), three factors are highlighted as relevant for successful treatment of this specific target group: early start of treatment, long-term maintenance treatment and frequent participation in group therapy.

Pregnant opioid addicts are also mentioned in the consensus statements by the Austrian Society of Neuropharmacology and Biological Psychiatry (ÖGPB 2008) and the Austrian Society of Pharmacologically Assisted Treatment of Addiction (ÖGABS 2009), which include similar, although less detailed, recommendations.

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BGBl II 2011/158 v. 13. 5. 2011. Das Inverkehrbringen, der Import und das Verbringen von Räuchermischungen, die cannabinomimetisch wirksame Stoffe enthalten.

BGBl II 2011/179 v. 15. 6. 2011. Änderung der Weiterbildungsverordnung orale Substitution.

BGBl II 2011/202 v. 28. 6. 2011. Änderung der Psychotropenverordnung.

Personal Communications (alphabetical order)

Name and page	Institution of function
Dotter-Schiller, Dr. Karin (p. 97)	Federal Ministry of Justice
Drobesch-Binter, Dr. Barbara (p. 24)	Agency for Addiction Prevention, Carinthia
Ederer, Klaus Peter (p. 24, 31, 35, 72, 77, 79, 104)	Addiction Coordinator of Styria
Fischer, Dr. Gabriele (p. 119, 121)	Medical University of Vienna, Department of Psychiatry and Psychotherapy
Frankl, Liesl (p. 26)	Beratungsgruppe.at, Vienna
Haltmayer, Dr. Hans (p. 70, 71)	VWS (Vienna Social Projects Association), ganslwirt
Hörhan, Dr. Ursula (p. 34, 35, 44, 45, 120)	Addiction Coordinator of Lower Austria
Hovorka, Christine (p. 101, 102)	Head of Social Work Division at Neustart association
Kern, Harald (p.)	Addiction Coordinator of Tyrol
Krenmayr, D. (p. 24)	Addiction Prevention Institute, pro mente Upper Austria
Klein, Dr. Jean-Paul (p. 56)	Federal Ministry of Health
Kulterer, Gerhard (p. 78)	Executive Office of the City of Klagenfurt, Carinthia
Lochner, Ewald BA (p. 68)	Addiction and Drug Coordination Office of Vienna
Meyer-Philippi, Gerd (p. 106)	Managing Director of CompWare Medical GmbH
Miksch, Dr. Gerhard (p. 42)	Drug Coordinator of Burgenland
Moser-Riebniger, Andrea (p. 98, 99)	Federal Ministry of Justice/Prisons Directorate
Neubacher, Thomas (p. 6, 31, 42, 121)	Drug Coordinator of Vorarlberg
Pilgerstorfer, Monika BSc (p. 48)	Austrian Road Safety Board
Prehslauer, Dr. Brigitte (p. 9, 45, 66, 118)	Drug Coordinator of Carinthia
Rögl, Nicole (p. 22, 23, 27)	Akzente Salzburg (Addiction Prevention Unit of Salzburg)
Schmidhofer, Dr. Hermine (p. 105)	Addiction and Drug Coordination Office of Vienna
Schopper, Dr. Johanna (p. 6)	Federal Ministry of Health, Federal Drug Coordinator
Schütz, Dr. Angelika (p. 70, 71)	Head of Outpatient Care Department at VWS (Vienna Social Projects Association)
Zeder, Dr. Ulf (p. 31, 119)	Addiction Coordinator of the City of Graz
Zotter, Severin (p. 69)	Caritas of Graz-Seckau Diocese (Kontaktladen)

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)⁸⁹

Austrian projects in the EDDRA database or EMCDDA Best Practice Portal, respectively (as at August 2011)

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)

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

Certificate training course “Addiction prevention and violence prevention”
(Institut Suchtprävention, OÖ)

⁸⁹

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

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)

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
(Schweizer Haus Hadersdorf, Vienna)

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)

Viktoria'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 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>

Suchtpräventionsdokumentation und Suchtpräventionsforschung des Anton-Proksch-Instituts

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

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 St. Pölten

<http://www.caritas-stpoelten.at/>

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/liaisondienste/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 (addiction clinic of the Medical University of Vienna)

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

Drogenberatung des Landes Steiermark (Drug 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/>

Jugendsuchtberatung Hot, Purkersdorf

<http://www.agathon.cc>

Jusy - Jugendservice Ybbstal, Waidhofen/Ybbs

<http://www.jusy.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>

Komfüdro (communication centre for drug users)

<http://www.caritas-tirol.at/hilfe-einrichtungen/menschen-mit-suchterkrankungen/komfuedro/>

Kontaktstelle in Suchtfragen, Salzburg (addiction information centre)

http://www.landesschulrat.salzburg.at/main.php?link=1/80&file=mitarb/org_ser_vicestellen.html&dim=1680,1020

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 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>
- Psychosoziale Zentren GmbH
<http://www.psz.co.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/betreuungsstellen/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 2011

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
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	15-24	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
				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
				14+	2
				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+	3
			Other illicit drugs (e.g., LSD)	15+	4
				15+	3
Bevölkerungsbefragung OÖ/ general population survey, Upper Austria (Seyer et al. 2010)	Upper Austria 2009 (lifetime)	General population aged 15 and older (n = 1 547) (15-59: n = 1 385)	Cannabis	15-59	19.6
			Ecstasy	15-59	3.2
			Amphetamines	15-59	3.5
			Cocaine	15-59	2.7
			Heroin	15-59	1.2
			Morphine	15-59	1.0
			LSD	15-59	1.8
			Solvents and inhalants	15-59	5.3
			Biogenic drugs	15-59	3.5
				15-59	3.5
Wiener Suchtmittelstudie/ drug survey, Vienna (IFES 2011)	Vienna 2011 (lifetime)	General population aged 15 and older (n = 600)	Cannabis	15+	21
			Ecstasy	15+	3
			Amphetamines	15+	3
			Cocaine	15+	5
			Opioids	15+	2
			Biogenic drugs	15+	6
			Other illicit drugs (e.g., LSD)	15+	6
				15+	2

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 and 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
			Opioids	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 and 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 24 (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 and 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 (Strizek et al. 2008)	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
Bevölkerungsbefragung OÖ/ general population survey Upper Austria (Seyer et al. 2010)	Upper Austria 2009 (lifetime)	Adolescents and young adults aged 15 to 24 (n = 590)	Cannabis	15-24	26.2
			Ecstasy	15-24	4.7
			Heroin	15-24	2.1
			Morphine	15-24	1.7
			Amphetamines	15-24	5.1
			Cocaine	15-24	2.6
			LSD	15-24	2.1
			Solvents and inhalants	15-24	8.9
			Biogenic drugs	15-24	1.3
Erhebung zum Suchtver- halten von Jugendlichen in NÖ/ youth survey, Lower Austria (Bittner et al. 2010)	Lower Austria 2009 (lifetime)	Adolescents and young adults aged 13 to 18 (n = 722)	Cannabis	14-17	7
			Ecstasy	14-17	1
			Cocaine	14-17	1
			Heroin	14-17	0
			Speed	14-17	1
			Solvents and inhalants	14-17	1
			Biogenic drugs	14-17	1
Flash Eurobarometer: Youth Attitudes on Drugs (European Commission 2011b)	Austria 2011 (lifetime)	Adolescents and young adults aged 15 to 24 (n = 501)	Cannabis	15-24	18.1

