European Monitoring Centre for Drugs and Drug Addiction

ÖBIG REITOX FOCAL POINT AUSTRIA

2013 NATIONAL REPORT (2012 data) TO THE EMCDDA by the National Reitox Focal Point

AUSTRIA

New Development and Trends

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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. These reports examine the issue of illicit drugs. The present report offers an overview of current developments regarding the political and legal framework, the epidemiological situation and interventions to reduce demand during the reporting period 2012/13. This year's report does not include chapters focused on selected issues; instead, specific importance has been attached to researching academic publications brought out in Austria and/or written by Austrian (co)authors. For a list of all publications in academic journals, as well as doctoral and master's theses, please consult the Annex. The publications that have been used for this report have also been included in the Bibliography.

Summary and discussion of major trends

Legislation, strategies and economic framework

In 2012 the Federal Ministry of Health completed the Guideline on responses to harmful use and dependence on benzodiazepines among patients in oral opioid maintenance treatment, and communicated it to the medical professionals in charge. Parallel to the Guideline, rules have been issued for flunitrazepam, which as of now can only be dispensed on the basis of specific addictive-substances prescriptions, while repeated dispensing of active ingredients in the benzodiazepine group, on the basis of a single prescription, has been abolished without exception. The Delphi study has been completed and presented. It defines addiction as a severe psychiatric, chronically recidivating disease. As a basic model for addiction policy, the 'addiction cube' model developed in Switzerland has been used and expanded. The main role of addiction policy has been defined as the minimisation of all problems related to the abuse of substances and to addiction, through adopting ethically acceptable measures that are appropriate for the intended purpose. This will be the basis for developing a national addiction and prevention strategy. The reporting period also saw the publication of an anti-drug strategy drawn up by the Ministry of the Interior, and the subsequent controversy, particularly over substitution treatment for opioid addicts, was also discussed in the media.

Drug use in the general population and specific targeted groups

The most recent results of the Vienna drug monitoring survey do not indicate significant changes in drug use. Cannabis continues to be the only illicit drug for which relevant prevalence rates are found among the general population. Surveys among university students show that in this group, problem patterns of alcohol use play a significantly greater role than the use of illicit drugs. In contrast to a number of media reports, the use of *new psychoactive substances* has hardly been relevant.

Prevention

Child and adolescent health has continued to be in the focus of health-policy activities. For instance, the new youth strategy is to be implemented in close cooperation with the Child and Adolescent Health Strategy. Regarding the prevention of addiction, which often forms part of health promotion, the predominant existing measures/programmes/projects have been developed further during the reporting period. Here, media education has been playing an increasingly important role. One focus is on selective prevention, and new projects especially address children in families with addiction problems, and also young people in labour-market policy programmes and occupation projects. The area of indicated prevention is slowly being expanded, oriented towards early detection and early intervention on the one hand, and young people with alcohol poisoning on the other.

Problem drug use

Opioid use, typically in the context of poly-drug use, currently accounts for the largest share of problem drug use in Austria. Approximately 90% of all clients of drug support and treatment centres indicate opioids as their primary drug. At present, Austria has between 30 000 and 34 000 problem drug users who use opioids. Around half of them live in Vienna (drug addiction continues to be more frequently found in urban areas than in rural communities). One out of four PDUs is female, and around one in four is under 25 years old. The introduction of *eSuchtmittel* [eDrugs] has improved the data situation and has permitted a re-analysis of the prevalence estimates of problem drug use (opioid use). Between the early 2000s and 2004/5, rising prevalence rates of PDU are apparent, mainly accounted for by larger numbers of adolescents and young adults starting to show problem patterns of drug use. The proportion of young people with PDU has meanwhile gone down again, however. Whereas Vienna has recorded constant prevalence rates in recent years, the other provinces have displayed increases (probably due to an equalising trend regarding the extent of drug problems in rural areas and small towns v. the large city of Vienna). Snorting continues to be a frequent form of opioid use. Between 15 000 and 17000 people tend towards injecting drug use.

Drug-related treatment

The reporting period again revealed pronounced differences with regard to examinations and decisions on health-related measures, in accordance with Section 12 of the Narcotic Substances Act (SMG). The manual on the uniform implementation of diagnoses under SMG Section 12 has now been completed, and has been issued to the provincial health administration authorities in charge by the Ministry of Health. No relevant changes have been apparent regarding the availability of opioid substitution treatment. The total number of doctors registered as qualified to deliver OST has remained almost the same, and the average numbers of OST patients per doctor's office greatly differ. Several publications on OST discussed the arguments for and against the use of slow-release morphine, which has been the focus of the recent debate. The fact that OST has become an accepted form of treatment has resulted in a steep rise in the number of opioid addicts undergoing OST, and thus of the in-treatment rate (2002: 4 883

persons; 2012: 16 892 persons. At present, more than half of all persons with problem patterns of opioid use are in opioid substitution treatment. Recent studies indicate that there is a group of severely addicted opioid users who are undergoing substitution treatment but are unable to stop injecting drug use (completely). This might indicate a need to discuss the option of opioid substitution treatment using injecting routes of administration (e.g. a heroin programme). On the other hand, the fact that injecting use of substitution medicines cannot be prevented completely means that one has to ensure that substitution medicines can be injected without avoidable health risks (e.g. because of talcum additives).

The most recent data from treatment centres confirm that opioids continue to predominate as primary drugs, while cocaine is rather insignificant. Here, cannabis again ranks second as a primary drug, after opioids. *New psychoactive substances* have hardly played a major role in this context.

(Responses to) health correlates and consequences

Several sources of data on hepatitis C prevalence among injecting drug users continue to reveal very high infection rates (around 70%). Hepatitis C thus constitutes a massive problem among injecting drug users, which is confirmed by the high hepatitis C coinfection rates in persons with HIV infections due to IDU. The figures relating to HIV still lie at low levels. In 2012, a total of 139 fatal drug overdoses were recorded in the context of autopsies. Another 22 deaths, for which no autopsies (but only external post-mortem examinations) were performed, are also very likely to have resulted from overdoses. Therefore, a total of 161 drug-related deaths due to drug overdoses is assumed for 2011 (2011: 201 cases). In addition to the treatment of addiction (see above), syringe exchange and sale are important for preventing infections: more than 4 million syringes were sold or exchanged in the context of drug support services, mostly at low-threshold centres. The Delphi study also emphasises the relevance of emergency interventions and harm reduction, and thus the need for free low-threshold services, outreach social work and syringe dispensing and exchange services all over Austria.

Social correlates and social reintegration

Drug users have again been strongly affected by social problems such as homelessness, unemployment as well as debt. For instance, in the 2012 population of DOKLI clients, only 6% of the clients undergoing inpatient treatment had jobs, which again is the smallest percentage of all groups of clients. In addition, only 50% of people taking up low-threshold services said their housing situation was stable. Specific measures have been adopted to reduce this problem, with the focus again on improvements regarding referral to adequate jobs, or to programmes exploring the clients' future prospects. In addition, leisure activities are organised. The existing housing programmes have been continued.

Drug-related crime

2012 saw a decline in the total number of drug-related reports to the police, with regard to both misdemeanours and felonies. A downwards trend is apparent for all substances except precursor substances. In 2012, the number of temporary waivers of reports decreased again, except regarding reports in connection with cannabis, mushrooms containing psilocin, psilotin or psilocybin, as well as psychotropic substances, where an increase has become apparent. It is possible only to a limited extent to compare the number of convictions to the figures of previous years, as 2012 saw a break in the time series due to a change in data collection. During the same period, the data on the application of the principle of treatment instead of punishment have shown a slight downwards trend. Experts are again pointing to the problem that the Ministry of Justice has limited its cost-coverage for inpatient treatment to a maximum period of six months, and that the provinces have to bear any follow-up costs.

Drug markets

Regarding seizures, cannabis has again predominated, while decreases are apparent for heroin, cocaine, mephedrone, as well as medicines containing narcotic drugs or psychotropic substances. In the party and clubbing scenes, at least, *new psychoactive substances* have not been as predominant as in previous years, and they have less often been detected as unexpected additives in 'traditional' substances such as ecstasy, speed or cocaine. The drug-tests revealed ecstasy pills containing very high doses of MDMA (more than twice as high on average as a few years ago). In the context of *checkit!*'s analyses of substances used within the party scene, many users had to be warned, as more than 25% of the samples tested contained ingredients that posed considerable health hazards, e.g. the addition of PMA/PMMA to ecstasy, levamisole to cocaine, and 4-MA to speed.

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Introduction

This is the 18th time that the REITOX Focal Point at GÖG (Gesundheit Österreich GmbH), ÖBIG business unit (GÖG/ÖBIG), is presenting 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 for drug-related matters and cooperates very closely with the relevant federal and provincial authorities in the field as well as addiction and drug treatment and support services.

The present report deals with the **illicit drug** situation in Austria and serves as both a national report to the Austrian Federal Ministry of Health and as Austria's contribution to the report on the drug situation in the European Union. Similar reports are being submitted by the REITOX Focal Points of all EU member states and by the EU candidates, in accordance with guidelines issued by the EMCDDA. These reports form an essential basis for the EMCDDA's annual report on the state of the drug problem in Europe (latest publication: EMCDDA 2012). Part A of the present report discusses new developments and trends with regard to the drug policy framework, the epidemiological situation and health-policy interventions aimed at demand reduction. It is based on previous reports (latest report: GÖG/ÖBIG 2012) and refers to the reporting periods from summer 2012 to summer 2013, while routine statistics refer to the year 2012. In contrast to our previous reports, this year no selected issues chapters have been included. In the present report, specific importance has instead been attached to researching academic publications in Austria and by Austrian (co-)authors. These publications, as well as the Austrian projects available in the European EDDRA database and relevant Austrian websites, are given in the Bibliography section. The Annex provides a number of additional tables with detailed information and data. Every year the REITOX Focal Points also submit data to the EMCDDA annual standard tables and structured questionnaires These data and information have also been integrated into the present report, which includes 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 a large volume of varied 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 and Addiction Coordination Offices have proved to be especially significant. In addition, a number of experts have provided background information and specific data for individual chapters of the present report. 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.

1 Drug Policy: Legislation, Strategies and Economic Analysis

1.1 Introduction

The Narcotic Substances Act (SMG; BGBl I 1997/112 v. 5. 9. 1997) constitutes the main framework of Austria's drug policy. The SMG distinguishes between narcotic drugs and psychotropic substances. Limit quantities have been laid down in Regulations, and if higher amounts of drugs are involved, severe punishment can be imposed. Special provisions exist for cannabis and hallucinogenic mushrooms. The SMG 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), as well as the Committee on Quality and Safety in Substitution Treatment. 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 provincial drug policy papers or addiction plans and nominated drug or addiction coordinators. A national addiction strategy is being prepared by the Federal Ministry of Health (BMG). For a detailed discussion of the political and organisational framework, please consult SQ32.

Funding for drug policy measures comes primarily from the Provincial Governments, the social insurance funds and the Federal Government. In Austria, the COFOG classification[1], use of which is encouraged by the EU, has not been fully implemented, and drug or addiction-related expenditure is not usually specified in the respective budgets (see GÖG/ÖBIG 2007). Therefore, again, no conclusive statements on expenditure in this area can be made regarding Austria.

1.2 Legal framework

Parallel to the Guideline on responses to harmful use and dependence on benzodiazepines among patients in oral opioid maintenance treatment, the Narcotic Substances Regulation (BGBl II 2012/357 v. 30. 10. 2012), the Narcotic Substances Limit Quantities Decree (BGBl II 2012/361 v. 30. 10. 2012) and the Regulation on Psychotropic Substances (BGBl II 2012/358 v. 30. 10. 2012) were amended to implement the modifications mentioned last year:

» Stricter rules have been issued for flunitrazepam (an active ingredient of the benzodiazepine group), which as of now can only be dispensed on the basis of specific addictive-substance

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1
The COFOG Classification of Functions of Government comprises 10 divisions, which are divided into groups and classes. In Austria, figures on expenditure broken down by COFOG divisions are available, but not by groups and classes.

prescriptions. This is aimed at raising awareness of addiction risks among doctors and at ensuring the traceability of each prescription issued.

» Medicines that contain other active ingredients of the benzodiazepine group may still be issued on the basis of standard prescriptions, but repeated dispensing (i.e. one prescription valid for several packages) has been abolished without exception. This is aimed at preventing people from accumulating large quantities of medicines and ensuring the use as indicated of the medicines.
» New formal regulations have been issued to facilitate the automated issuing of addictive-substance prescriptions, while in the case of hand-written prescriptions, double specification (in figures and words) continues to be necessary. In this way, the handling of automated prescription-issuing is made easier, and hand-written prescriptions continue to be protected against counterfeit and abuse.
» A database made available by the BMG through the joint administrative portal, plus opto-electronic[2] identification of narcotic drug stickers in pharmacies, will help to quickly and easily detect any narcotic-drug stickers or prescriptions that have been reported missing or stolen. In this way, the potential for abuse can be reduced.
» New provisions have been adopted with regard to take-home schemes for medicines containing narcotic drugs that have been regularly prescribed: the maximum permissible quantity that may be dispensed to clients travelling abroad is limited to their need for 30 days. Similar to the Guidelines issued by the International Narcotic Control Board (INCB), the procedures to be followed depend on the abuse potential of the medicine that has been prescribed. Standardised official certifications based on the Schengen Agreement will make it easier for travellers to and from Austria to take with them the medicines they need during their journey.
» Tapentadol, an active ingredient used for pain treatment, has been defined as a narcotic drug, in the same way as similar substances, and included in Annex I of the Narcotic Substances Regulation.
» Authorised pharmaceutical specialities with active ingredients obtained from natural cannabis extract (e.g. for symptomatic treatment of spasticity in multiple sclerosis) may be dispensed on the basis of addictive-substance prescriptions; this procedure already exists for the prescription of synthetically produced delta-9-tetrahydrocannabinol.

1.3 National action plan, strategy, evaluation and coordination

The political and administrative framework has not seen any major changes during the reporting period. The **Federal Drug Forum** (see Fig. 1.1) held two regular meetings during the relevant period (October 2012, April 2013). The themes on the agenda included diverse issues connected to treatment instead of punishment, the completion of the manual on uniform implementation

2
Opto-electronics combines electronic data preparation and data processing with the transmission properties of light.

of Section 12 of the Narcotic Substances Act (SMG), the new anti-drug strategy launched by the Ministry of the Interior, and the implementation of SMG Section 13 by schools.

The reporting period did not see any further **modifications of the drug and addiction policy programmes** at federal or provincial levels. However, within the reporting period, the Delphi study preparing a national addiction prevention strategy with special emphasis on risks for children and young people[3], drawn up on behalf of the Ministry of Health, was completed and presented in July 2013. Choosing the Delphi method as an approach has helped the experts find a far-reaching consensus on how to respond to addiction problems in Austria in a more comprehensive way (Uhl et al. 2013a)[4]. This expert consensus has been regarded as essential because an Austrian strategy for preventing and responding to addiction is to be derived from the findings.

In the context of the Delphi study, at first the general understanding of addiction (dependence) as a severe psychiatric, chronically recidivating disease was discussed. As a basic model of prevention and addiction policy, the 'addiction cube' model developed in Switzerland[5] was used and developed further by including non-substance-related forms of addiction, supporting processes such as addiction research and further training, as well as the general framework, as a central basis. The main role of addiction policy was defined as minimising the sum of all problems related to abuse of substances and to addiction, with measures that are ethically acceptable and appropriate for the intended purpose. This includes goals such as the following:

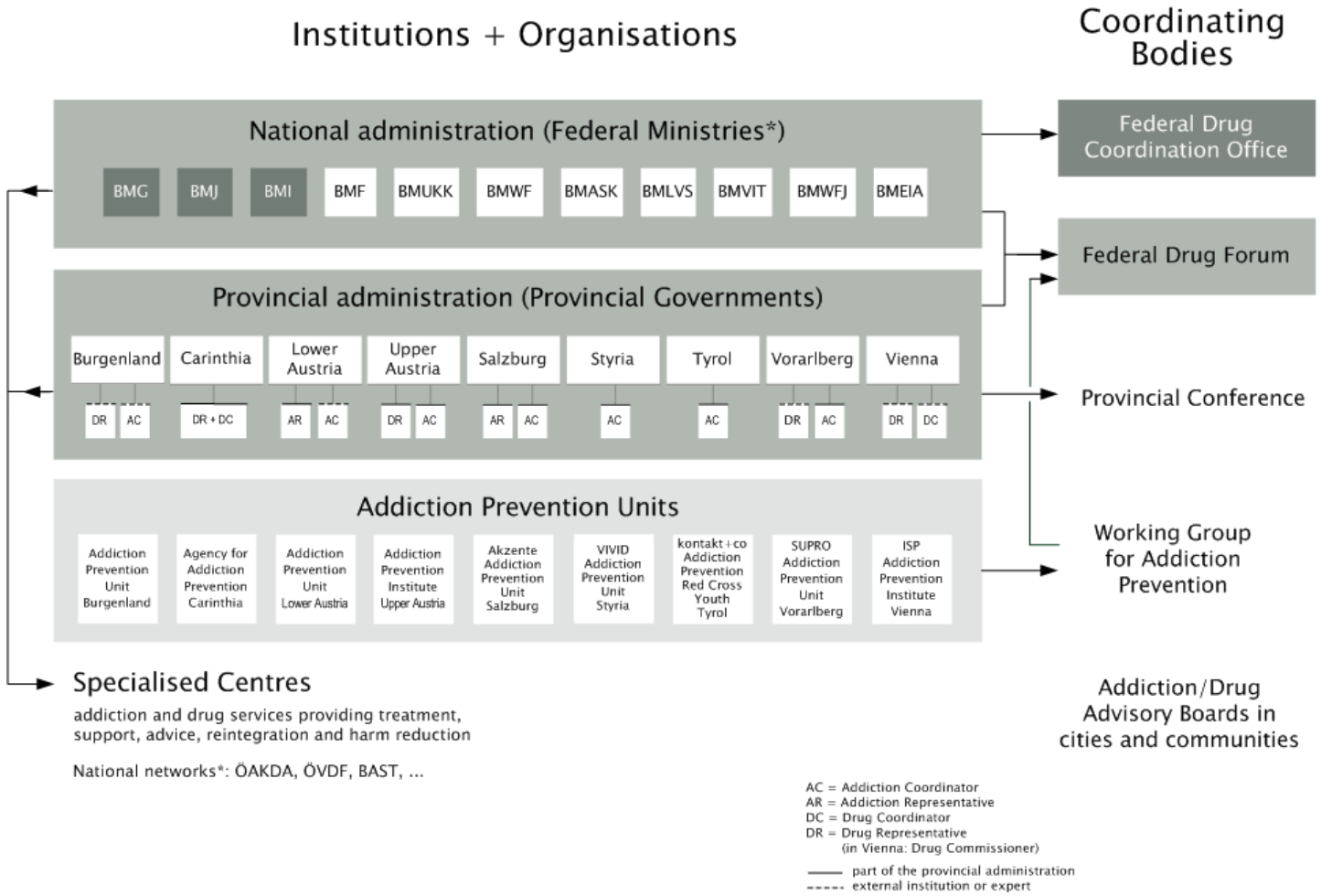
» Negative effects of the use of psychoactive substances or non-substance-related addictive behaviour should be kept as small as possible (see also Chapter 7.2), or should be prevented from developing.
» Persons with addiction problems should receive support of a kind that helps them stay, or become, healthy and socially integrated; and they should have control over, and find meaning in, their lives to the greatest possible extent. They should be integrated in the health and social care system in line with their needs.
» Socially acceptable forms of coexistence for all people should be found.

3
To download the German version go to http://bmg.gv.at/cms/home/attachments/9/7/1/CH1347/CMS1372766555263/delphistudie_20130628.pdf (4 July 2013).

4
The participants included 100 scientists, practitioners and administration experts in the fields of addiction-related prevention and support as well as security, plus several representatives from the business sector. In the course of a two-year decision-making process, a high degree of consensus, or a more than 2/3 agreement, was reached on most issues, and in a few cases, there were only small majorities.

5
See http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/ (30 July 2013; in German).

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



* see List of Abbreviations.

Source and graphic representation: GÖG/ÖBIG

Funding for prevention, support and treatment services provided by federal, provincial and local authorities should be based on clear regulations and ensure the equal, uniform availability of the entire range of available (comprehensive, diversified) services. A slim majority of the participants argued in favour of an earmarked tax on the sale of substances or activities with high abuse or addiction potential, with the revenues to be used for funding prevention and treatment. The approach of encompassing diverse substances and types of addiction that has predominated in recent years has been endorsed, while it has been agreed that the health-related aspects of the use of illicit substances should be stressed more strongly. Regarding prevention practices, priority should be given to systematic, evidence-based approaches and they should be coordinated with all stakeholders. Reduced use and controlled use should play a more important role in support and treatment services. Addiction research, evaluation and documentation have been defined as essential foundations for arriving at concrete conceptions of the causes and consequences of addiction, as a basis for conscious decisions regarding responses to the phenomenon of addiction. As a next step on the way to a national addiction and prevention strategy derived from the Delphi study, the BMG will establish a working group (Schopper, personal communication).

Despite these developments, in November 2012 the Ministry of the Interior (BMI), pointing to a rise in drug delinquency, published an 'Anti-Drug Strategy' with the following five points:

» In order to promote prevention activities in schools, as of 2013 the current number of police officers specialising in prevention (255) is to be increased by 44.

» Section 14, para. 2 of the SMG is to be amended so that police officers may involve the health authorities within a shorter time, and first consumers, in particular, can thus be medically examined soon after the police intervention.

» Need for improvement is indicted with regard to the quality of examinations by the health authorities: hair samples should be taken instead of performing a urinalysis, as this allows the detection of drug use over a longer time (see also Chapter 9.3).

» Substitution treatment of opioid addicts is not regarded as effective in view of the goal of drug abstinence. The BMI therefore proposes using other methods of treatment.

» The activities to combat drug trafficking are to be intensified, through targeted street-level activities on the one hand and through cross-border cooperation with Balkan countries on the other.

The publication of this strategy met with massive criticism from experts in prevention and addiction support. This discussion was also covered by the media. One point of criticism was that most of the activities outlined in the Anti-Drug Strategy do not fall under the BMI's competence but are health policy matters, and that the scientifically proven success of opioid substitution treatment (especially regarding stabilisation and ensuring the survival of opioid addicts) is being denied. In a response to a Parliamentary Enquiry to the Federal Ministry for the Interior[6],

6
See http://www.parlament.gv.at/PAKT/VHG/XXIV/J/J_14611/index.shtml (27 June 2013; in German).

this initiative was explained by the absence of any discussion of this matter at the political level (BMI 2013b). It was acknowledged afterwards that medically assisted long-term treatment was not questioned. The details of the arguments stated in the context of the media discussion of OST are treated in Chapter 5. This development has again shown that the discourse regarding substitution medicines, in particular, but also regarding the implementation of substitution treatment, is characterised by pronounced differences in interests and ideologies.

To establish the actual validity of hair analyses (see also Chapter 9.3), the Vienna Addiction and Drug Coordination organised an expert discussion that took place in February 2013. It was explained that different substances are incorporated into and removed from the hair matrix to different extents. Positive testing does not provide information on the quantity and duration of previous drug use nor on current drug influence. Therefore, such tests should be used neither instead of preventive or other drug-related measures, nor for the routine screening of the general population (Schmid 2013).

Events focusing on the recent developments in drug policy include the REITOX Academy organised by GÖG in December 2012, in which new developments in Portugal, Denmark and the Netherlands were among the topics discussed. In June 2013 the Province of Tyrol (Departments of Health and Social Affairs) organised the Tyrolean Addiction Meeting[7], with topics such as new, or recently questioned, positions in drug policy, e.g. abstinence, moderate use, acceptance and quality of life, and the recent controversy over substitution treatment also formed part of the discussion.

The expansion, announced last year (GÖG/ÖBIG 2012), of the tasks and functions of Salzburg's Drug Coordination Office to create an Addiction Coordination Office has meanwhile been concluded (Suchtkoordination des Landes Salzburg 2013). In order to draw up a more comprehensive addiction support and treatment programme, the evaluation of the drug support system will be complemented by an evaluation of the services provided for clients addicted to alcohol, medication or gambling. In the area of addiction prevention, steering groups for specific settings were established to enhance the focus on secondary prevention and interventions for defined target groups with regard to families (including childcare outside the family), schools and young people at work, and as well as in spare-time contexts.

Styria's addiction policy is also being expanded to include psychoactive medicines and non-substance-related forms of addiction, and a set of measures is being prepared (Ederer, personal communication). Further themes that have been on the political agenda include products to stimulate alertness and productivity, the opening-up of the regular medical and psychosocial care system to addicted patients, as well as a basic documentation system as a steering instrument for addiction policy.

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For further information (in German) please visit http://www.kontaktco.at/suchttagung/.

In 2012 the Vienna Addiction and Drug Coordination started to discuss the advancement of Vienna's Drug Policy Programme. The 1999 Programme will be amended to include new relevant aspects and themes, such as responses to addiction to legal psychoactive substances, and a broader definition of addiction is being applied (SDW 2013).

1.4 Economic analysis

The financial regulations in the field of drugs did not see any changes during the reporting period. Regarding public budgets, it is not possible to make any conclusive statements based upon them, as most budgets do not specify drug-related items. However, due to the difficult budget situation in a number of provinces, measures that have already been planned are having to be postponed, or their implementation is uncertain (e.g. in Carinthia and Salzburg; see Chapter 7.3). In those provinces where the funding has remained the same, as a consequence of rising fixed costs, the number of clients to whom services can be made available may fall (e.g. in Styria, see Chapter 5.3). Other provinces, however, have been able to increase the resources for addiction treatment and support services (e.g. Tyrol; see Chapter 5.3).

The funding problems that arise in the areas of prevention, as well as support and treatment services (especially treatment instead of punishment), due to the complex legal situation and overlapping competences of federal, provincial and local authorities, as well as the social insurance funds, have repeatedly been discussed in the Federal Drug Forum and are also dealt with in the Delphi study (see Chapter 1.3). So far, no solution to this problem is in sight.

A recent study on treatment instead of punishment examined, among other issues, the costs of treatment and criminal prosecution. It was established that, based on the available data, it is hardly possible to arrive at a valid estimation of the overall social cost (Schumann and Soyer 2012b)[8]. Nevertheless, to get a rough idea,, partial studies were conducted to gather various data and estimate the corresponding costs. For instance, Metz et al. (2012) collected data on the cost of medical treatment, which revealed great differences in both the cost of inpatient treatment, depending on hospital and province, and on the type of necessary treatment (e.g. intensive care costs are between EUR 309 and 444 per patient per day), as well as outpatient opioid maintenance treatment, depending on the substitution medicine administered (in 2011 the prices for the social insurance funds were between EUR 114.75 and 271.10 per patient per month). Schumann and Soyer (2012a) also estimated the cost of criminal prosecution. The costs of legal aid that have to be taken over, in cases where the defendant is in pre-trial custody and their counsel for the defence has been appointed by the court, amount to an average of EUR 1 500 per case. By 1 April 2011, a total of 2 044 persons were imprisoned for violation of the SMG, which – assuming daily costs of approx. EUR 100 – corresponds to a total annual cost of

8
The results are based on two research projects which were funded by the Austrian National Bank and Mundipharma and consisted of a literature search as well as analyses of available data.

imprisonment of approx. EUR 74 mill. In addition, an average annual of EUR 1 201 per person is spent on medicines dispensed in the context of substitution treatment in prison. To compare cost efficiency, Schuman and Soyer (2012b) extrapolated the cost of health-related measures, assuming short-term inpatient treatment of 20.2 days followed by long-term opioid maintenance treatment. Based on international analyses, and including corrections to account for the situation in Austria, these costs are estimated to amount to approx. EUR 4 800 annually per patient, and it is emphasised that early treatment will reduce the follow-up costs. The authors conclude that the cost of treatment (approx. EUR 4 800 annually per patient) is considerably lower than the average annual cost of imprisonment, which is around EUR 36 500 per person.

For further information on cost coverage by the Federal Ministry of Justice (in accordance with SMG Section 41 for health-related measures) please consult Chapter 9.4.

2 Drug Use in the General Population and Specific Targeted Groups

2.1 Introduction

In 2004 and 2008, two representative studies focusing on alcohol, tobacco and drugs, and 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-related sections 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 been repeatedly carried out for specific settings. Occasionally, data from secondary prevention projects such as *MDA basecamp* or *checkit!* as well as specialised surveys, may be used for making estimates of drug use in youth scenes.

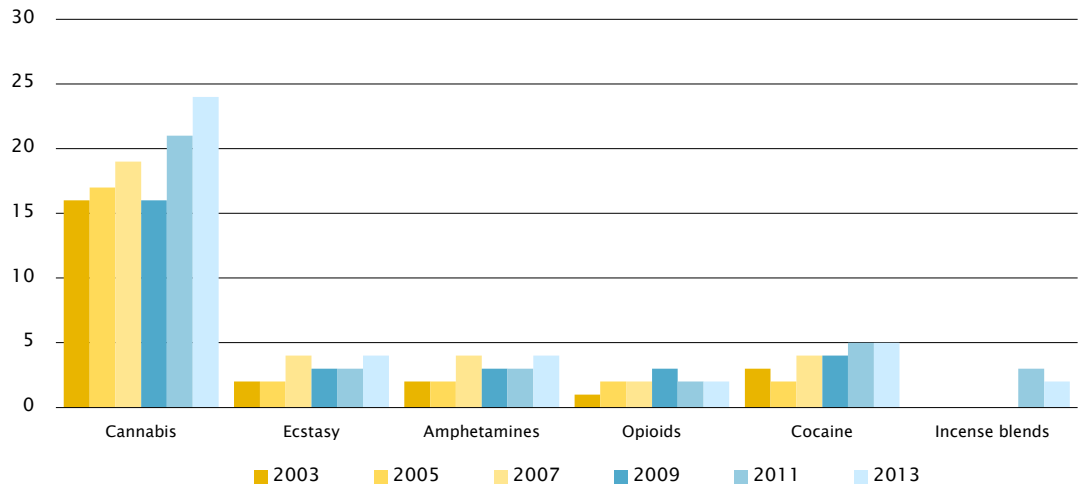
As to the prevalence of drug use, a distinction is made between lifetime prevalence (drug use at some point during a person's lifetime), 12-month prevalence (drug use in the past year) and 30-day prevalence (drug use in the past month). Statements on current drug use can only be derived from 12-month 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, approximately 2% to 4% of the population have some experience of ecstasy, cocaine and amphetamines, and approximately 1% and a maximum of 2% have some experience of opioids (see Tables A1 and A2). In recent years, the range of substances taken in the context of experimental use has widened. Within certain scenes and groups of young people, one finds high prevalence rates for a variety of substances, including biogenic drugs, solvents and inhalants. However, in most cases, use of illicit substances is limited to a short period in life. Very few data are available regarding the use of *research chemicals* and *legal highs* in the general population, which, however, indicates insignificant prevalence levels, in contrast to the great interest in this theme reflected by media coverage.

2.2 Drug use in the general population

Vienna's drug monitoring survey[9] (IFES 2013), published in 2013, provides an overview of drug use in the general population of Vienna.