Summarised by GÖG/ÖBIG

Table A3:

Number of directly drug-related deaths in Austria by cause of death from 2001 to 2010

Cause of death	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Opioid poisoning	17	17	40	38	31	27	9	13	18	13
Poly-drug poisoning involving opioids(s)	119	119	115	133	134	137	138	136	153	148
Poly-drug poisoning involving narcotic drug(s) without opioids	3	3	8	4	4	5	5	4	1	0
Fatal poisoning of unknown type	0	0	0	10	22	28	23	16	15	9
Verified directly drug-related deaths, total	139	139	163	185	191	197	175	169	187	170
Drug-related deaths without verification by autopsy ¹	-	-	-	-	-	-	-	32	19	17

Source: BMG; calculation and representation by GÖG/ÖBIG

1: for more details see GÖG/ÖBIG 2011b

Table A4:

Number of verified drug-related deaths in Austria by province from 2001 to 2010

Province	2001	2002	2003	2004	2005	2006	2007	2008 ¹	2009 ²	2010 ³	2001-2010
Burgenland	0	0	2	5	3	3	5	1	1	3	23
Carinthia	5	7	6	4	6	7	4	6	5	6	56
Lower Austria	14	12	13	31	29	38	27	34	26	30	254
Upper Austria	8	6	13	15	13	14	12	20	21	10	132
Salzburg	7	7	5	7	8	6	3	11	13	17	84
Styria	9	13	14	12	17	12	16	21	10	11	135
Tyrol	16	13	13	15	17	16	11	18	15	18	152
Vorarlberg	11	6	5	8	6	6	7	2	14	10	75
Vienna	69	75	92	88	92	95	90	55	82	65	803
Unknown	0	0	0	0	0	0	0	1	0	0	1
Total	139	139	163	185	191	197	175	169	187	170	1 715

Source: BMG; calculation and representation by GÖG/ÖBIG

1: 32 drug-related deaths without verification by autopsy

2: 19 drug-related deaths without verification by autopsy

3: 17 drug-related deaths without verification by autopsy

Table A5:

Number of verified directly drug-related deaths in Austria by age group and total by gender from 2001 to 2010

Age group	2001		2002		2003		2004		2005		2006		2007		2008 ¹		2009 ²		2010 ³	
	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%
19 and younger	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	12	7.1
20-24	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	36	21.2
25-29	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	41	24.1
30-34	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	17	10.0
35-39	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	17	10.0
40 and older	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	47	27.6
Total	139	100	139	100	163	100	185	100	191	100	197	100	175	100	169	100	187	100	170	100
Women	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	30	17.6
Men	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	140	82.4

1: 32 drug-related deaths without verification by autopsy.

2: 19 drug-related deaths without verification by autopsy.

3: 17 drug-related deaths without verification by autopsy.

Source: BMG; calculation and representation by GÖG/ÖBIG

Table A6:
Distribution of verified directly drug-related deaths in Austria by cause of death
and age in 2010

Cause of death			Age group										
			< 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	> 49	Total	
Fatal poisoning	Opioids	One opioid	0	1	2	2	2	1	0	1	3	12	
		Several opioids	0	0	0	1	0	0	0	0	0	1	
		+ alcohol	0	1	1	4	1	0	2	2	1	12	
		+ psychoactive medicines	0	7	17	17	8	7	6	5	4	71	
		+ alcohol + psychoactive medicines	0	0	6	4	4	7	4	4	3	32	
	Opioids and other narcotic drugs	Narcotic drug(s) only	0	0	3	1	0	0	0	0	1	5	
		ND + alcohol	0	1	3	3	0	0	0	0	0	7	
		ND + psychoactive medicines	0	1	2	3	1	2	2	3	1	15	
		ND + alcohol + psychoactive medicines	0	0	1	3	0	0	0	1	1	6	
	Narcotic drugs without opioids	Narcotic drugs 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	0	0	
	Fatal poisoning/unknown type			0	1	1	3	1	0	1	2	0	9
	Directly drug-related deaths/total			0	12	36	41	17	17	15	18	14	170
of these: men			0	6	28	36	15	14	11	17	13	140	

ND = narcotic drugs(s).

Source: BMG; calculation and representation by GÖG/ÖBIG

Table A7:

Distribution of verified directly drug-related deaths in Austria by cause of death and province in 2010

Cause of death		Province										
		B ¹	C	LA ²	UA ³	S ⁴	ST	T	VB	V ⁵	A ⁶	
Fatal poisoning	Opioids	One opioid	0	0	1	4	1	0	0	2	4	12
		Several opioids	0	0	0	0	1	0	0	0	0	1
		+ alcohol	0	0	1	1	0	1	0	0	9	12
		+ psychoactive medicines	3	3	12	1	7	7	7	5	26	71
		+ alcohol + psychoactive medicines	0	0	7	1	4	1	7	1	11	32
	Opioids and other narcotic drugs	Narcotic drug(s) only	0	0	2	0	1	0	1	0	1	5
		ND + alcohol	0	0	0	1	1	0	2	1	2	7
		ND + psychoactive medicines	0	2	3	1	1	1	1	0	6	15
		ND + alcohol + psychoactive medicines	0	1	2	0	1	0	0	0	2	6
	Narcotic drugs without opioids	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	0	0
	Fatal poisoning/unknown type		0	0	2	1	0	1	0	1	4	9
	Directly drug-related deaths/total		3	6	30	10	17	11	18	10	65	170
Verified directly drug-related deaths per 100 000 inhabitants aged 15 to 64		1.6	1.6	2.9	1.1	4.7	1.4	3.8	4.0	5.6	3.0	
Directly drug-related deaths per 100 000 inhabitants aged 15 to 64		3.2	1.6	2.9	1.3	5.0	1.4	3.7	4.0	6.4	3.3	

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: 3 drug-related deaths without verification by autopsy.
- 2: 1 drug-related death without verification by autopsy.
- 3: 2 drug-related deaths without verification by autopsy.
- 4: 1 drug-related death without verification by autopsy.
- 5: 10 drug-related deaths without verification by autopsy.
- 6: 17 drug-related deaths without verification by autopsy.

Source: BMG; calculation and representation by GÖG/ÖBIG

Table A8:

Development of AIDS cases in Austria by risk situation from 2001 to 2010

Risk situation	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Homo-/bisexual contact	21	19	7	16	14	17	19	17	17	5
Injecting drug use	27	20	14	12	14	6	13	16	10	4
Heterosexual contact	33	41	22	32	17	30	22	26	25	11
Other cause/unknown	12	17	10	11	14	10	17	11	7	11
Total	93	97	53	71	59	64	72	71	59	31

Source: BMG; calculation and representation by GÖG/ÖBIG

Table A9:

Distribution of reported violations of the Narcotic Substances Act in Austria by first offenders and repeat offenders, development from 2001 to 2010

Reports	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total number of reports	21 862	22 422	22 245	25 215	25 892	24 008	24 166	20 043	22 729	23 853
First offenders	11 033	11 269	12 117	14 346	15 569	15 808	16 053	13 634	14 893	19 409
Repeat offenders	10 052	10 380	9 288	9 990	9 520	7 636	7 569	5 990	7 258	3 681

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 reported violations of the Narcotic Substances Act (narcotic substances only) in Austria from 2001 to 2010

Province	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Burgenland	712	805	984	967	923	1 033	1 008	871	953	716
Carinthia	1 758	1 676	1 659	1 464	1 529	1 190	1 408	1 153	1 372	1 522
Lower Austria	2 975	3 319	3 017	3 531	3 632	3 050	3 464	2 583	3 165	2 978
Upper Austria	2 677	3 054	2 782	3 521	3 769	3 209	3 786	3 245	3 908	3 660
Salzburg	1 471	1 384	868	1 077	1 092	1 001	1 116	1 015	1 096	1 099
Styria	1 601	1 910	1 570	1 705	1 516	1 435	1 929	1 372	1 669	1 607
Tyrol	2 449	2 229	2 102	2 695	2 775	2 607	2 454	1 982	2 555	2 692
Vorarlberg	1 447	1 265	1 146	1 044	1 008	1 240	1 153	976	1 027	1 143
Vienna	6 212	6 210	7 652	8 524	8 797	7 925	6 611	5 883	6 056	7 001
Total	21 302	21 852	21 780	24 528	25 041	22 690	22 929	19 080	21 801	22 418

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

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

Table A11:
Distribution of reported violations of the Narcotic Substances Act in Austria
by drug type from 2001 to 2010

Drug type	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cannabis	19 760	19 939	17 706	20 252	20 900	19 021	19 063	15 063	17 513	17 066
Heroin and opioids	3 802	3 954	4 717	4 770	4 720	3 516	3 294	2 865	3 157	3 677
Cocaine + crack	3 416	3 762	4 785	5 365	5 491	4 252	4 263	3 551	3 930	3 332
Amphetamines + methamphetamine	-	1 532	1 727	1 843	1 795	1 639	2 112	1 405	1 749	1 669
LSD	506	327	214	196	160	164	196	101	193	137
Ecstasy	2 940	2 998	2 473	2 362	2 106	1 763	1 889	1 127	966	388
Mephedrone	-	-	-	-	-	-	-	-	-	209
Medicines containing narcotic drugs	-	809	872	1 420	1 795	2 800	2 714	2 294	2 693	3 113
Other narcotic drugs	-	540	320	304	427	355	323	263	363	185
Psychotropic substances	-	3	11	11	4	14	20	13	16	37
Psychotropic medicines	821	736	603	892	1 081	1 687	1 535	1 185	1 174	1 666
Precursor substances	-	4	5	0	4	8	2	12	1	3

- = 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 reported violations of the Narcotic Substances Act in Austria
by drug type and province in 2010

Drug type	B	C	LA	UA	S	ST	T	VB	V	Total
Cannabis	684	1 450	2 459	2 900	934	1 495	2 709	935	3 500	17 066
Heroin und opioids	75	277	451	685	49	107	107	292	1 634	3 677
Cocaine + crack	102	268	309	518	136	117	380	207	1 295	3 332
Amphetamines + methamphetamine	116	91	340	416	169	108	110	79	240	1 669
LSD	20	6	35	13	8	7	24	6	18	137
Ecstasy	33	42	52	56	64	42	38	25	36	388
Mephedrone	0	18	52	6	2	71	11	0	49	209
Medicines containing narcotic drugs	51	172	250	590	132	216	142	63	1 497	3 113
Other narcotic drugs	12	18	34	33	21	14	20	5	29	185
Psychotropic substances	2	0	10	2	2	1	9	6	5	37
Psychotropic medicines	17	38	103	212	42	60	107	40	1 047	1 666
Precursor substances	1	0	0	2	0	0	0	0	0	3

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 2001 to 2010

Year	Total number of convictions under the SMG	Convictions under SMG Section 28 or 28a	Convictions under SMG Section 27	Convictions in Austria	
				Total number	Under the SMG (percentages)
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
2010	4 363	1 466	2 838	38 394	11.4

Until 2007:

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

As of 2008:

SMG Section 27 = illicit handling of narcotic substances;
SMG Section 28 = preparation for trafficking in narcotic substances;
SMG Section 28a = 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 (judicial criminal 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 2010

Basis of conviction		14-19 years	20-24 years	25-29 years	30-34 years	> 34 years	Total
SMG total	Men	618	1 319	822	444	693	3 896
	Women	42	147	124	58	96	467
SMG Section 28 or 28a	Men	95	363	286	201	359	1 304
	Women	9	48	33	28	44	162
SMG Section 27	Men	522	949	525	238	313	2 547
	Women	33	96	88	27	47	291

SMG Section 27 = illicit handling of narcotic substances;
SMG Section 28 = preparation for trafficking in narcotic substances;
SMG Section 28a = 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 (judicial criminal 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 2010

Basis of conviction		Fine	Prison sentence			Other punishment ¹	Total
			Probation	No probation	Partial probation		
SMG total	Young people	68	91	46	17	21	243
	Adults	905	1 138	1 335	595	147	4 120
SMG Section 28 or 28a (felonies)	Young people	2	10	6	1	2	21
	Adults	42	325	752	263	63	1 445
SMG Section 27 (misdemeanours)	Young people	66	81	40	16	19	222
	Adults	852	786	566	329	83	2 616

Young people = persons younger than 18 at the time of the offence.

SMG Section 27 = illicit handling of narcotic substances;

SMG Section 28 = preparation for trafficking in narcotic substances;

SMG Section 28a = trafficking in narcotic substances.

¹ Other punishment: partial probation (Criminal Code, Section 43, Para. 2), referrals to institutions (Criminal Code, Section 21, Paras.1 and 2, Section 22, Section 23), no additional punishment (Criminal Code Section 40) and, only in the case of young people, conviction with punishment reserved (Juvenile Court Act Section 13) and conviction without punishment (Juvenile Court Act Section 12).

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 (judicial criminal statistics); representation by GÖG/ÖBIG

Table A16:
Development of alternatives to punishment applied in Austria from 2001 to 2010

Waiving of reports/ suspension of proceedings	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	8 145	8 974	9 023	9 666	11 660	10 379	10 175	9 384	10 627	11 807
SMG Section 35 (waiving of reports)*	7 346	7 817	7 902	8 599	10 668	9 173	9 008	8 399	9 661	10 643
Of these: SMG Section 35, Para. 4 (cannabis)*	1 570	1 876	1 499	2 016	2 697	1 895	1 841	2 249	2 780	3 166
SMG Section 37 (dismissal of proceedings)*	799	1 157	1 121	1 067	992	1 206	1 167	985	966	1 164
SMG Section 39 (suspension of sentence; treatment instead of punishment)	254	337	318	427	452	507	540	638	624	733

* These data were communicated to the Ministry of Health by the public prosecutors and the courts.