Figure 2.1:
Lifetime experience of illicit drugs in Vienna's general population from 2003 to 2013 (percentages)



The drug categories of the survey were: cannabis = cannabis products, e.g. hashish, marijuana; amphetamines = amphetamines, speed; opioids = e.g. opium, morphine, heroin, methadone; incense blends = e.g. Spice, Lava Red.
Note: If a year does not have a column, this type of drug was not included in the survey of that year.

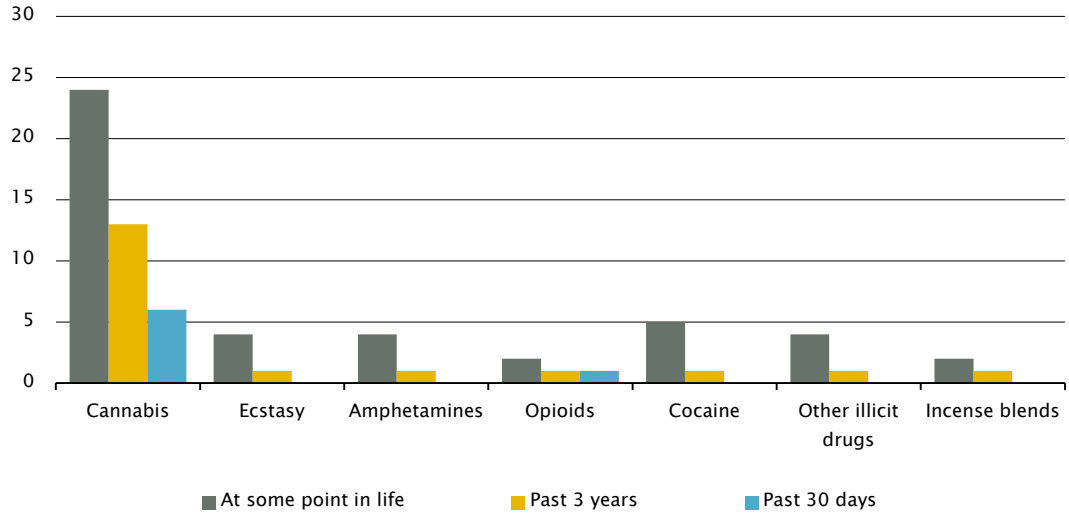
Source: IFES 2013; graphic representation: GÖG/ÖBIG

Valid statements on trends can only be given for cannabis. Here, an increase in life-time prevalence has been apparent in the long run. In the case of cocaine a long-term rise in lifetime prevalence is also apparent, even though at a considerably lower level (see Figure 2.1). The degree of experience of *new psychoactive substances* is generally low (incense blends such as Spice or Lava Red: 2 %; mephedrone[10]: 1%).

9
Vienna's 2013 drug monitoring survey was conducted from March to April 2013 among a representative sample of 600 persons (stratified multi-stage clustered random sampling based on recent address data available at the Institute) as oral interviews at the respondents' homes. This survey on experience of drug use has been carried out on behalf of the Vienna Addiction and Drug Coordination every two years since 1993, with similar methodologies.

10
Even though mephedrone has since 2010 been classified as a substance falling under the SMG, it belongs, like many other new psychoactive substances, to the group of synthetic cathinones.

Figure 2.2:
Lifetime experience and prevalence of use in the past three years and past 30 days among the population of Vienna, percentages, in 2013



The drug categories of the survey were: cannabis = cannabis products, e.g. hashish, marijuana; amphetamines = amphetamines, speed; opioids = e.g. opium, morphine, heroin, methadone; incense blends = e.g. Spice, Lava Red.

Note: If no column for experience of use is given, the corresponding percentage is less than 1%.

Source: IFES 2013; graphic representation: GÖG/ÖBIG

Figure 2.2 illustrates that illicit drug use (in contrast to alcohol and nicotine) is usually limited to a short period in life

Regarding lifetime prevalence of cannabis use, the group under 30 accounts for 22% – with no differences apparent between women and men – which is slightly lower than the overall average of 24%. In the older age groups, the percentage of men with experience of cannabis is considerably higher than the proportion of women. This applies to both the age group from 30 to 50 (men: 36%; women: 20%) and to the group over 50 (men: 31%; women: 15 %). Experience of cannabis is significantly smaller in the group of 60 or older (12%). In the case of all other drugs, the prevalence of use is so small that no valid statements on differences in terms of age and gender can safely be given. The figures show that it is almost exclusively men who indicate experience of ecstasy, incense blends or amphetamines (IFES 2013).

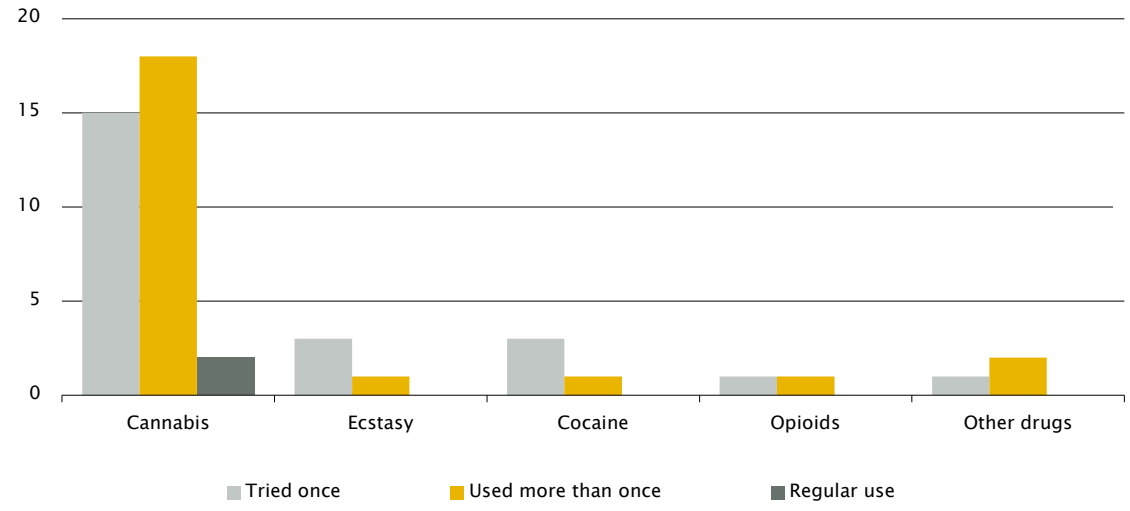
2.3 Drug use in the school and youth population

The reporting period did not see any studies on drug use in the school and youth population. However, two studies are available that include drug use among university students (see Chapter 2.4).

2.4 Drug use among targeted groups

A study on the relationship between temperament and psychoactive substance use among students (Unseld et al. 2012)[11] revealed a lifetime prevalence of cannabis use of 35%. For all other illicit drugs surveyed, the lifetime prevalence rates were considerably smaller (see Figure 2.3). Only 2% of the respondents indicated regular use of cannabis. The CAGE questionnaire[12], however, revealed a diagnosis of alcohol abuse for 25% of the respondents (CAGE = 1) and of alcohol addiction, for 22% (CAGE = 2–4). Even though questionnaires are of very limited use for diagnosing addiction, it shows that the prevalence of alcohol abuse is many times higher than illicit drug use.

Figure 2.3:
Experience of illicit drug use among university students in Austria



Source: Unseld et al. 2012; graphic representation: GÖG/ÖBIG

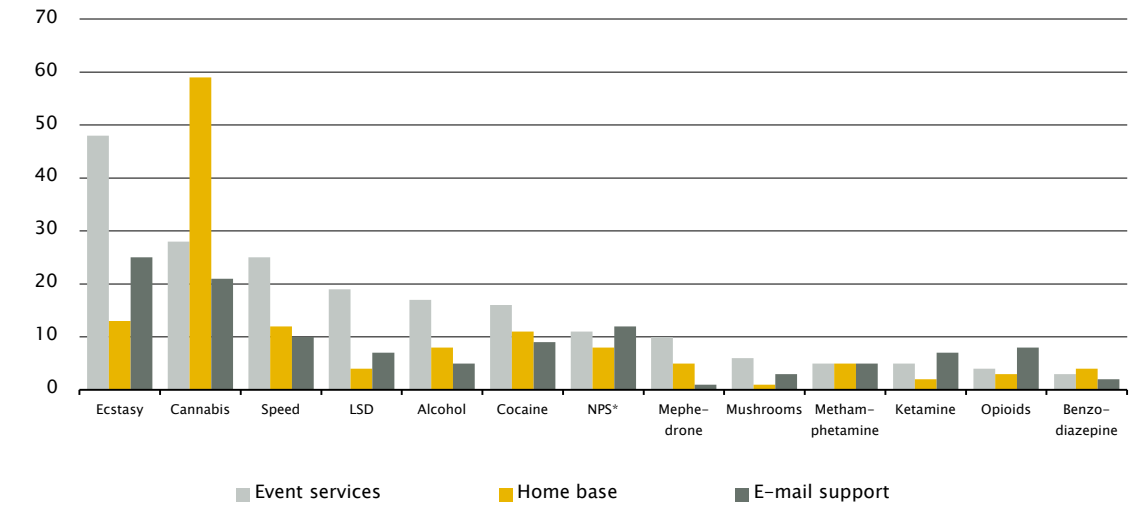
11
Questionnaires were sent to a total of 3 000 students living in 20 halls of residence run by the Austrian Young Workers' Movement (questions on temperament and substance use). From October to November 2009, 1 380 questionnaires were returned (dropped into a sealed box at the residence hall). 60% of the respondents were female, and around 3 out of 4 were between 19 and 25 years old.

12
The CAGE questionnaire surveys the following symptoms: feeling the need to cut down on one's drinking, criticism by others, feeling guilty about drinking, and drinking in the morning. Depending on the symptoms indicated, the resulting score ranges from 0 to 4.

A diploma thesis comparing substance use by university students in Vienna and Innsbruck arrives at similar results (Matznetter 2012)[13]. 19% of the respondents said they had used cannabis in the past six months, while daily cannabis use was indicated only by 2%, and weekly use by 3%. For the remaining illicit drugs, the prevalence of use in the past six months was less than 2%. In Vienna, the prevalence of cannabis use (21%) was slightly higher than in Innsbruck (16%). This survey also used the CAGE questionnaire for examining alcohol abuse. For 24% the scores were between 2 and 3 (suspicion of alcohol addiction), and 2% had a score of 4 (strong suspicion of alcohol addiction).

Indirect information on substances used in party settings can be obtained from the substances mentioned in advice talks by *checkit!* (see Chapters 7.2 and 10.4). Depending on the type of support setting, the predominant substances are cannabis or ecstasy (see Figure 2.4). *New psychoactive substances* rank third in the context of e-mail support (after cannabis and ecstasy (SHW 2013d). The percentage of e-mail enquiries in which *new psychoactive substances* were discussed has gone down by 16 percentage point as against the year before.

Figure 2.4:
checkit!: Substances mentioned in advisory talks by setting, in 2012



Note: * NPS = *new psychoactive substances (research chemicals)*

Source: SHW 2013d; graphic representation: GÖG/ÖBIG

This also applies to the advice services by *MDA basecamp* (see Chapter 7.2), where cannabis and ecstasy/amphetamines are the substances that are most often discussed both on the phone and in personal talks at the home base as well as online (*MDA basecamp* 2013). *New psychoactive*

13
In Vienna, a total of 1 036 students were interviewed by means of questionnaires handed out during courses at the university. The data from Innsbruck (837 respondents) are from a previous study and relate to the year 2006. 36% of respondents were male, and their average age was 21.5.

substances are important primarily in services for party settings, but here the percentage of enquiries has also gone down from 41% in 2011 to 32% in 2012. In the context of online advice, enquiries concerning *research chemicals* decreased from 15% in 2011 to 4% in 2012, and in home base talks, from 14% to 2% (Franz, personal communication). All in all, these data seem to indicate a decreasing relevance of *new psychoactive substances* in party settings, which is also reflected in the decline of *new psychoactive substances* found in the analyses by *checkit!* (see Chapter 7.2).

3 Prevention

3.1 Introduction

In Austria, addiction prevention 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) 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. Specific activities and interventions regarding legal substances as well as non-substance-related forms of addiction form part of the range of measures that are available. However, the focus of the present report is on unspecific measures, or interventions specifically focusing on illicit substances. The majority of interventions that directly address children and young people focus on promoting life skills, but, depending on the children's age, risk and risk behaviour, are discussed as well.

In addition to a number of standard programmes carried out at nationwide level *(Eigenständig werden* [Becoming independent] and *plus*; see Tables A31 to A33), in recent years numerous regional activities have also been routinely initiated and advanced. Prevention measures currently being taken are described on the individual websites and in the annual reports and newsletters of the Addiction Prevention Units, ARGE Suchtvorbeugung (coordinating body of the addiction prevention unit)[14], 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 been continually 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 the regional level, only certain selected examples can be described in the present report.

Other activities of the Addiction Prevention Units that are worthy of mention include network-building and public relations work, the (financial) support of prevention initiatives and the organisation of further training events for experts. In autumn 2012, ARGE Suchtvorbeugung organised an expert meeting on gender and addiction, gender-sensitive prevention and interventions. Expert meetings and other conferences take place regularly at the provincial level as well, with themes covering the entire field of prevention.

14
For a list of all services of the nine Units please visit www.suchtvorbeugung.net/suchtpraeventionsinfo/Hauptseite (in German).

3.2 Environmental prevention [15]

The immediate environment is a determining factor for the likelihood that young people will experiment with psychoactive substances, and go on using them. An attempt is therefore being made, by means of diverse measures, to create environments that are protective and reduce the probability of psychoactive substance use. These activities in the context of environmental prevention range from measures to reduce the availability of substances and specific youth protection interventions and health promotion[16], to actions in other policy areas that determine the situations in life and the choices that young people have, and thus have significant indirect effects on health. For a detailed discussion of health determinants and interrelated factors concerning the health of children and young people, please consult Haas et al. 2012).

It is not possible in the context of the present report to describe the entire range of structural measures in this field. Only a few selected areas can be discussed in more detail. The statutory minimum ages stipulated by the individual provincial laws for purchasing and using alcohol and tobacco, as well as for spending time in public places, have been described in last year's report (GÖG/ÖBIG 2012). It has again not been possible in the reporting period to harmonise the legislation on the protection of young people at a national level. The theme of alcohol is also discussed in the manual Handbuch Alkohol (Uhl et al. 2009) and its subvolumes (Uhl et al. 2011 and 2013b).

Based on the EU Youth Strategy 2010–18 and its fields of action, as of 2012, a participatory process has been started to draw up an Austrian Youth Strategy.[17] During the first stage, visions for the eight fields of action have been developed (BMWFJ 2013). For the purpose of this report, the field 'health and well-being' is the most relevant. The corresponding vision includes the coordinated implementation of health promotion, health care, information and prevention, with the focus on concrete needs, and the development and life situation of young people, taking into account the principles of empowerment. Health and well-being, especially of children and young people, should take precedence over any other interests, and appropriate low-threshold health promotion measures should be offered to enable young people to maintain and promote their health. The measures in this area also address the theme of young people's mental health, including an exchange on new research results and possible fields of action. The field of action 'health and well-being' will be implemented in close cooperation with the Child and Adolescent Health Strategy (see GÖG/ÖBIG 2012).

15
According to the EMCDDA, environmental prevention strategies address the entire population and are aimed at altering the immediate cultural, political and social environments and norms.

16
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.