Until 2007:

SMG Section 35 = temporary waiving of reports by the public prosecutors;

SMG Section 35, Para. 4 = waiving of reports in the case of small quantities of cannabis for personal use;

SMG Section 37 = temporary dismissal of proceedings by the court.

As of 2008:

SMG Section 35 = temporary waiving of reports by the public prosecutors;

SMG Section 35, Para. 4 = waiving of reports in the case of small quantities of cannabis for personal use;

SMG Section 37 = temporary dismissal of proceedings by the court.

Source: BMG; BMJ; calculation and representation by GÖG/ÖBIG

Table A17:
Number of seizures of narcotic drugs/substances in Austria from 2001 to 2010

Narcotic drug/substance	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cannabis	5 249	5 294	5 422	6 202	6 012	5 770	5 732	5 050	5 733	6 195
Heroin	895	836	1 263	1 383	1 371	883	765	673	901	1 048
Cocaine	768	863	1 271	1 475	1 507	1 044	1 087	936	984	946
Amphetamines + methamphetamine	161	239	321	342	328	334	380	299	400	466
LSD	32	20	33	29	20	20	39	20	39	43
Ecstasy	352	308	276	286	295	248	250	181	131	63
Mephedrone	-	-	-	-	-	-	-	-	-	73
Medicines containing narcotic drugs	418	392	445	812	1 117	1 571	1 234	1 015	1 121	1 456
Other narcotic drugs	123	139	84	87	97	84	92	58	79	72
Psychotropic substances	1	0	6	5	2	2	10	1	2	13
Psychotropic medicines	566	515	432	678	823	1 300	1 019	843	697	993
Precursor substances	0	2	2	0	2	7	1	12	0	1

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

Table A18:

Seizures of narcotic drugs/substances in Austria by quantity from 2001 to 2010

Narcotic drug/substance	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cannabis (kg)	456	743.1	925.9	1 680.9	819.9	1 880.4	1 276.0	873.6	1 139.3	1 292.3
Heroin (kg)	288	59.5	42.8	235.0	282.2	34.3	117.0	104.0	189.6	96.0
Cocaine (kg)	108	36.9	58.3	75.5	244.9	61.8	78.1	78.38	53.2	241.0
Amphetamines + methamphetamine (kg)	2.9	9.5	54.3	27.6	9.6	38.9	19.4	13.00	64.9	23.4
LSD (trips)	572	851	298	2 227.5	2 108.5	10 831.5	1 058	225.50	1 581.0	533.5
Ecstasy (number of pills)	256 299	383 451	422 103	122 663	114 104	30 855	66 167	45 335	5 847.5	7 275
Mephedrone	-	-	-	-	-	-	-	-	-	2.9
Medicines containing narcotic drugs (no. of pills)	3 755	3 919	10 827	9 031	9 057	12 253	10 376	7 180	8 233.5	11 630.5
Other narcotic drugs (kg)	10.2	6.0	1.8	21.4	5.0	2.4	3.6	2.9	5.3	5.5
Psychotropic substances (kg)	0.00	0.00	0.15	0.05	0.00	0.03	0.20	0.00	0.01	2.6
Psychotropic medicines (units)	32 377	20 081	15 650	21 119	27 105	44 416	26 289	24 675	36 624.5	28 178
Precursor substances (kg)	0.00	241.00	25.00	0.00	0.10	9.85	0.17	22.16	0.0	1.0

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 2001 to 2010

Ingredients	Samples bought as ecstasy (percentages)									
	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)	2010 (n=76)
MDMA	77.2	68.0	83.2	72.0	67.9	74.6	60.7	61.6	15.2	21.1
MDMA + MDE	2.2	14.1	7.7	9.7	0.0	1.5	0.0	0.0	0.0	0.0
MDMA + MDA	1.5	6.7	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.0
MDE and/or MDA	7.1	0.4	0.0	7.5	0.0	0.0	0.0	1.4	1.0	0.0
MDMA + caffeine	0.0	0.7	0.7	1.1	5.7	5.2	0.9	0.7	1.0	0.0
MDMA + amphetamines	0.4	0.0	0.7	0.0	1.9	1.5	0.0	0.0	0.0	0.0
MDMA + various combinations*	0.4	0.0	3.5	1.1	13.2	0.0	6.0	7.5	1.9	5.3
PMA/PMMA	0.4	0.0	0.7	0.0	0.0	0.0	0.0	0.0	1.0	0.0
Amphetamines	0.0	1.9	1.4	0.0	1.9	4.5	0.0	0.7	1.0	1.3
Methamphetamine	2.6	1.5	0.0	0.0	0.0	0.7	0.0	0.0	1.0	0.0
Caffeine	0.0	1.5	0.0	1.1	0.0	0.7	1.7	0.0	0.0	6.6
mCPP/mCPP + various combinations**	0.0	0.0	0.0	0.0	0.0	1.5	16.2	17.8	52.4	47.4
Various combinations*	7.1	5.2	2.1	7.5	9.4	9.0	14.5	10.3	25.7	11.8
Various combinations***	-	-	-	-	-	-	-	-	0.0	6.6

* 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.

*** Research chemicals (RCs) + various combinations: only RCs or RCs and one or more other substances.

Source: Vienna Social Projects Association (VWS); representation by GÖG/ÖBIG

Table A20:

Ingredients of samples bought as ecstasy or MDMA in powder or crystalline form or as capsules and analysed by the *ChEck iT!* project at parties and clubbing from 2005 to 2010

Ingredients	Samples bought as ecstasy or MDMA in powder or crystalline form or as capsules (percentages)					
	2005 (n=10)	2006 (n=21)	2007 (n=27)	2008 (n=31)	2009 (n=25)	2010 (n=91)
MDMA	100.0	100.0	81.5	87.1	69.6	51.6
MDMA + MDE	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + MDA	0.0	0.0	0.0	0.0	0.0	0.0
MDE and/or MDA	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + caffeine	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + amphetamines	0.0	0.0	0.0	3.2	0.0	0.0
MDMA + various combinations*	0.0	0.0	11.1	0.0	4.3	7.7
PMA/PMMA	0.0	0.0	0.0	0.0	0.0	0.0
Amphetamines	0.0	0.0	0.0	0.0	0.0	0.0
Methamphetamine	0.0	0.0	0.0	0.0	0.0	1.1
Caffeine	0.0	0.0	0.0	0.0	0.0	1.1
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	3.2	21.7	0.0
Various combinations*	0.0	0.0	7.4	6.5	4.3	3.3
Research chemicals (RCs) + various combinations***	-	-	-	-	8.7	35.2

* Various combinations: combinations of more than two amphetamine derivatives and/or other substances and/or unknown substances.

** Piperazine/piperazine + various combinations: piperazine and one or more other ingredients.

*** Research chemicals (RCs) + various combinations: only RCs or RCs and one or more other ingredients.

Source: Vienna Social Projects Association (VWS); representation by GÖG/ÖBIG

Table A21:

Ingredients of samples bought as speed and analysed by the ChEck iT! project at parties and clubbing from 2001 to 2010

Ingredients	Samples bought as speed (percentages)									
	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)	2010 (n=124)
Amphetamines	60.8	46.0	35.1	22.0	33.3	24.0	22.5	15.2	9.7	14.5
Amphetamines + caffeine	9.8	8.0	15.8	19.5	6.1	29.3	10.1	27.3	50.4	61.3
Amphetamines + methamphetamine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0
Amphetamines + various combinations*	3.9	17.2	29.8	39.0	24.2	24.0	31.8	34.3	15.0	10.5
Methamphetamine	2.0	3.4	1.8	2.4	3.0	0.0	10.1	1.0	0.9	1.6
Caffeine	11.8	8.0	0.0	4.9	9.1	1.3	1.6	3.0	8.8	1.6
MDMA	0.0	1.1	0.0	0.0	6.1	4.0	0.0	1.0	0.0	0.0
Various combinations*	11.8	16.1	17.5	12.2	18.2	17	23.3	14.1	14.2	7.3
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	0.0	0.0	0.0	0.8	2.0	0.9	0.8
Research chemicals (RCs) + various combinations***	-	-	-	-	-	-	-	-	0.0	2.4

* Various combinations: combinations of more than two amphetamine derivatives and/or other substances and/or unknown substances.

** Piperazine/piperazine + various combinations: piperazine and one or more other ingredients.

*** Research chemicals (RCs) + various combinations: only RCs or RCs and one or more other ingredients.

Source: Vienna Social Projects Association (VWS); representation by GÖG/ÖBIG

Table A22:

Number of persons currently registered as patients in substitution treatment in the monitoring system of the Austrian Ministry of Health, by first treatment/continued treatment and province in 2010

Treatment	B	C	LA	UA	S	ST	T	VB	V
Continued treatment	220	423	1 667	1 112	459	1 184	669	562	6 309
First treatment	39	121	371	251	45	153	130	125	872
Total	259	544	2 038	1 363	504	1 337	799	687	7 181

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 Ministry of Health 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 A23:

Persons starting drug treatment or requiring addiction services in 2010, 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	0	0
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	1	1	1	2	3	2	1	2	1	0	0	0
15 to 19	16	18	17	12	14	12	15	23	17	4	16	7
20 to 24	27	27	27	20	34	24	30	31	30	31	35	32
25 to 29	21	21	21	25	22	24	24	21	23	30	25	29
30 to 34	13	11	13	19	10	16	13	9	12	17	14	16
35 to 39	9	8	9	10	6	9	8	6	7	8	4	7
40 to 44	6	6	6	6	5	6	5	4	5	6	3	6
45 to 49	5	5	5	4	4	4	3	3	3	2	1	2
50 to 54	2	2	2	1	0	1	1	1	1	1	1	1
55 to 59	1	0	1	0	0	0	1	0	0	1	0	1
60 to 64	0	0	0	0	1	0	0	0	0	0	1	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	5 469	1 427	6 896	536	218	754	2 843	959	3 802	1 135	334	1 469
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 2011a, DOKLI analysis 2010

Table A24:

Persons starting drug treatment or requiring addiction services in 2010, by gender and livelihood, percentages

Livelihood/employment	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	
Gainful employment	-	-	-	11	9	10	33	26	32	8	8	8
Registered as unemployed	-	-	-	38	15	31	37	29	35	46	39	44
Welfare assistance	-	-	-	9	17	11	7	13	9	14	19	16
Child, school student, university student	-	-	-	5	4	5	4	10	5	2	6	3
Military service, alternative military service, parenthood leave, retired	-	-	-	4	10	6	5	8	5	9	8	9
Housework, (re)training, other	-	-	-	1	1	1	5	5	5	12	15	13
No gainful employment, no other form of livelihood	-	-	-	7	12	8	4	5	4	2	1	1
No gainful employment, other form of livelihood unknown	-	-	-	25	33	27	5	3	5	6	4	6
Valid indications	-	-	-	433	172	605	2 716	917	3 633	1 051	313	1 364
Unknown	-	-	-	90	41	131	96	31	127	66	13	79
Missing	-	-	-	13	5	18	31	11	42	18	8	26

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 2011a, DOKLI analysis of client year 2010

Table A25:
Persons starting drug treatment or requiring addiction services in 2010,
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	-	-	-	-	-	-	1	1	1	2	1	2
Carinthia	-	-	-	-	-	-	13	10	12	2	3	2
Lower Austria	-	-	-	-	-	-	11	11	11	12	14	13
Upper Austria	-	-	-	-	-	-	13	12	13	15	13	15
Salzburg	-	-	-	-	-	-	4	4	4	3	3	3
Styria	-	-	-	-	-	-	7	8	7	9	11	10
Tyrol	-	-	-	-	-	-	1	1	1	8	8	8
Vorarlberg	-	-	-	-	-	-	12	10	12	6	9	7
Vienna	-	-	-	-	-	-	37	43	39	42	38	41
Foreign country	-	-	-	-	-	-	0	0	0	1	0	1
Valid indications	-	-	-	-	-	-	2 757	922	3 679	1 063	321	1 384
Unknown	-	-	-	-	-	-	69	32	101	60	7	67
Missing	-	-	-	-	-	-	17	5	22	12	6	18

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 2011a, DOKLI analysis of client year 2010

Table A26:

Persons starting drug treatment or requiring addiction services in 2010, by present housing situation and gender; percentages

Present housing situation	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
Stable (e.g., flat of one's own)	-	-	-	21	34	25	88	85	87	83	88	84
Unstable (e.g., homeless)	-	-	-	55	49	53	6	9	7	12	9	11
In institution, plus stable housing situation	-	-	-	12	9	11	4	5	4	4	2	4
In institution, plus unstable housing situation	-	-	-	12	9	11	2	2	2	1	1	1
Valid indications	-	-	-	439	175	614	2 741	915	3 656	1 029	303	1 332
Unknown	-	-	-	85	37	122	87	41	128	76	19	95
Missing	-	-	-	12	6	18	15	3	18	30	12	42

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 2011a, DOKLI analysis of client year 2010