17
See http://www.bmwfj.gv.at/Jugend/Jugendstrategie/Seiten/default.aspx (22 April 2013; in German).

The activities in the context of *early childhood intervention* are also closely connected with the Child and Adolescent Health Strategy. Early in 2013, the corresponding appraisal (see GÖG/ÖBIG 2012) was completed in cooperation with regional partners; since then the focus of activities has been on developing an 'ideal model' (which combines universal and indicated services), transfer of knowledge and the support of model projects in the individual provinces. For this purpose, one national and nine provincial events on this issue have been scheduled in 2013.[18] A specific area of early childhood intervention is covered by the activities addressing children in at-risk families, which have been organised by the provincial Addiction Prevention Units (see Chapter 3.4). Projects of a more comprehensive design are run as well, e.g. *Wir werden Eltern* [We're going to be parents] and *Wir sind Eltern* [We are parents] in Tyrol, which aim to address as many young parents or parents-to-be as possible, to inform them about the available training and advisory services and to motivate them to use these services at an early stage.[19]

Building supportive social environments is also supported under the new 2013 Act on Federal Child and Youth Support (BGBl I 2013/69 v. 1. 5. 2013), which defines the principles, goals and tasks of child and youth support services. Their activities include advice on parenting and development questions, as well as support to overcome problems and crises in the family.

The Ministry of Education (BMUKK) defined six quality areas for schools, which include 'classroom and school as a social environment'. These quality areas form the basis for the further development of teaching and schools. Activities in this field will be supported in the context of the framework goal of further development towards individualisation and competence-orientation of learning and teaching at schools of general education.[20]

Dropping out of school or training may increase the probability of developing addictive patterns or behaviour. Therefore, measures aimed at avoiding/reducing school-drop-out rates are also mentioned in this context. They include coaching for young people, i.e. advice, assistance and support services (in a three-stage model), for the phase between the end of compulsory school and integration into a further training system. In cooperation with teachers, students who are at risk of marginalisation are identified and, if necessary, supported by a youth advisor. Early in 2012, the Ministry of Social Affairs issued guidelines that define the target groups, procedures, cooperation structures and job requirements for youth advisers (BMASK 2012). During a pilot year in Vienna and Styria, approximately 13 000 young people were addressed, and 85% of them took up advisory/assistance/support services, with good results (BMASK 2013). As of 2013, these services have been offered all over Austria.

18
For further information on all activities please visit www.fruehehilfen.at (in German).

19
For further information please visit http://www.kontaktco.at/fachbereiche/familie/wir_werden_eltern (in German).

20
For further information please visit www.sqa.at (in German).

3.3 Universal prevention[21]

For an overview of activities in the context of universal prevention and its general framework, please consult SQ 22/25. **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 promotion. It is recommended that prevention measures at schools should 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 prepared and all stakeholders 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. Prevention activities addressing students in older age groups usually focus on discussing and reflecting on patterns of use.

Theatre education has long since proved its worth as a method of preventing addiction. In 2012 a new theatre play for primary schools was rehearsed in Lower Austria, which is based on the join-in school theatre approach and is combined with an obligatory information event for parents and an optional educational conference for teachers (Hörhan, personal communication). *Treffpunkt ICH* [Meeting MYSELF] focuses on the issues of social pressure, fear of failure, boredom, aggression and self-esteem. In cooperation with the students, approaches to dealing with unpleasant feelings and the conflicts presented are sought.

In 2012, the *GrenzGang* [Borderline walk] project run by the Addiction Prevention Institute (ISP) was complemented by a *GrenzGangTag* [1-day borderline walk] (SDW 2013), a one-day outdoor event for students from years 7 to 13 that primarily addresses those groups which, for organisational or financial reasons, cannot, or do not want to, take part in the one-week *GrenzGang* programme outside Vienna. Experience-based approaches are used to promote life skills in general, and particularly skills for handling at-risk situations.

A doctoral thesis[22] on the outcomes of **peer education** in prevention (Stella-Kaiser 2012) shows how difficult it is to prove long-term effects in the context of short-term research work. The results correspond to those of former studies (e.g. Dobler-Mikola et al. 1997), according to which, under certain circumstances, peer approaches in prevention can have good results, but careful preparation, selection and ongoing support are essential.

The prevention activities focusing on **kindergartens** and **families** have been continued (primarily

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21
Universal prevention focuses on different settings (e.g. school, towns, kindergartens) in order to address larger groups of the population who, irrespective of their individual situations, are equally likely to develop patterns of substance use.

22
The thesis is a study conducted during a three-year peer education project aimed at health promotion and the prevention of addiction at two upper secondary schools in Vienna. The students were asked to complete questionnaires at five different points in time, with items on self-efficacy, health etc.

further training programmes, information materials, and parents' evenings). Many activities also address parenting skills. For instance, in the reporting period the parent manual on how to protect children from addiction was revised (Institut Suchtprävention 2013a).

The majority of prevention measures taken at the **workplace** aim to prevent trainees from developing patterns of addiction behaviour, particularly by means of awareness-raising, reflection and guidance for action led by trainers and other key persons at work and in halls of residence for trainees. There are also interventions that aim to prevent the development of addiction among at-risk adults, and to find adequate responses for such situations at work. Here, the problem of drinking is predominant.

In 2013 Blue|Monday, a provider of addiction prevention services at the workplace, celebrated its 10-year anniversary, and organised a number of activities: for instance, the *blauPAUSE* [Take a break] drama was presented, and prevention at the workplace was discussed.[23] In 2012 a new universal prevention training programme was drawn up in the context of the Tyrolean programme on prevention at the workplace, with the courses starting in 2013 (kontakt+co 2013).

Prevention in **recreational settings** also focuses on further training programmes for multipliers. In recent years, the services for young people provided by the Addiction Prevention Units have focused increasingly often on new media, and address both young people at school and in recreational settings. For instance, *Digital Story Telling* is a method of raising and discussing prevention topics. In the reporting period, multipliers in Lower Austria were trained in this field, and the corresponding prevention activities will start in September 2013 (Hörhan, personal communication).

In Vorarlberg, the project *Reflect and Act 2.0*, which addresses young people, uses new media and their channels of communication to offer a new approach to information on well-being, health and addiction, and young people are encouraged to take an active part in the project, so that their lifeworlds are appropriately taken into account (Prenn, personal communication). Learning theory, risk competence research, social marketing and communication strategies are used in films and digital stories to provide opportunities for young people to reflect on issues and lifeworlds that are important to them and to have a platform for exchange. A core team of 15 to 20 young people have been integrated into the project; they receive a special training and may then use a media workshop to express their ideas through their own productions. In this way, knowledge can be communicated, reflection processes can be initiated and, in the long run, health-related life skills and actions can be expanded. By the beginning of June, approximately 200 young people had received the training, the *www.suchthaufen.net* platform has been visited by an average of 1 500 to 2 000 young people, and two to three contributions by young people have been added every week. Multipliers in various settings are also trained to help and support young people in their multimedia reflection on their social environments and on health-related themes.

23
For further information please visit www.bluemonday.at/cms/3781/8564/10_Jahre_10_Jahre_blue|monday/ (in German).

Prevention at the 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, whenever possible, be initiated from within the community and should be adapted to its special needs. Following the discussion on the CTC programme[24] (see GÖG/ÖBIG 2011b), a set of prevention activities has been planned in Upper Austria, which, after an analytical phase, may be used as part of the *Wir setzen Zeichen* [We're making a point] community project, whenever needed. During the reporting period, a newsletter was prepared to enhance exchange and communication between the participating communities and to encourage them to start a variety of activities (Institut Suchtprävention 2013a).

Further activities in the reporting period include a pilot study on the experience of multipliers regarding the implementation of prevention in their everyday routines[25]. The majority of those multipliers who actually implemented prevention activities had done this as part of their work, and, in the 12 months before the survey, contacted a total of 40 161 persons (56% of them were young people between 13 and 18), a proportion of 69% of whom was directly reached in school settings (Institut Suchtprävention 2013b). In addition, approximately 9 500 persons were reached indirectly, as 29% of the respondents made addiction-related decisions that had effects on larger groups of people (e.g. prohibiting smoking at club events). 61% of these decisions again related to school settings. The results show that the strategy to train multipliers as key actors in the implementation and communication of prevention has indeed been successful. However, the necessary (further) training programmes have to be of high quality, and adequate resources as well as supportive structures in the individual settings are needed to ensure the best possible effects.

The Viennese Addiction Prevention Institute (ISP) and the *equalizent* qualification centre for deaf people and sign language have designed and launched a special website for deaf people, which provides information on addiction and prevention facts in Austrian sign language (PID 2013).

3.4 Selective prevention in at-risks groups and settings[26]

SQ26 gives an overview of selective prevention measures and the framework in which they take

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24
Communities That Care: programme to prevent addiction, violence and aggression in communities.

25
In spring 2012, an online survey was carried out, in which 506 persons (13% of those invited) took part (Birgmann 2012). More than half of them (71% women, 29% men) are teachers, followed by youth social workers in recreational settings and clubs, decision-makers in enterprises, and others.

26
Selective prevention focuses on smaller groups which, due to biological, psychological, social or environmental risk factors – irrespective of each individual situation – are more likely to develop patterns of substance use than the general population (e.g. children of addicted parents).

place. Austria has planned to expand its activities in the field of selective prevention. A number of services for **children in at-risk families** have therefore been intensified. The nationwide and regional *ENCARE* networks continue to play an important role here, e.g. for training multipliers, which takes place in the context of existing educational structures (e.g. at Universities of Education) on the one hand, and in the form of special courses and workshops (e.g. for kindergarten teachers) on the other.

The *Wirbelkiste* [Whirligig box] group programme for children between 8 and 12 who live in families with alcohol problems, which was developed by VIVID in cooperation with RAINBOWS and the Graz Sigmund Freud Psychiatric Hospital, is based on the promotion of life skills and the resilience model (VIVID 2013). A total of nine two-hour sessions take place where the children can have fun, play and talk with others on the one hand, while, on the other, they are encouraged by a variety of methods to discover their own strengths, build self-confidence, become aware of their feelings and express their needs. By learning alternative strategies of action they are enabled to cope with difficult situations in life more easily. Parallel to the sessions for children, two-hour parent meetings are organised. They aim to support the parents and raise their awareness of their children's needs. In 2013, a pilot group was started.

In the reporting period, the evaluation of the three-year cross-border INTERREG project[27] *Kinderleicht – Zukunft. Von Anfang an* [Child's play: Having a future, right from the start] (see GÖG/ÖBIG 2011b) was completed. This project had been planned and implemented by Caritas in Tyrol in cooperation with Caritas in Garmisch-Partenkirchen, Germany. It was run in three model regions, with the goal of promoting the healthy development of children of addicted parents and thus preventing the development of psychiatric disorders or addiction (Puhm and Uhl 2013), by establishing a set of advisory services for children, young people and their families as well as information and education activities, public relations work and networking. The goals specifically defined for the services that directly address children and young people correspond to those of the Styrian *Wirbelkiste* project described above. The conclusion drawn from the evaluation results[28] are that the target group in Tyrol should be expanded to include children of parents suffering from mental distress and that intensified attempts are needed to reach the parents earlier. The services should thus be advertised in places where support is offered to parents in a situation of crisis. Good cooperation with the parents concerned is of great importance for increasing uptake. To this end, a number of proposals for public relations activities were made,

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27
The INTERREG Community initiative financed under the European Regional Development Fund (ERDF) aims to stimulate interregional cooperation in the EU.

28
For the purpose of structural evaluation, the project activities were surveyed and described and, to provide a formative evaluation, its implementation was monitored and input was given through continual feedback, and also the options for implementation were assessed with regard to feasibility evaluation. Apart from continuous documentation, qualitative interviews were conducted with major project partners, parents, children and young people, and a questionnaire survey was carried out. The project and evaluation periods lasted from early 2010 to early 2013. During this period, it was possible to reach 18 children and young people in Tyrol, and 37 in Garmisch-Partenkirchen.
One must bear in mind here that direct work with children and young people was only one one of several strategies.

primarily aimed at reducing apprehension on the part of the parents. Defining and positioning the services more precisely, in order to distinguish them from other types of services, could reduce rivalries and increase referral, and the cooperation with the youth support services should be expanded. In direct interactions with children and young people, effective forms of communication with one another should be addressed more intensively.

In Carinthia, a pilot group was initiated in 2012 following the *Trampolin* [Springboard] project that had been implemented at the national level in Germany. The experience gathered in this context had also been used for a comprehensive evaluation (Drobesch-Binter, personal communication). At the implementation stage, however, difficulties became apparent, which reflected the experience gained in the services described above.

A new project in Vorarlberg combines group services and work with animals to contribute to enhancing the life skills and communicative competences of children and young people between 4 and 14 who live in families with addiction problems (Stiftung Maria Ebene 2013). Parallel to the activities for the children (5 in 2012), regular parent talks are held. The shuttle services for the children have shown to be very useful, as they ensure the children's attendance and give the parents time to relax.

Young people taking part in labour market policy programmes and occupation projects are another target group of selective prevention. The majority of activities in this field are further training measures for trainers in these programmes and projects. Since 2011, VIVID has run a course on preventing addiction among young people in training and job contexts, which has met with great interest (VIVID 2013). The participants are taught prevention-related subjects (e.g. addictive substances and the legal situation) and methods (e.g. motivational interviewing) to help them find competent responses to young drug users. One module deals with models of action aimed at helping enhance health promotion and addiction prevention in the programmes and projects. Fulfilling practical tasks encourages the participants to examine the situation in their programme or institution and to initiate activities there.

In Tyrol, the new apprentice workshops of the *workplace prevention* programme are now specifically offered to young people taking part in labour market policy programmes (Gollner, personal communication). Following positive feedback, the respective services have been expanded.

Another group that is to be addressed with specific measures is **young people in social education institutions.** Carinthia started an addiction course for staff of youth support services two years ago, which now has an additional focus on youth psychiatric care and risk competence (Drobesch-Binter, personal communication).

Further 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. In November 2012 *checkit!*, celebrating its 15th anniversary, organised the

expert meeting *Reduse* on new aspects and developments in recreational drug use, in which approaches to new synthetic substances in Europe were discussed (SHW 2013d)[29].

The specific situation of **immigrants** may be connected with an elevated risk of addiction (Penka 2004), and **immigration** can in itself be an event in life that triggers addiction (Barth and Czycholl 2005). Here, selective prevention primarily focuses on those groups of immigrants who, because of their current situation in life and because of specific social factors, are particularly vulnerable and cannot be adequately addressed in the context of universal prevention. In the reporting period *AG Sim*, a Lower Austrian working group on addiction services for the immigrants' community, drew up a project on transcultural prevention (Hörhan, personal communication). Currently the required staff are being trained, and activities will start as of 2014.

3.5 Indicated prevention[30]

In Austria, indicated prevention primarily focuses on early identification and early intervention as a response to substance use (while signs of dependence have not yet become apparent). They are thus exclusively based on risky or addictive patterns of behaviour and related behavioural disorders and in most cases refer to alcohol use. In this context, the *Grenzwert*[31] [Limit value] pilot project developed by the Carinthian Agency for Addiction Prevention deserves mention: it addresses young people under 18 who have been admitted to one of two Carinthian hospitals due to alcohol intoxication, encouraging them to take part in a social education programme. The project evaluation has shown that while the initial talk meets with acceptance, it is hard to motivate the young people to take part in, or complete, a programme in an outpatient advisory centre after the stay in hospital (Fenzl et al. 2012). The low degree of motivation is attributed to the general attitude towards alcohol in our society. For young people who have little experience of alcohol use, the mere fact of needing inpatient treatment may have the desired effect, even without any further intervention. In the case of young people who are also facing problems in their social environment, however, the programme does not seem to be sufficient (Fenzl et al. 2012). In the course of the project, a questionnaire for hospitals was drawn up (Drobesch-Binter,

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29

For further information please visit www.checkyourdrugs.at/reduse_12 (in German).