Table A27:
Persons starting drug treatment or requiring addiction services in 2010,
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		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
Opioids	38	47	40	60	68	62	53	63	56	73	75	74
Heroin	26	31	27	41	42	41	37	43	39	52	53	52
Methadone	2	4	3	0	1	1	6	7	7	11	14	12
Other substitution substances	15	20	16	28	29	28	23	28	24	42	46	43
Other opioids, or opioids not specified	1	1	1	3	4	3	3	2	2	2	2	2
Cocaine group	7	8	7	9	7	9	10	8	9	20	15	19
Cocaine	7	8	7	9	7	9	10	8	9	20	15	19
Crack	0	0	0	0	0	0	0	0	0	0	1	0
Cocaine not specified	0	0	0	0	0	0	0	0	0	0	0	0
Stimulants	3	5	3	1	2	1	4	5	5	8	8	8
Amphetamines (e.g., speed)	2	3	2	1	1	1	3	3	3	6	7	6
MDMA (ecstasy), other derivatives	1	2	1	0	1	0	2	2	2	5	5	5
Stimulants not specified	0	1	1	0	0	0	1	1	1	1	0	1
Tranquillisers/hypnotics	7	14	9	14	13	14	8	11	9	22	27	23
Benzodiazepines	7	14	9	14	12	13	8	11	9	22	27	23
Barbiturates	0	0	0	0	0	0	0	0	0	0	0	0
Other hypnotics/ tranquillisers	0	1	0	0	2	1	0	0	0	0	0	0
Hallucinogenic drugs	0	0	0	0	0	0	0	0	0	2	1	1
LSD	0	0	0	0	0	0	0	0	0	1	1	1
Hallucinogenic drugs not specified	0	0	0	0	0	0	0	0	0	0	0	0
Cannabis	30	23	29	12	7	11	35	21	32	28	17	25
Solvents and inhalants	0	0	0	0	0	0	0	0	0	0	0	0
Alcohol	5	7	5	3	4	3	5	5	5	6	8	6
Biogenic drugs	0	0	0	0	0	0	0	1	0	1	1	1
Other drugs	0	1	0	0	0	0	1	1	1	1	0	1
Only use not relevant for treatment	26	20	25	16	11	14	3	5	3	2	3	2
Additional drug use only	4	5	4	9	11	10	7	7	7	7	9	8
Valid indications	6 266	1 696	7 962	623	236	859	3 763	1 225	4 988	2 057	642	2 699
Number of persons with valid indications	4 897	1 212	6 109	457	180	637	2 600	845	3 445	997	306	1 303
Unknown	507	182	689	65	34	99	165	85	250	108	22	130
Missing	65	33	98	14	4	18	78	29	107	30	6	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.

Bold type indicates main categories.

Sampled population: all clients.

Source: GÖG/ÖBIG 2011a, DOKLI analysis of client year 2010

Table A28:
Persons starting drug treatment or requiring addiction services in 2010,
by injecting drug use and age; percentages

Injecting drug use	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
No	70	60	68	17	15	17	60	53	58	29	26	28
Yes	30	40	32	83	85	83	40	47	42	71	74	72
Valid indications	4 694	1 187	5 881	345	145	490	2 630	875	3 505	989	310	1 299
Unknown	641	205	846	140	48	188	185	74	259	96	19	115
Missing	134	35	169	51	25	76	28	10	38	50	5	55

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 2011a, DOKLI analysis of client year 2010

Table A29:
Exchange and sale of syringes by province in 2010

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	4 ²	1	247 771
Salzburg	1	2	8 446
Styria ³	4 ²	2	432 772
Tyrol	2	3	358 642
Vorarlberg	6 ⁴	7	287 929
Vienna	2	0	2 808 011
Total	19	15	4 143 571

1: - No information/data provided.

2: Including one street social work service.

3: Syringes are only available in Graz, the capital of Styria.

4: Including two street social work services.

Source: Standard Table 10: Syringe Availability 2011; calculation by GÖG/ÖBIG

Table A30:
Current health problems of clients of Vienna's drug treatment and support centres
(BADO) from 2004 to 2009

Current health problems	2004	2005	2006	2007	2008	2009
Chronic hepatitis C	30	35	31	29	29	26
Dental problems	19	23	21	19	19	19
Gastrointestinal problems	11	16	14	12	12	13
Psychiatric diseases	9	10	12	13	11	14
Dermatological and venous problems	7	10	8	7	7	8
Aids, HIV infection	4	4	4	4	4	4
Spasms, epileptic seizures	5	6	6	5	5	6
Chronic hepatitis B	4	4	3	2	3	2
Chronic ill health	1	1	1	1	2	3
Gynaecological problems	2	4	4	4	3	3
STD (sexually transmitted diseases)	*	1	1	*	*	*
Other health problems	9	8	8	9	11	13
No current health problems	41	35	38	39	39	37

* = share of less than 1%.

Note: Any information on health-related problems exclusively relates self-reports by clients and is based neither on specific diagnostic questions nor on medical findings.

Source: IFES 2010; 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 involved by means of parent meetings and letters, 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 holistic view of individuals, orientation towards personal resources, interactive learning and integration of group processes. In the participating 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 A31:

Become Independent, school year 2010/2011

Province	Number of completed trainings SY 2010/11	Number of training lessons for teachers ¹ SY 2010/11	Number of certified teachers SY 2010/11	Share of teachers contacted (%)	Number of primary schools included SY 2010/11	Share of primary schools included (%)	Number of parents' meetings SY 2010/11	Number of workshops SY 2010/11	Number of primary school teachers contacted by SY 2010/11	Share of primary school teachers contacted by SY 2010/11 (%)	Number of primary schools included by SY 2010/11	Share of primary schools included by SY 2010/11 (%)
B	3	24	29	2.9	9	4.6	n.a.	n.a.	140	14.1	71	36.2
C	2	48	30	1.3	6	2.1	0	2	233	10	89	33.1
LA	3	68	43	0.7	7	1.1	0	0	512	8.7	131	20.7
UA	10	280	177	7.8	45	12.7	n.a.	n.a.	1.288	23.4	343	59.8
S	3	84	32	1.7	19	10.1	0	2	300	15.5	107	56.9
ST	2	60	39	1.0	9	1.69	0	5	343	8.74	146	27.6
T	2	62	34	1.2	14	3.7	0	2	343	12.1	170	44.3
VB	8	208	176	10.8	30	18	1	n.a.	543	33.4	78	46.9
V	6	151	122	2.2	14	2.2	n.a.	n.a.	1.164	21.2	214	79.0

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 school programme *plus* is implemented in years 5 to 8 (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 students 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 A32:

plus programme, school year 2010/2011

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 SJ 2010/11	Share of teachers contacted (%)	Number of schools included SY 2010/11	Number of classes included by SY 2010/11	Share of schools included by SY 2010/11 (%)	Number of teachers contacted by SY 2010/11	Share of teachers contacted by SY 2010/11 (%)	Number of schools included by SY 2010/11	Share of schools included by SY 2010/11 (%)	Number of classes included by SY 2010/11
B	16	54	44	2.8	14	n.a.	7	54	3	16	30.2	n.a.
C	3	62	58	1.9	10	18	9	58	1.9	15	13.5	35
LA	2	47	68	0.7	11	68	3.4	68	0.7	11	3.4	68
UA	7	192	135	1.4	35	90	12.5	135	1.4	35	12.5	90
S	3	60	35	1.7	11	23	11	35	1.7	11	11	23
ST	4	105	76	1.8	11	19	6.2	76	1.8	27	15.3	47
T	4	35	77	1.8	32	72	23.5	77	1.8	32	23.5	72
VB	4	76	43	1.6	16	n.a.	23.4	74	2.9	22	32.2	n.a.
V	2	40	43	0.5	27	28	12.7	63	0.7	36	16.9	42

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 in both 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 A33:
movin, 2010

Province	Direct/final target group (age group)	Indirect target group (advisors, counsellors, multipliers)	Number of courses/course series in 2010	Number of training lessons for multipliers in 2010	Number of certified participants in 2010	Documentation yes/no	Process evaluation yes/no
C	Young people from 12 to 21	Social education workers, social workers, school medical officers	3	48	50	yes	yes
LA	Young people, pregnant women, mothers with newborns, smokers	Midwives, psychologists of the Lower Austria Health Insurance Fund, staff of the non-smoking phone hotline, youth work teams	3	60	30	yes	yes
UA	Young people from 12 to 21	Detached youth work teams, basic youth social work course for provincial youth officers, trainers in courses of the Public Employment Service	3	48	46	yes	yes
S	Young people from 12 to 21 (in youth centres or social support services)	Detached youth work teams, staff of youth welfare offices, teachers, trainers, police officers specialising in prevention, smokers' support services	4	64	49	yes	yes
ST	Young people from 12 to 21	Detached youth work teams, youth social workers and counsellors, social education workers, non-smoking counsellors	3	60	42	yes	yes
T	Young people from 12 to 21	Advisors, social workers	1	3	15	no	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	3	72	37	yes	yes
V	Young people from 12 to 21	Detached youth work teams; key persons in schools, apprenticeship training and enterprises	8	189	89	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.