30

The focus of indicated prevention is on people who already show early signs of substance use or problematic patterns of behaviour that are associated with drug use, and who do not yet meet the criteria for a diagnosis of dependence, but for whom the risk of developing addictive behaviour is particularly high because of their individual situations. The indicators for elevated risks given by the EMCDDA include social or behavioural disorders, as well as early aggressive behaviour, and also withdrawal from families and friends.

31

The project is based on the *HaLT-reaktiv* component of the German model project *HaLT*. The data of 166 children and young people who had been admitted to hospital because of alcohol intoxication were used for the evaluation carried out during the project. Only 44 of them agreed to take part in the pilot project, and 17 of these dropped out before the project was completed.

personal communication) to make it easier to identify young people who are in danger of becoming addicted or who show high-risk patterns of behaviour (not only with regard to drinking).

In the reporting period, Vorarlberg's *CHOICE* programme (see GÖG/ÖBIG 2012) was taken over by VIVID for implementation in Styria. It addresses young people in labour market policy programmes and occupation projects (VIVID 2013), who have an elevated risk potential but do not show manifest addictive behaviour or at-risk patterns of use. *CHOICE* is oriented towards the young people's needs, and builds on existing resources. Methods specifically designed for young people enable the participants to become aware of, accept, express and control their own feelings. Approaches to the resolution of conflicts and the enhancement of self-esteem also form part of the programme. The first feedback has confirmed the positive experience of participants in Vorarlberg. It has also been reported that there has been no negative feedback from the young people and that they warmly welcome the 'exclusive character' of the service (individual young people are selected for participation) and the pleasant atmosphere. The trainers report that a number of participants in the programme had also shown new sides and patterns of behaviour that they had not seen in them before.

In March 2013 an expert meeting on early detection and early intervention in prevention and youth work took place in Linz, Upper Austria. The themes on the agenda included substance use and its function during that phase in life, ways to identify problem patterns of use as well as early intervention from support to control (Institut Suchtprävention 2013a)[32].

3.6 National and local media campaigns

In Austria, by agreement with experts in the field, no media campaigns on illicit substances are being launched. The only exception are media campaigns in the context of public relations work for individual, usually community-oriented, projects, or awareness-raising campaigns concerning legal substances.

32
For a documentation of the meeting please visit http://praevention.at/seiten/index.php/nav.6/view.32/level.2 (11 June 2013; in German)

4 Problem Drug Use

4.1 Introduction

The EMCDDA's current definition of problem drug use is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'[33]. However, recent discussions at the EU level aim to expand this definition (e.g. including problem use of cannabis as well). Austria's definition of problem drug use largely corresponds to that of the EMCDDA, but emphasises 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 2008b).

As of 1993, the capture-recapture (CRC)[34] 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 9.2), the substitution registry (see Chapter 5.3) and drug-related deaths (see Chapter 6.4). 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 including 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 route 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 drug, the treatment centres have registered another large group: people with cannabis as their primary drug. Many of these drug users have been referred to compulsory treatment, however (see GÖG/ÖBIG 2011a and GÖG/ÖBIG under preparation).

According to recent estimates covering 2010 and 2011 respectively, a nationwide prevalence of 30 000 to a maximum of 34 000 problem opioid users, most of them poly-drug users, seems plausible (see ST7 and ST8). This means that between five and six out of every 1 000 Austrians aged between 15 and 64 are problem drug users. Three out of four are men, and around one out of five is under 25 (40% are aged between 25 and 34).

Besides the prevalence of problem drug use involving opioids, the prevalence of injecting drug

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33
www.emcdda.europa.eu/themes/key-indicators/pdu (7 August 2012).

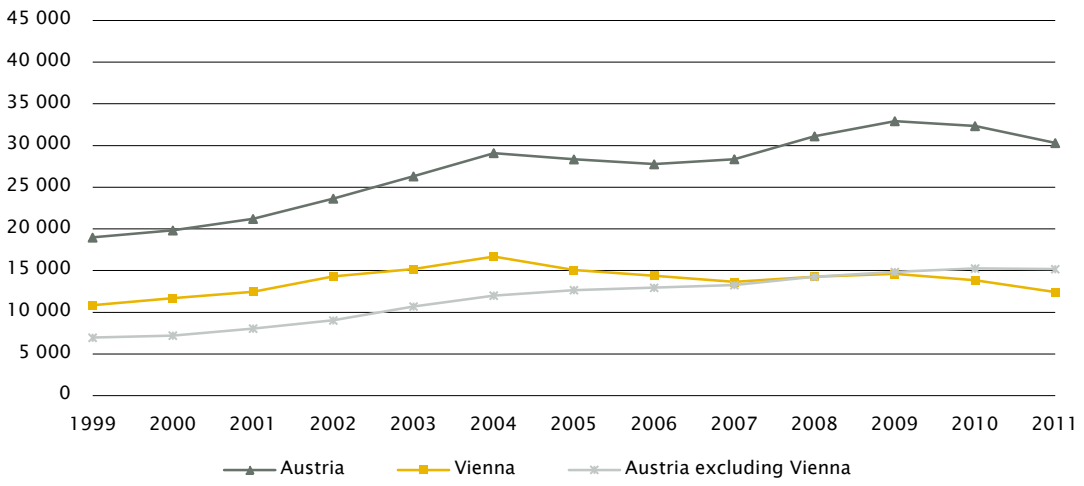
34
The capture-recapture method is a statistical procedure of dark figure estimation, based on the comparison of two (2-sample CRC estimate) or several sources of data (e.g. 3-sample CRC estimate).

use is also relevant from the point of view of epidemiology. No specific estimates are available in this regard, however. If the number of persons registered in the DOKLI system (see Chapter 5.3) who indicate opioids as their primary drug and injecting use as their preferred route of administration (around one in two) is extrapolated to all problem drug users who take opioids, the estimated number of (primarily) injecting drug users lies between 15 000 and 17 000 people in Austria. These figures probably represent an upper limit, however, as it seems safe to assume that injecting drug users are more likely than others to turn to drug support and treatment services, as they suffer from severe drug problems.

The prevalence rate of alcohol dependence, compared to illicit drugs, is estimated to be 5% of the population aged over 15 in Austria (Uhl et al. 2009a). A total of 350 000 people in Austria are thus considered to be alcoholics (Uhl et al. 2009a).

4.2 Prevalence and incidence estimates of PDU

Figure 4.1:
Prevalence estimate of problem drug use involving opioids: absolute figures for Austria, for Vienna and for Austria excluding Vienna, over time



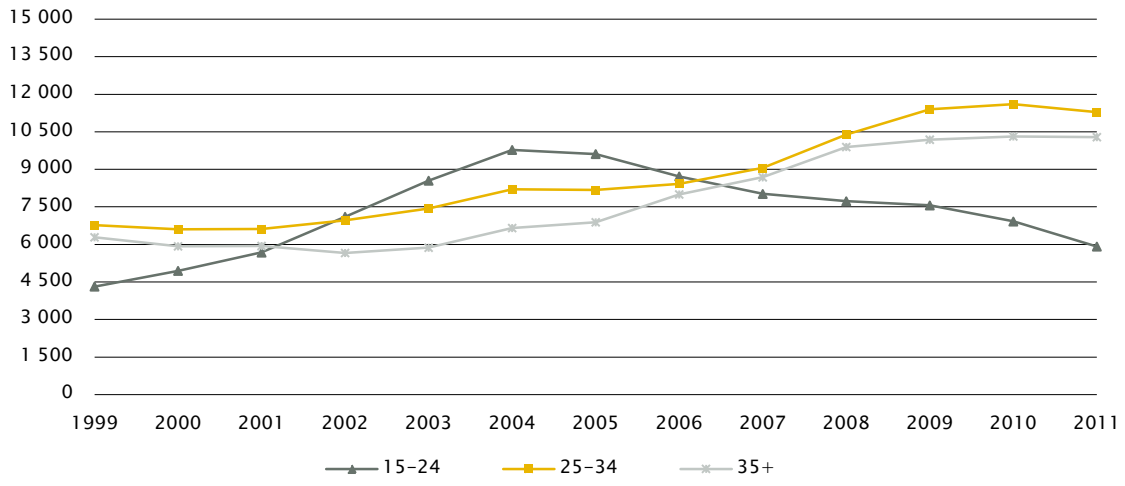
Note: For the period from 1999 to 2010, the moving mean of three years has been used (e.g. for 1999, the mean of 1998 to 2000), and in the case of 2011, the estimate for this year has been given.

Source and graphic representation: GÖG/ÖBIG under preparation

In Austria, scientific estimates of the prevalence of problem drug use are only available for opioids and poly-drug use involving opioids. For the capture-recapture method, which forms the basis for the prevalence estimates, data on opioid substitution treatment (OST), as well as reports to the police relating to opioids were used and, for a number of years, drug-related deaths were also included for validation.

GÖG/ÖBIG re-analysed the time series of the estimates from 1999 to 2011, taking into account the change in data quality of the substitution registry[35], and related them to other data sources. Figure 4.1 shows a pronounced rise after the year 2000, to reach almost 30 000 persons in 2004/05. Since then, the prevalence estimates have been between 28 000 and 33 000 persons (without taking confidence intervals into account), or between 26 000 and 34 000 (on the basis of 95% confidence intervals).

Figure 4.2:
Prevalence estimate of problem drug use involving opioids, absolute figures by age group, over time



Note: For the period from 1999 to 2010, the moving mean of three years has been used (e.g. for 1999, the mean of 1998 to 2000), and in the case of 2011, the estimate for this year has been given.

Source and graphic representation: GÖG/ÖBIG under preparation

If the developments in Vienna and in Austria without Vienna are studied separately, marked differences become apparent. Whereas the figures for Vienna were rising until 2004, they have stagnated since then. In the rest of Austria outside Vienna, the prevalence rates have continued to go up. Until 2009, the estimated figures for problem drug users in Vienna tended to be slightly higher than in the other provinces, but as of 2009 the prevalence rates are estimated to be higher in the rest of Austria, not counting Vienna. This is probably due to an equalising trend regarding the extent of drug problems in rural areas and small towns versus the large city of

35
In past years, the problem of ghost cases significantly affected the quality of data on OST. If the end of treatment was not documented, the corresponding clients continued to appear in the statistics as people currently undergoing treatment even after the actual end of treatment (= ghost cases). In order to correct this error, a special formula had to be developed. When the *eSuchtmittel* [eDrugs] system was introduced, the ghost case problems could be eliminated (GÖG/ÖBIG under preparation), and corrections have thus no longer been necessary.

Vienna. However, Vienna, as Austria's only large city[36], continues to be most strongly affected by drug problems, followed by the provinces of Vorarlberg and Tyrol.

For a more detailed study of the background of prevalence trends, age-stratified estimates are useful (see GÖG/ÖBIG re-analysed the time series of the estimates from 1999 to 2011, taking into account the change in data quality of the substitution registry, and related them to other data sources. Figure 4.1 shows a pronounced rise after the year 2000, to reach almost 30 000 persons in 2004/05. Since then, the prevalence estimates have been between 28 000 and 33 000 persons (without taking confidence intervals into account), or between 26 000 and 34 000 (on the basis of 95% confidence intervals).

Figure 4.2). From 2000 to 2004, the prevalence rates doubled in the youngest age group (15 to 24). This means that a larger number of adolescents and young adults started to develop problem patterns of drug use during that period. Since then, the prevalence rates have gone down considerably again for this age group (= smaller number of new drug users). As the group who started to take drugs between 2000 and 2004 gets older, the number of older persons showing problem patterns of drug use has continually risen (especially in the age group from 25 to 34).

The 2012/13 drug epidemiology report (GÖG/ÖBIG under preparation) will include a more detailed discussion of prevalence estimates and comparisons with other data sources, as well as a validation of the 2-sample CRC estimates by 3-sample CRC estimates, taking into account the data on drug-related deaths.

It should also be mentioned that results obtained through the CRC method, due to methodological limitations, only permit rough approximations. A more detailed description of methodological problems is given, for instance, in Uhl and Seidler 2011, ÖBIG 2003, GÖG/ÖBIG 2006 and GÖG/ÖBIG 2010c.

4.3 Data on PDUs from non-treatment sources

Analyses of patterns of drug use among persons examined under SMG Section 12[37] (here, data from all provinces except Carinthia and Vienna are available) show that the vast majority of

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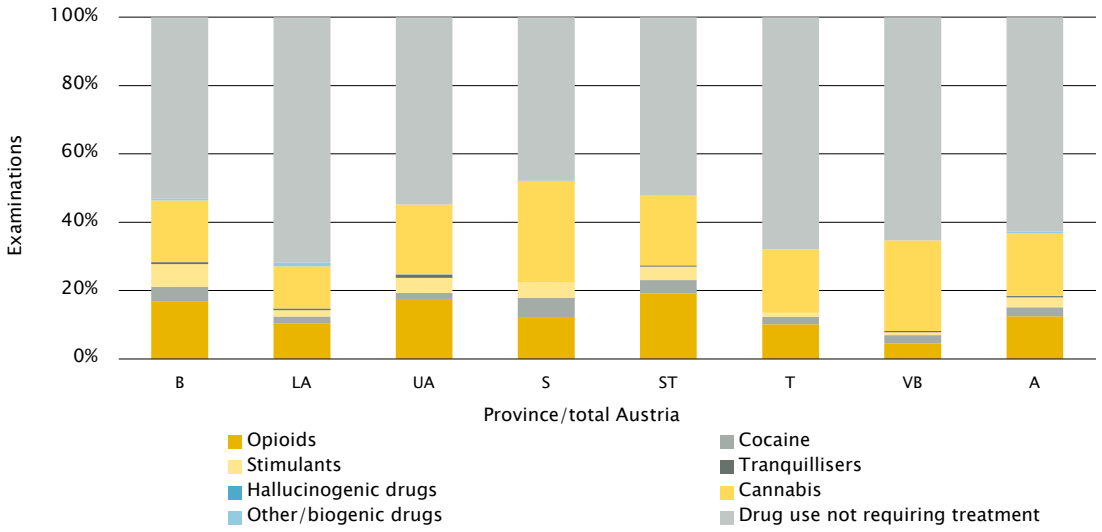
36
Drug addiction still is more frequently found in urban areas than in rural communities.

37
Persons who are suspected of drug use and who, after information provided by the police, a head of school, a military authority or driving licence authority, are given a medical examination by the health authorities to check the possible need for undergoing a health-related measure. The results of the examinations must be reported to the Federal Ministry of Health. For 2012, a total of 5 652 results of examinations of 5 476 persons are available (several persons were examined more than once in 2012). A total of 3 118 examination results included information on drug use; and in 358 examinations drug use was reported to be 'unknown'. In the examinations carried out in Vienna, rather than substance-related statements

examinations indicate either a need for treatment due to opioid use or need for treatment due to cannabis use[38].

Figure 4.3:
Drug use deemed to require treatment (primary drug according to the hierarchical primary drug definition) among persons examined in accordance with SMG Section 12, by province, in 2012



Source and graphic representation: GÖG/ÖBIG under preparation

This is in line with other data from the treatment sector (e.g. DOKLI; see GÖG/ÖBIG under preparation). However, the percentages accounted for by these two primary drugs strongly differ in the individual provinces. Marked discrepancies between provinces are also apparent with regard to the percentage of examinations in which drug-related treatment has not been deemed necessary. For instance, in the province of Salzburg, the percentage of examinations in which cannabis use requiring treatment is diagnosed is comparably large, while the percentage of cases in which drug use not requiring treatment is indicated is fairly small. It is not plausible to assume that the patterns of drug use differ to such a high degree in the different provinces, and Figure 4.3 points rather to pronounced differences in examination practices in the individual

on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances. Figure 4.2 relates to those 3 118 examination results which included information on drug use. For technical reasons, Carinthia has not yet provided any 2012 data on health-related measures.

38
The case histories of drug patients compiled by the health authorities may reveal a need for treatment due to the use of several drugs. To provide a better overview, Figure 4.3 uses the hierarchic primary drug definition that is also applied in the DOKLI system. In cases where patients indicate more than one primary drug, a primary drug hierarchy system is applied to select one primary drug. For instance, if a person indicates both opioids and cannabis as their primary drug, they are classified as opioid users in accordance with the primary drug hierarchy. The following hierarchy is used: opioids > cocaine > stimulants > tranquillisers > hallucinogenic drugs > cannabis.

provinces (e.g. a case that is diagnosed as drug use without need for treatment in one province may be classified as cannabis use requiring treatment in another; see also Chapter 5.2).

In Tyrol, 156 clients of the KOMFÜDRO low-threshold centre (a communication centre with syringe exchange) were interviewed, and the residues of substances in the used syringes that had been returned were analysed[39]. 87% of the participants in the survey were undergoing substitution treatment, with Substitol® as the substitution medicine that was most often prescribed (71%), followed by Subutex® (11%). When asked what substance they had taken for their latest injecting use, 79% indicated slow-release morphine, followed by cocaine (6%) and heroin (4%). These results largely correspond with the results of the analyses of drug residues in the syringes (Nagel 2012). The results of the study indicate that there seems to be a group of persons severely addicted to opioids who manage to be integrated into substitution treatment but are unable to give up injecting drug use (completely). Still, they at least observe safer-use rules when injecting drugs. When interpreting the study results, one has to bear in mind that it focuses on the group of injecting drug users, and its results thus cannot be assumed to apply to all persons undergoing OST (see also Chapter 5.2).

Upper Austria has repeatedly provided information on local scenes that tend to use methamphetamine, which is snorted in the context of recreational use on the one hand, and sometimes also injected by opioid addicts (Schwarzenbrunner, personal communication).

4.4 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.

39
63% of the respondents were men, 40% of them were aged between 20 and 29, 34% were aged between 30 and 39, 21% over 39, and 5% aged under 20. The majority of the respondents said that they had already been injecting drugs for a long time (29% for over 10 years, 33% for between 6 and 10 years, 34% for between 1 and 5 years, and 4% for less than 1 year). The average age of first injecting use was 19.

5 Drug-related treatment: Treatment demand and treatment availability

5.1 Introduction

Austria has an almost nationwide network of drug-related support and treatment services. A total of almost 200 specialised centres provide inpatient and outpatient services related to addiction and illicit substances (investigations by GÖG/ÖBIG). Drug 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.

Austria attributes great importance to the diversification of available treatment options. As a result, in the past decade the inpatient sector has seen 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 or recreational settings, and withdrawal is also possible in outpatient departments. The majority of support and treatment services are not oriented towards specific substances, and increasingly also include services for users of legal substances and non-substance-related forms of addiction (e.g. gambling), both of which cannot be discussed in this report. 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 requirements and the needs of addiction patients in the best possible way, a range of different substances are available for opioid substitution treatment. As the general goal is to maintain a comprehensive treatment and support network, most service providers also organise a variety of preparatory and after-care measures as well as recreational and reintegration services (see Chapter 8.3), and also interventions for specific target groups (e.g. young people or persons with psychiatric comorbidity). An overview of the drug support and treatment services is provided by Suchthilfekompass[40] [Addiction Support Compass] and other regional sources of information, as well as ST24, SQ27 and Maps 5.1, 5.2, 5.3 and 5.4 For detailed descriptions of available services please consult the websites as well as the annual reports and newsletters of the individual service providers, GÖG/ÖBIG's previous reports and the EMCDDA's Best practice portal (see Bibliography).

Since 2006, data on clients of drug-related services have been obtained from the DOKLI nationwide documentation system, which covers the majority of relevant centres that deliver support and treatment 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

40
See http://suchthilfekompass.goeg.at/ (in German).

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 ST TDI), is a further data source worthy of mention. Regarding the personal data of clients, only gender, age and province of residence are entered. Vienna's BADO Basic Documentation of addiction and drug treatment and support services is another important source of data. On 1 January 2012, BADO was replaced by the DOKU NEU system (see GÖG/ÖBIG 2012).

5.2 General description, availability and quality assurance

5.2.1 Strategy/policy

Treatment strategies are defined in the **drug or addiction strategies and policy programmes** of the individual provinces and in the relevant laws and regulations. In the reporting period, no new drug and addiction strategies or policy programmes were adopted.

As a result of the reorganisation of service provision by the Vienna addiction and drug services network (SDHN) and the Vienna Hospital Association (KAV) (see GÖG/ÖBIG 2012), since January 2013 inpatient treatment for clients of the Viennese SDHN has no longer been provided only by Anton Proksch Institute and Grüner Kreis, but also by Schweizer Haus Hadersdorf (SDW 2013). As of 2013, outpatient services have no longer been provided only by Dialog, but by Grüner Kreis, Schweizer Haus Hadersdorf and the PASS association as well. The CONTACT hospital connection service, which is in charge of ensuring the continuity of service provision, refers addicted patients from psychiatric departments of KAV hospitals to SDHN centres, in accordance with defined criteria.

Considerable differences continue to be apparent with regard to the results of medical examinations carried out (under the SMG) to establish the need for health-related measures in response to drug use, in accordance with Section 11 of the SMG (see Table 5.1 and Chapter 4.3). The number of persons examined per 100 000 inhabitants aged between 15 and 64 also strongly differs according to province, ranging from 29 in Styria to 182 in Vienna. Figure 5.1 shows the health-related measures that were deemed to be necessary in 2012 for persons showing patterns of opioid use requiring treatment (see also GÖG/ÖBIG under preparation). Typically (i.e. in Austria, excluding Carinthia and Vienna), treatment by a doctor and psychosocial support are deemed to be necessary, while in Burgenland support by clinical psychologists is given preference over psychosocial support, and in Vorarlberg, psychosocial services are regarded as appropriate in almost all cases, and, to a smaller extent, treatment by a doctor as well. One has to bear in mind that health-related measures are taken in different contexts (e.g. as an alternative to a report to the police or court proceedings, or in the context of criminal proceedings; see also Chapter 9.4), but the available data do not allows us to draw any conclusions as to the reasons why a health-related measure has been deemed to be necessary.

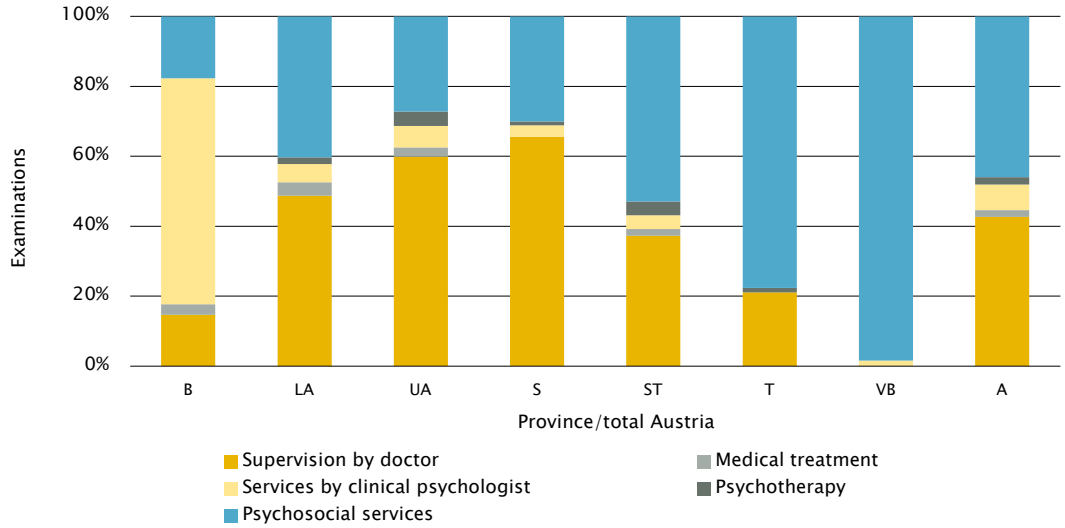
Table 5.1:
Examinations, persons examined and resulting health-related measures in Austria, in 2012

Type of health-related measure required	Percentages of examinations per province[6]								
	B	LA	UA	S	ST	T	VB	V	A
No health-related measure required.	49%	63%	31%	34%	49%	34%	43%	62%	52%
SMG Section 11, para. 2, fig. 1[1]	7%	12%	42%	28%	13%	38%	0%	3%	15%
SMG Section 11, para. 2, fig. 2[2]	14%	8%	17%	11%	10%	9%	2%	32%	18%
SMG Section 11, para. 2, fig. 3[3]	30%	1%	4%	2%	3%	5%	0%	1%	3%
SMG Section 11, para. 2, fig. 4[4]	0%	1%	2%	1%	3%	1%	0%	2%	1%
SMG Section 11, para. 2, fig. 5[5]	5%	10%	25%	36%	24%	28%	54%	1%	14%
Number of examinations	168	1 288	662	385	237	489	247	2 176	5 652
Number of persons examined	165	1 201	630	374	236	458	243	2 169	5 476
Percentage of persons examined per 10 000 persons between 15 and 64	86	111	66	103	29	94	96	182	96

[1] = supervision by doctor
[2] = treatment by a doctor (including withdrawal and opioid substitution treatment)
[3] = counselling and care by clinical psychologist
[4] = psychotherapy
[5] = psychosocial services
[6] = Due to technical problems, no 2012 data are available for Carinthia.

Source and graphic representation: GÖG/ÖBIG under preparation

Figure 5.1:
Number of health-related measures in accordance with SMG Section 12 deemed to be necessary for opioid users, percentages, in 2012



Note: The reports by the district health authorities only mention opioid abuse, irrespective of whether other drugs have been indicated as well. In each case, more than one health-related measure may be deemed to be necessary. Double counts cannot be ruled out either.
Due to technical problems, no 2012 data are available for Carinthia. In the examinations carried out in Vienna, rather than substance-related statements on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances.

Source and graphic representation: GÖG/ÖBIG under preparation

The manual on the uniform implementation of SMG Section 12 (see GÖG/ÖBIG 2012) was revised during the reporting period, and in spring 2013, it was officially issued to all district administration authorities, which are in charge of health affairs (Schopper, personal communication). This guideline is aimed at harmonising the implementation practices of the authorities in charge of diagnosing drug use that requires treatment, and deciding on health-related measures for drug users.

The reporting period again saw efforts to improve **access to opioid substitution treatment** for persons addicted to opioids: primarily, the strategies that have already been decided continue to be implemented. In Tyrol, the expert commission on the regional coordination of opioid substitution treatment, which had to be established in accordance with Section 23i of the Narcotic Substances Regulation, has resumed its activities and will be focusing on ways to improve the quality of opioid substitution treatment (Gstrein, personal communication). In Styria, two new outpatient departments have been opened, in accordance with the strategy described last year (see GÖG/ÖBIG 2012): the addiction medicine and opioid substitution treatment centre at the Bruck Provincial Hospital, and the Walkabout outpatient treatment centre Mariahilf (see GÖG/ÖBIG 2012), which also administers opioid substitution treatment (Ederer, personal communication). In addition, a check list on substitution was drawn up, which serves as a basis for (further) training programmes organised by the Medical Association, on the one hand, and as a practical electronic manual[41] for doctors delivering opioid substitution treatment, on the other (Ederer, personal communication). It provides an overview of the general conditions of opioid substitution treatment, describes the roles, functions and routines followed by doctors and public health officers, as well as pharmacists, and explains the available substitution medicines and patterns of use. What is especially useful is that it describes vulnerable groups of patients and possible transitions to other forms of treatment.

By the end of June 2012, Salzburg's SUST substitution centre for opioid addicts was closed because demand for its services continued to be inadequate (Suchtkoordination des Landes Salzburg 2013). While plans exist to establish a second institutional substitution service provider in central Salzburg, in addition to the Christian Doppler Hospital, Salzburg lacks doctors qualified for delivering opioid substitution treatment.

By June 2012, a total of 657 doctors were on the list of doctors entitled to give OST, with 502 (76%) of them actually delivering opioid substitution treatment. Figure 5.2 shows the development of the number of OST doctors by province. Because of the short time series, no definite trends can be identified, but, all in all, hardly any changes are apparent compared to the year before. Map 5.1 shows the distribution of doctors entitled to deliver opioid substitution treatment.

41
Available at www.substituieren.at (in German).

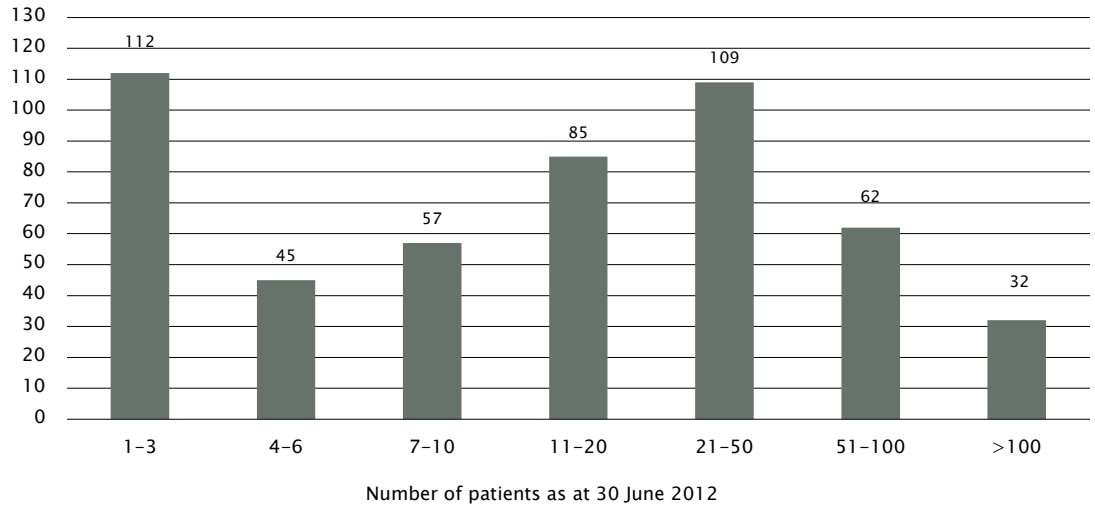
Figure 5.2:
Development of the number of doctors registered as OST doctors at the Ministry of Health, by province, 2011–2013

Source and graphic representation: GÖG/ÖBIG under preparation

One has to bear in mind that, on the one hand, not all doctors who are entitled to give opioid substitution treatment and who have been registered at the Ministry of Health actually deliver OST, and, on the other, doctors may be providing treatment to patients from neighbouring provinces as well. If the number of doctors who are actually available is related to the overall population, it shows that Carinthia and Vorarlberg have the smallest number of OST doctors per 100 000 inhabitants aged between 15 and 64, and that the ratio is best in Burgenland, Vienna and Lower Austria (see also Map 5.2). When interpreting the figures, however, organisational differences between individual provinces have to be considered (central v. decentralised provision of opioid substitution treatment).

On 30 June 2012, a total of 14 940 people were in opioid substitution treatment, which corresponds to an average of 30 patients per OST doctor. However, the actual numbers of patients per doctor may differ greatly. While 157 doctors (31%) deliver treatment to 6 or less patients, 94 doctors (19%) have more than 50 substitution patients (see Figure 5.3). This can be explained by the fact that part of the opioid substitution treatments are delivered by general practitioners in the context of their standard services, while other patients are treated by doctors specialising in OST. On the other hand, a publication by Eisenbach-Stangl (2013) points out that the number of OST patients per doctor's office should not exceed 30, but in fact there are doctor's offices with up to 300 substitution patients, or more. According to Köchl and Fischer (2012), it not considered advisable for one office to treat 100 or more opioid-addicted patients per month. With regard to the goal of integrating addicted patients into the general health-care system, it would be sensible to aim at a more equally balanced distribution.