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 A34:

Selected prevention activities in different settings

Setting	Name of project/pro-gramme (province) [Translation of name]	Direct target group (age group)	Indirect target group (multipliers)	Short description
Families	<i>FamilienBande - Was geht ab?! (S)</i> [Family ties - what's missing?]	Young people from 10 to 16	Parents	The project addresses adults and aims at raising their awareness of their function as role models and also at promoting risk competence and responsible decision-making. The parent tables are a main element of the project: here trained facilitators visit groups of parents at the home of a host family to discuss, and provide assistance in, parenting issues related to drug use or playing games on the Internet as well as conflicts with children. The programme aims at motivating especially parents who do not often attend school-related events.
Communities	<i>Wir setzen Zeichen (UA)</i> [We're making a point]	General population	Diverse professions and areas of activity of communities	The project aims at implementing prevention oriented towards specific needs. In general, at first the current situation as well as local demands and existing services are studied. After consulting community representatives with regard to selection of themes, usually measures are taken that focus on awareness-raising and providing information for the public, on observation of youth protection regulations, promotion of life skills among children and discussion of at-risk patterns of behaviour among young people. If necessary, these measures are combined with services for enterprises and spare-time settings as well as for specific target groups.
Kindergartens	<i>Erziehung beginnt bei den Erziehenden, Suchtvorbereitung auch (V)</i> [Education comes from educators, and prevention, too]	Children up to 6	Kindergarten teachers, after-school care staff	The project provides further training in prevention for kindergarten teachers and after-school care staff. The training focuses on children in families with addiction problems and helps participants to develop and advance educational approaches that promote life skills among children.
Schools	<i>Schule SUCHT Vorbeugung (ST)</i> [Schools in search of prevention]	Students as of year 5	Teachers, parents	This is a medium to long-term project (depending on stakeholders' preferences) for school students in year 5 or older. The teachers in charge of project planning (at least 2 for every class) are offered assistance specifically oriented towards the needs of the class in question (expectations, age of students, previous experience, preferred themes). A manual on prevention in school settings is issued, which includes three general themes related to addiction as well as seven focal themes to be treated during class. In the context of a workshop, a subject is chosen and, in cooperation with the Addiction Prevention Units, prepared for discussion in class.

continued next page

Table 34, continued

Setting	Name of project/programme (province) [Translation of name]	Direct target group (age group)	Indirect target group (multipliers)	Short description
Youth work	<i>Join 2gether-coaching</i> (T)	Young people	Staff of youth centres and similar organisations	In two modules of a total of 10 to 12 hours, staff of youth centres and similar organisations are trained in interacting with and responding to young people who are suspected of illicit drug use. The main subjects include problem identification, appropriate responses to the problem, rules and models for dealing with the issue as a team and assistance with regard to other support systems. The training course takes place in the youth centres.
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 consumption as well as finding alternative problem solving strategies.
Vocational orientation courses, therapeutic special schools	<i>CHOICE</i> (VB)	Students in year 7 or older (age 12 to 24)	Parents, teachers and other attachment figures or role models	<i>CHOICE</i> is based on principles of health psychology. Its focus is on promoting self-perception and emotional as well as cognitive self-regulation among youths facing high risks. Being able to perceive and regulate one's feelings is a most important basis for preventing the development of abuse as well as other biological, psychological and social health risks.
Driving schools	<i>Peer Drive Clean!</i> (C)	People attending driving schools	Peers (college students)	Driving under the influence of alcohol and drugs is very dangerous with regard to road safety. Young people face special risks here as their tolerance to alcohol is lower and they are no experienced drivers. <i>Peer Drive Clean!</i> addresses this problem and aims at informing young people on the specific risk of alcohol and drug use when driving a car. The mandatory driving lessons include a peer lesson, i.e., specially trained young people who have obtained their driving licence a short time ago present the module on alcohol and drugs in road traffic, with the focus placed on information and discussion, and encouraging participants to explore their own patterns of behaviour.
Austrian Armed Forces	<i>Lecture to conscripts</i> (LA)	Conscripts		In a cooperation with the Armed Forces Command of Lower Austria, a lecture on addiction and prevention specifically targeting young people, combined with a film, is delivered to conscripts in the context of the army physicals. The focus is on providing general information and discussion of the diverse aspects of this theme, and encouraging the young men to explore their own patterns of use and get familiar with available support services.

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.