Figure 5.3:
Number of patients receiving opioid substitution treatment, by doctor, in 2012



Sources: eSuchtmittel; calculation by GÖG/ÖBIG; graphic representation: GÖG/ÖBIG

The diploma thesis[42] by Bauer (2012) points to several obstacles that have already been surveyed in a number of previous studies and may explain why many general practitioners are not interested in delivering opioid substitution treatment. For instance, the administration of cases is regarded as very bureaucratic (complete documentation, safekeeping of narcotic drug stickers and substitution medicines), and doctors are facing the challenge of keeping a balance between general legal conditions, medical necessities and their patients' individual situation.

In recent months, opioid substitution treatment and the substitution medicines prescribed in this context have caused some controversy. A new publication by Eisenbach-Stangl (2012)[43] lists the main points of criticism and opposing arguments that have been put forward. Most of the criticism focuses on the prescription of slow-release morphine. It is argued that tablets/capsules might be diverted and sold on the black market, that there is no evidence of the effectiveness of treatment, and that injecting the ingredients of dissolved capsules involves health hazards. Another point of criticism focuses on prescription practices that are regarded as irresponsible and as a reason for drug-related deaths. Those in favour of the current OST regulation argue that injecting use is not restricted to slow-release morphine but is frequently found for other substitution medicines as well, that in the case of capsules it is at least possible to separate the

42
The thesis has been designed as a literature study but also incorporates practical experience at a general practitioner's office in Vienna that delivers opioid substitution treatment.

43
This publication was drawn up in the context of the ALICE RAP project of the European Union and is based on interviews with 15 experts (mostly personal interviews, and 3 telephone interviews).

capsule and the active ingredient, and that the cause of death following poly-drug use can hardly be attributed to one single substance. Others point out that the use of substitution substances contrary to the intended purpose for which they have been prescribed is a foreseeable consequence of the diversity of OST services that are available. Doctors are free to decide on the type of substitution substance and dosage they prescribe, which some critics see as the reason for overly generous prescriptions or take-home schemes, while others maintain that this freedom on the part of doctors is an essential part of effective treatment and the necessary rapport between doctor and patient. The publication also mentions possible conflicts of interests that might be behind the current discussions, such as economic interests (high-threshold inpatient v. low-threshold outpatient services), professional aspects (general practitioners v. psychiatrists) or diverging ideological positions (of the political parties involved). Still, such debates are not at all helpful for the provision of the best possible services oriented towards the needs of addicted patients. However, despite the controversy described by Eisenbach-Stangl, Austrian experts generally agree that opioid substitution and maintenance treatment is an essential part of the range of treatment options for opioid addicts.

The current discussion regarding the use of prescribed substitution substances not in line with the intended purpose often ignores the perspectives and motives of the patients concerned, and the fact that many interrelated factors have to be taken into account (e.g. retention rate and rate of survival). Several recent publications have been compiled in GÖG/ÖBIG (2013a), and further relevant information is provided by the EQUATOR study[44], which examined the typical practices of substitution treatment of opioid addicts in several European countries, including Austria. To sum up, it has shown that the majority of patients studied had undergone several treatment cycles so far, and that they periodically tended to start and discontinue treatment (Fischer et al. 2012). This alternation is attributed to several factors (e.g. waiting lists, inadequate dosage, non-availability of the entire range of services), and it is interpreted particularly as an indication of need for improvement in OST services with regard to meeting harm-reduction goals. On average, the addiction patients in opioid substitution treatment in Austria who had been interviewed had undergone 1.3 treatment cycles so far, while those currently not undergoing OST, had undergone only 0.9 cycles. The average of all countries surveyed is approx. 1.8. A proportion of 36% of the respondents in Austria said that they were currently receiving psychosocial support services (Dale-Perera et al. 2012). Approximately 31% of the drug users interviewed in Austria who were in OST, and 30% of the respondents not undergoing OST, indicated general practitioners or pharmacists as sources of information (Benyamina and Stöver 2012). Besides this fact, 2% of the OST patients interviewed in Austria said that they regularly used heroin in addition to the substitution medicine. 18% indicated occasional additional heroin use. Compared to the data of another European study (TREAT) quoted by Fischer et al. (2012), according to which around 30% of OST patients indicated additional heroin use on more than 25 days in the past month, and another 30% said they had used heroin on 5 to 24 days in that period, the

44
The persons interviewed for the EQUATOR study included 2 298 opioid addicts in OST, 887 opioid addicts not undergoing OST, as well as 703 doctors delivering treatment, in 10 European countries (AT, DE, DK, EL, FR, IT, NO, PT, SE, UK) (Fischer and Stöver 2012). In Austria, 228 opioid addicts in OST, 50 opioid addicts without OST and 77 doctors were interviewed.

figures given for Austria seem rather low. According to Stöver (2012b), a proportion of 28% of respondents in Austria said they had given their substitution medicine to others, exchanged or sold it at least once, and another 20% said that they always took their medicine under supervision. In the other countries surveyed, these percentages are between 16% and 39%, or between 21% and 26%, respectively. 38% of the respondents said they had already injected the substitution medicine prescribed at least once (Dale-Perera et al. 2012). This might indicate a need for discussion concerning the option of opioid substitution treatment using injecting routes of administration (e.g. a heroin programme) in Austria. On the other hand, the fact that injecting use of substitution medicines cannot be prevented completely means that one has to ensure that substitution medicines can be injected without avoidable health risks (e.g. because of talcum additions).

Additional aspects complementing the above academic studies are discussed below. A manufacturer of a substitution medicine based on slow-release morphine conducted a comparative study with methadone, as is required for authorisation. The study was completed late in 2012, submitted and regarded as sufficient proof of efficiency by BAGS/AGES (Austrian Federal Office for Safety in Health Care/Austrian Medicines and Medical Devices Agency). It has been emphasised that all the required precautions for medicines containing opioids must be observed. Estimates regarding substitution medicines sold on the black market are given in Chapter 10.3. When discussing this matter, one should always bear in mind that at present, 16 892 people are in OST, and that the in-treatment rate has massively risen in the course of time, due to the good acceptance of this form of treatment (see Chapter 5.3).

The Vienna Addiction and Drug Coordination (SDW 2013) reports the following figures on *Vienna's current cooperation project to ensure the intended use as prescribed of substitution medicines* (GÖG/ÖBIG 2011b): From the end of 2008 to the end of 2012, approximately 2 400 cases were referred to public health officers, and for 19%, a change to daily-dose-dispensing of substitution medicines was decided. 83% of patients get their substitution medicine on a daily basis. 67% have been prescribed Substitol®, and in the case of 68%, the capsules are opened in the pharmacy. Since the start of the project, a total of 1 326 cases have been referred to the Institute for Addiction Diagnostics for examination.

In response to the intensive, controversial media coverage of the issue of opioid substitution treatment, in March 2013 the Ministry of Health held an expert forum on quality and safety in opioid substitution treatment in Austria, to contribute to assessing the present situation. According to the participants, the development of opioid substitution treatment in Austria can be regarded as a success, and they agree that opioid addicts need to have access to the best possible treatment, which should be available on a low-threshold basis, and that a diversified range of services should be offered (also with regard to substitution medicines).

The reporting period saw the completion of a study[45] on the prescription of **benzodiazepines** in the context of opioid maintenance treatment (IFES 2012b). In the case of 95% of the patients who took part in the entire study, their use of benzodiazepines could be stabilised as a result of the treatment. In two out of three cases, even a small dose reduction was achieved. In 85% of participants, no indication of substantial additional benzodiazepine use was found in the last assessment quarter. For the majority of patients, their additional drug use could be reduced over the entire survey period. No indication of a changeover to other psychoactive substances was found among 93% of the patients. It was possible to reduce either additional use of psychoactive substances, or the doses used, during the study.

5.2.2 Treatment systems

Map 5.1 provides an overview of the distribution of doctors in Austria who are entitled to deliver OST to opioid users. It shows the percentage of doctors who, as at June 2013, have completed the further training required and are thus qualified for opioid substitution treatment, compared to the entire treatment potential (i.e. doctors who, because of their specialisation, would in theory be qualified to provide OST[46]). The map also provides information on the distribution of those doctors who are entitled to both define the required dose and to deliver continued treatment (v. those who may only provide continued treatment). Map 5.2 shows the number of doctors who were actually available for OST[47] in 2012, in relation to the population aged 15 to 64.

For an overview of centres specialising in addiction services (excluding 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, a number of services providers of the

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In the context of user observation, questionnaires surveying the case histories of 109 patients were completed. Over the survey period of 1.5 years, 41 persons took part in a total of four quarterly interviews as well as in the concluding interview. The main criteria for inclusion in the study were a diagnosis of opioid addiction, maintenance treatment for at least six months, a diagnosis of benzodiazepine addition, use of benzodiazepines in addition to the substances taken in the context of maintenance treatment, agreement on the part of the patients, as well as adequate clinical and psychological stability.

46
The map includes all doctors who, according to the list of doctors of the Austrian Medical Association, are either general practitioners or doctors specialising in psychiatry and psychotherapy medicine, or in child and youth psychiatry (additional specialisation: neuropaediatrics).
The data on established doctors are from 2012, with their main office addresses at that time. The data on doctors entitled to OST have been taken from the list of OST doctors (LISA) maintained at the Ministry of Health.

47
Doctors may also provide treatment to addicted patients from other provinces. This means that, in some provinces, a larger number of doctors is actually available than given in the LISA list of doctors qualified for delivering opioid substitution treatment. On the other hand, there are provinces where fewer doctors than those eligible according to the LISA list actually provide treatment.

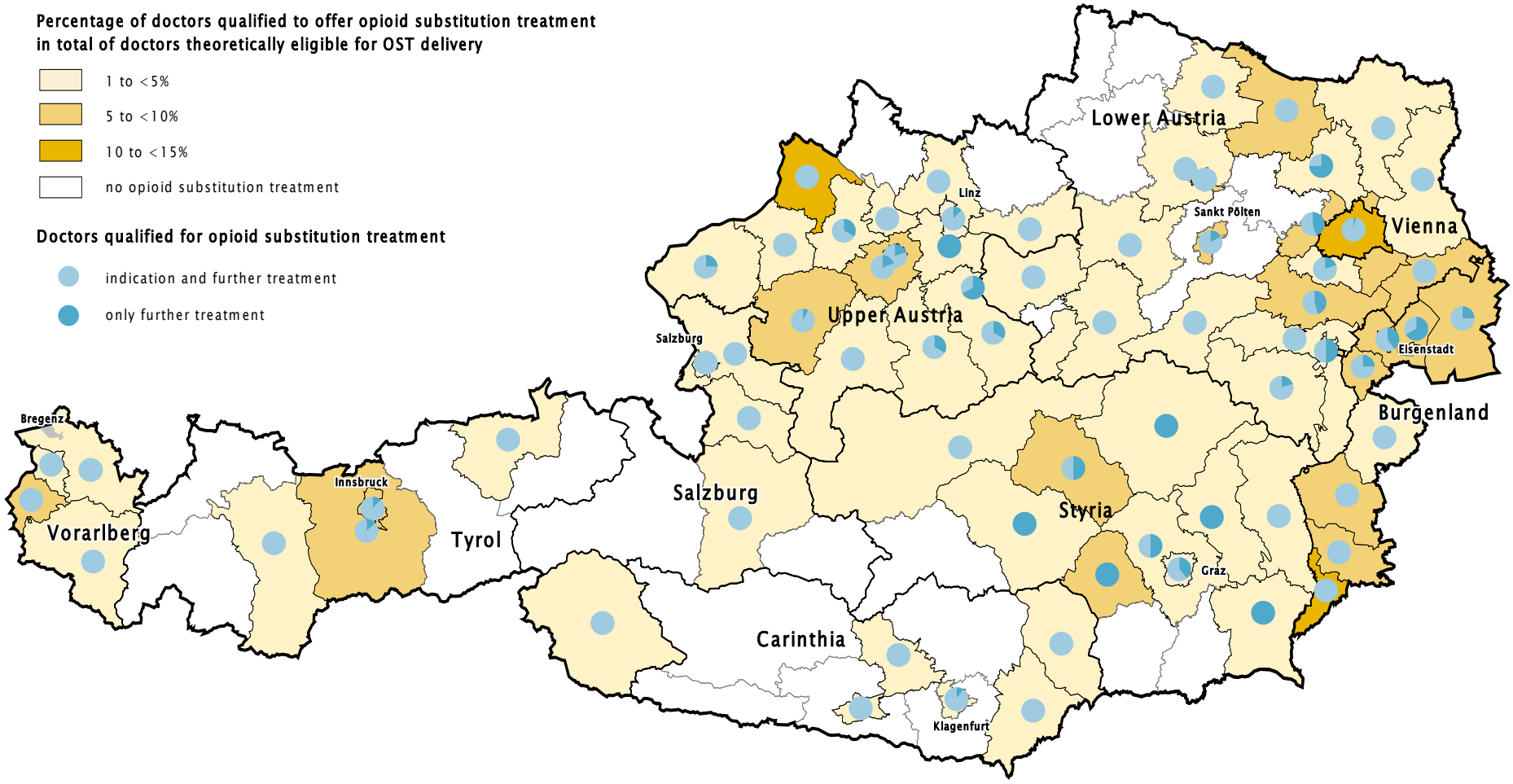
Vienna addiction and drug services network (SDHN) are in fact located outside Vienna. It should also be taken into account that drug addicts may receive treatment and support services in non-specialised centres as well (e.g. psychiatric clinics, social care centres, shelters for the homeless, care and nursing homes). The maps attempt to illustrate the situation regarding the regional availability of addiction support and treatment services, while avoiding unnecessary complexity. They show towns and cities where drug services are available. As a rule, availability of services near a person's place of residence is desirable, in order to ensure the best possible access to advisory and treatment services for all who need them. As this is one of the guidelines of Styria's addiction policy as well, the b.a.s association established and evaluated branch offices with a small number of staff in four pilot municipalities and evaluated the services (b.a.s 2013). This showed that all clients who had been interviewed said they would also visit already existing support centres farther away. It has thus been concluded that a compromise is needed regarding the regionalisation of outpatient support centres. On the other hand, massive demand for mobile services among older clients has become apparent.

Although the **capacities** of addiction support and treatment services in Austria have been continually expanded, many centres have waiting lists, and clients have to accept waiting times. In the inpatient and residential sector, the Carina treatment unit reports waiting times of several months, while after increasing the number of beds, the Lukasfeld treatment unit has been able to reduce the waiting time for detoxification to approximately one week (Stiftung Maria Ebene 2013). However, the waiting times depend on many different factors (see GÖG/ÖBIG 2012) and may vary greatly. Apart from waiting times, a number of outpatient service providers report other consequences of scarce or insufficient capacities. For instance, in 2012, the drug advice services for adolescents and young adults provided by the Z6 Youth Work Centre in Innsbruck (Tyrol) registered a significant increase in the provision of long-term services, which in turn caused gaps regarding short-term contacts. As a result of stagnating funds, in 2012 b.a.s. was unable to provide services to as many clients as in 2011 (b.a.s 2013).

Still, other developments have been reported as well. In Tyrol, additional resources were made available to expand the services at the B3 specialised department at the Hall psychiatric hospital, the Addiction Advice Association and the drug outpatient department in Innsbruck (Gstrein, personal communication). This will help combine medical treatment and psychosocial support. At the B3 specialised department at Hall/Tyrol, the additional resources are primarily used for preparatory and after-care in the context of inpatient treatment, by scheduling drug-specific consulting hours. Furthermore, Haus am Seespitz and Emmaus, two centres oriented towards drug-free treatment, expanded their target groups and now admit persons with alcohol addiction and with opioid addiction.