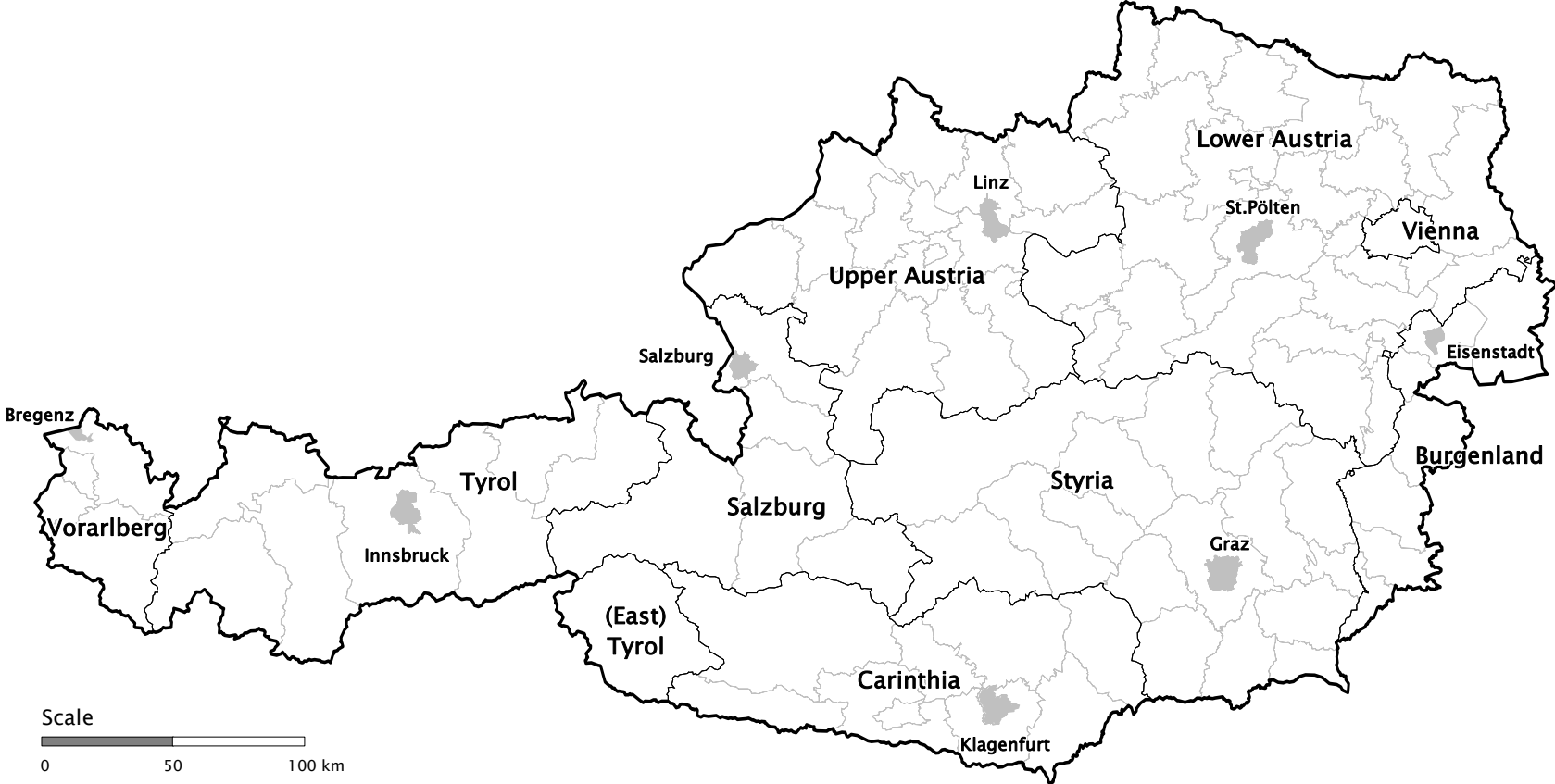
Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; representation by GÖG/ÖBIG

Table A35:
Austrian population statistics by age group (groups of 5 and 15 years, respectively)
and gender; annual average of 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 and 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 and 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

abs.	absolute
AC	Addiction Coordinator
AGES	Austrian Agency for Health and Food Safety
AIDS	acquired immune deficiency syndrome
AKH	General Hospital Vienna
AHIVCOS	Austrian HIV Cohort Study
AMS	Public Employment Service
APA	Austria Press Agency
AR	Addiction Representative
ART	anti-retroviral therapy
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
BMI	Federal Ministry of the Interior
BMI/.BK	Federal Ministry of the Interior/Federal Criminal Agency
BMJ	Federal Ministry of Justice
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
COFOG	Classification of Functions of Government
CRC	capture-recapture
DC	Drug Coordinator
DLD	Documentation of diagnoses and services of Austrian hospitals
DOKLI	nationwide documentation system of clients of Austrian drug services
DR	Drug Representative
DRD	drug-related death
DUI	driving under the influence
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
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	Fonds Gesundes Österreich [Health Austria Fund]
GÖG	Gesundheit Österreich [Health Austria]
GÖG/ÖBIG	Gesundheit Österreich/ÖBIG
GÖG/FGÖ	Gesundheit Österreich/FGÖ

HAART	highly active antiretroviral therapy
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
IDU	Injecting drug user
IFES	Institute for Empirical Social Studies
ISD	Institute for Addiction Diagnostics
ISP	Addiction Prevention Institute
JA	prison
KIJA	child and youth advisory office
LA	Lower Austria
LISA	list of doctors qualified for opioid substitution treatment
LSD	d–lysergic acid diethylamide
MA	Department of the City of Vienna
mCPP	meta–chlorophenylpiperazine
MDA	3,4–methylenedioxyamphetamine
MDE	3,4–methylenedioxy–N–ethylamphetamine
MDMA	3,4–methylenedioxy–methylamphetamine
ÖBIG	Österreichisches Bundesinstitut für Gesundheitswesen (Austrian Health Institute)
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
ÖGPB	Austrian Society of Neuropsychopharmacology and Biological Psychiatry
OST	Opioid Substitution Treatment
PAZ	police detention centre
PCR	polymerase chain reaction
PMA	paramethoxyamphetamine
PMMA	para–methoxymethamphetamine
PSD	Community Mental Health Centre
RCs	research chemicals
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 (social work service in Vienna)
SDDCARE	Senior Drug Dependents and Care Structures
SDW	Addiction and Drug Coordination Office of Vienna
SMG	Narcotic Substances Act
SQ	structured questionnaire

ST	standard table
Tb	tuberculosis
UA	Upper Austria
UN	United Nations
VWS	Vienna Social Projects Association
WHO	World Health Organization

Annex C

Standard Tables & Structured Questionnaires

List of 2010 Standard Tables 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. The collected information is used for the update of the statistical bulletin, the European Report on the drug situation as well as other products of the EMCDDA⁹⁰.

- STANDARD TABLE 01: STANDARDISED RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE
- STANDARD TABLE 02: METHODS AND RESULTS OF SCHOOL SURVEYS ON DRUG USE
- STANDARD TABLE 03: CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS (latest update: 2008)
- STANDARD TABLE TDI: CHARACTERISTICS OF INDIVIDUALS STARTING TREATMENT FOR DRUGS BY TYPE OF TREATMENT
- STANDARD TABLE 05: ACUTE/DIRECT DRUG-INDUCED DEATHS
- STANDARD TABLE 06: EVOLUTION OF ACUTE/DIRECT 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: Part 1: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS – Methods, Part 2: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS, Part 3: VOLUNTARY RESULTS FOR BEHAVIOURAL SURVEILLANCE AND PROTECTIVE FACTORS, Part 4: NOTIFIED CASES OF HEPATITIS C AND B IN INJECTING DRUG USERS
- 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
- STRUCTURED QUESTIONNAIRE 22/25: UNIVERSAL PREVENTION (latest update: 2010)
- STRUCTURED QUESTIONNAIRE 23/29: PREVENTION AND REDUCTION OF HEALTH-RELATED HARM ASSOCIATED WITH DRUG USE
- STRUCTURED QUESTIONNAIRE 26: SELECTIVE PREVENTION (latest update: 2010)

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For further information see <http://www.emcdda.europa.eu/>

- STRUCTURED QUESTIONNAIRE 27: Part 1: TREATMENT PROGRAMMES, Part 2: QUALITY ASSURANCE TREATMENT
- STRUCTURED QUESTIONNAIRE 28: SOCIAL REINTEGRATION AND REDUCTION OF SOCIAL INCLUSION OF DRUG USERS (latest update: 2010)
- STRUCTURED QUESTIONNAIRE 31: TREATMENT AS AN ALTERNATIVE TO IMPRISONMENT APPLICABLE FOR DRUG USING OFFENDERS IN THE EUROPEAN UNION (latest update: 2010)
- STRUCTURED QUESTIONNAIRE 32: POLICY AND INSTITUTIONAL FRAMEWORK