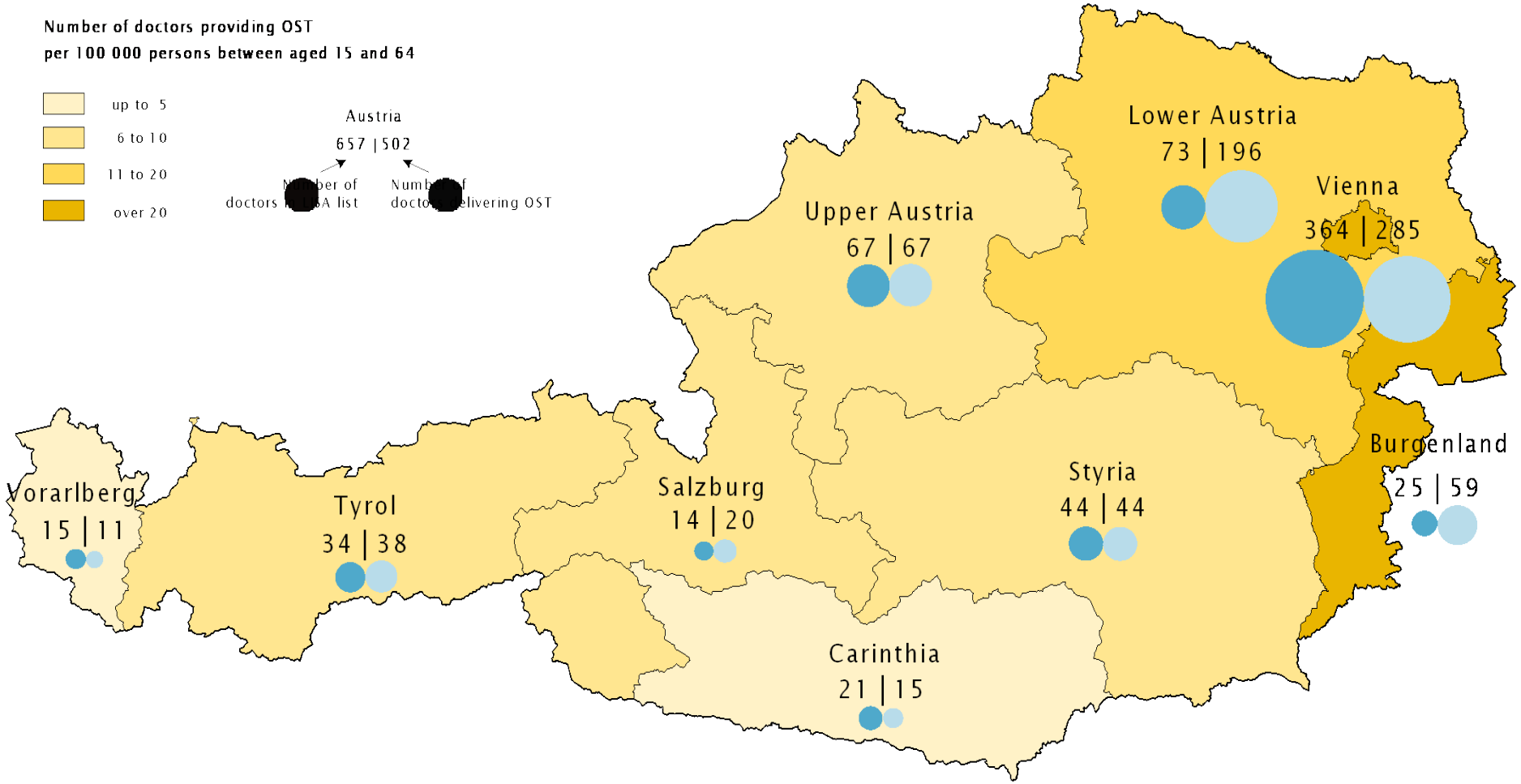
The Clean drug advice centre in Vorarlberg reports a steep rise (of 50%) compared to the previous year, regarding uptake of medical services, which is attributed to new clients in opioid substitution treatment who have been taken over by Clean (Stiftung Maria Ebene 2013).

Map 5.1:
Distribution of doctors entitled to deliver oral opioid substitution treatment in Austria, as at June 2013



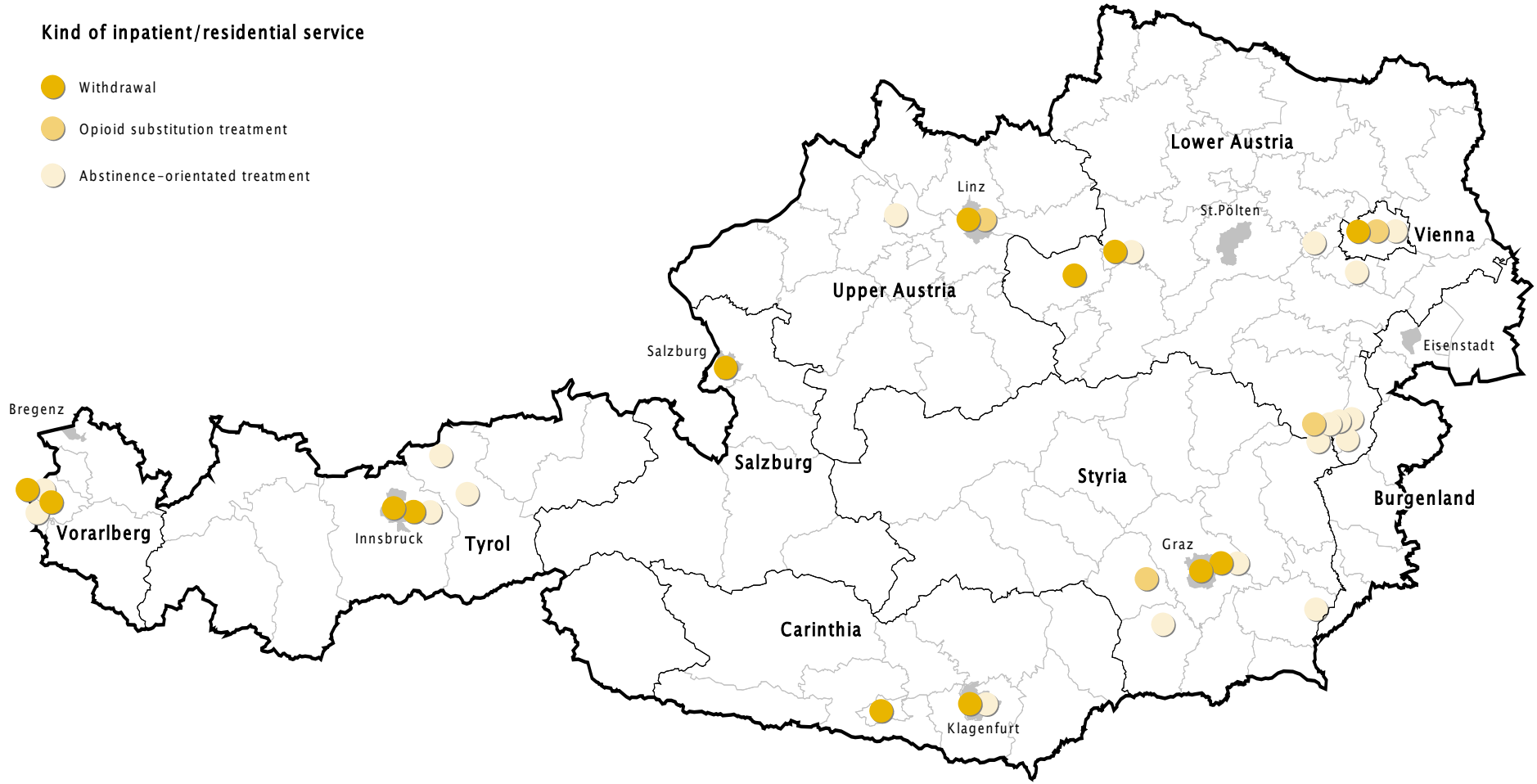
Source: BMG (LISA list) and list of doctors of the Austrian Medical Association; graphic representation: GÖG/ÖBIG

Map 5.2:
Doctors in Austria qualified for, and actually delivering, opioid substitution treatment, as at June 2012



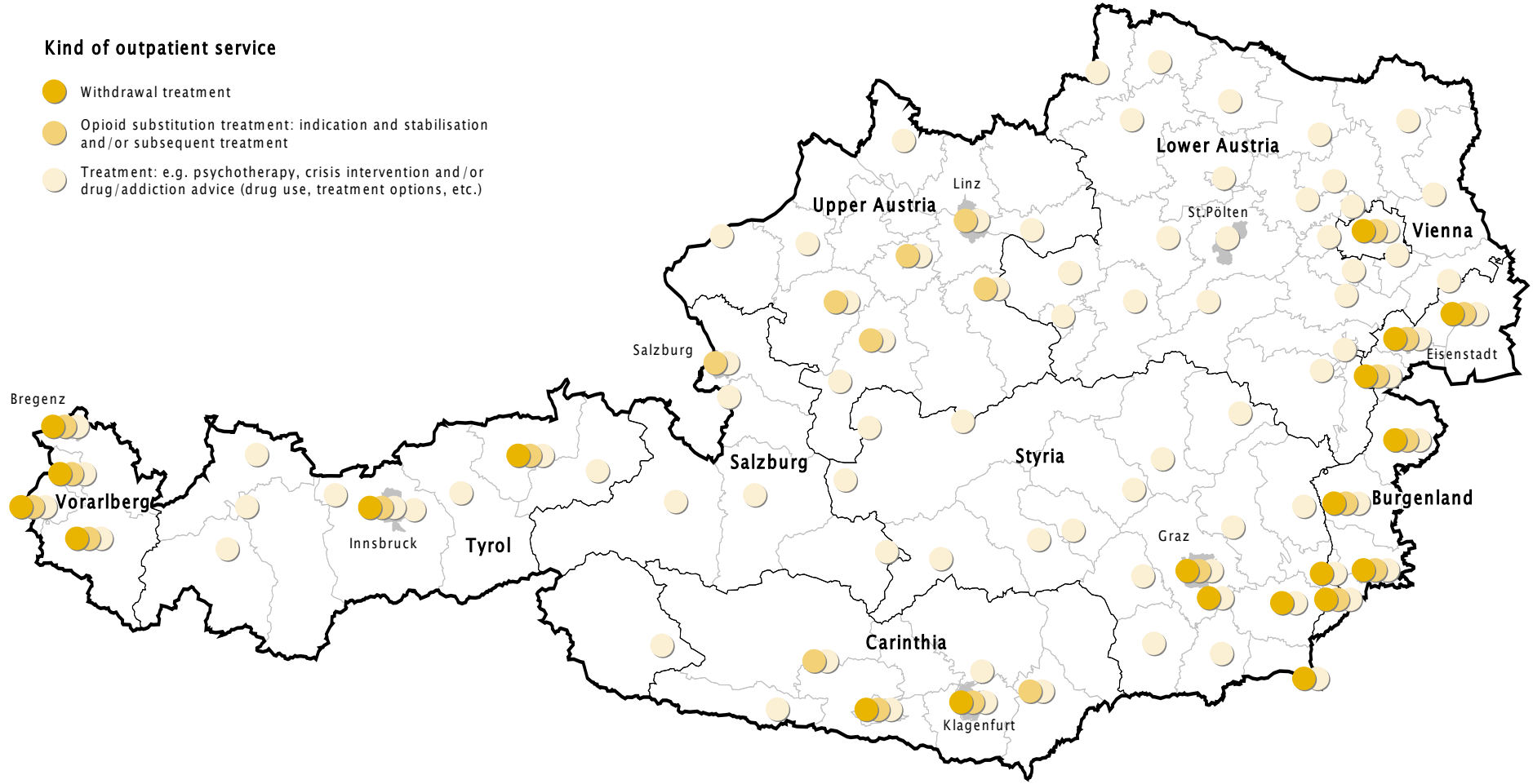
Source: BMG (LISA list) and eSuchtmittel; graphic representation: GÖG/ÖBIG

Map 5.3:
Specialised inpatient/residential treatment services for addiction patients in Austria, in 2013



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

Map 5.4:
Specialised outpatient support and treatment services for addicted clients in Austria, in 2013



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

Regarding **specific target groups**, new guidelines for cooperation have been drawn up by the Viennese working group on children in families with addiction problems, to provide guidance for the cooperation of Vienna's addiction and drug services network, medical institutions and the Youth and Family Welfare Office of the City of Vienna (ENCARE Austria 2012). They cover the period from pregnancy to birth until after discharge from hospital. To achieve good results, the essential factors here are to ensure a transparent communication between the families concerned and the service providers, as well as case progress conferences, contacts both in person and by phone, in order to provide information on interventions, and the division of tasks (Schmidhofer et al. 2013). The guidelines also include conflict management routines in case no consensus is found. This cooperation agreement helps all stakeholders understand the working situation of the other parties involved. In order to further enhance this, annual information events are to take place. Experience so far has shown that cooperation has improved significantly and that misunderstandings have been resolved more quickly. From October to December 2012, coaching or exchange of experience across cases took place in 27 cases, and nine supporters' conferences were held.

In 2013, the *DESK* project for improving services for pregnant addicts in Lower Austria (see GÖG/ÖBIG 2012) was expanded to include the districts of Wiener Neustadt and Neunkirchen (Hörhan, personal communication). The main components of the project include a workshop on pregnancy and drugs as well as the *movin'* further training programmes, which are regularly offered to the professionals involved. A booklet on professional responses to pregnancy and drugs was drawn up, in cooperation with the Vienna Addiction and Drug Coordination (SDW)[48]. The project also includes regional working groups, each of which is in charge of one or two districts of Lower Austria and is thus able to respond to specific situations, and a social-care prenatal diagnostics booklet has been issued to support mothers preparing for birth and the time afterwards (Bublik 2013).

Movin' further training courses are organised by the Addiction Prevention Units in most provinces (see also Table A33), with a focus on training multipliers in youth work. In the context of research by the REITOX Focal Point early this year, several Units reported difficulty in motivating doctors to take part in the courses. Several strategies were adopted to increase their interest in the training. The most promising approach seems to be course implementation by other doctors, combined with further training credits or financial incentives. This experience was confirmed at a meeting in Lisbon in January 2013 on short-term interventions and motivational interviewing. According to reports from Carinthia, the staff of social education centres for young people has regarded the *movin'* courses as were very helpful for responding to young people using psychoactive substances.

Regarding opioid addiction in pregnant women or their babies, the reporting period saw the publication of a few results of the MOTHER study (see Jones et al. 2012), in which the Medical

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For further details please visit http://drogenhilfe.at/5421/broschurenreihe-zum-thema-sucht-und-schwangerschaft/ (11 June 2013; in German).

University of Vienna had taken part. When studying the secondary analyses given below it should be considered that the corresponding data have originally been gathered with a different focus. The results should thus be verified in further specific studies. In the context of the MOTHER study, a review[49] was conducted which confirmed the use of buprenorphine as an effective treatment of opioid addiction during pregnancy (Jones et al. 2012). The effects on both the mother and the foetus or new-born baby were studied. It should be underlined, however, that diverse treatment options should be available (including different substitution medicine), in order to be able to use the most appropriate form of treatment for each case. A comparison[50] between the European pilot study (Winklbaur-Hausknost et al. 2013) and the European part of the MOTHER study has led to further recommendations, such as starting to treat the mothers at an early stage, with doses based on objective information (urinalysis), in order to reduce additional drug use and to treat the neonatal abstinence syndrome (NAS) in new-born babies, with doses that take into account weight and withdrawal symptoms (Winklbaur-Hausknost et al. 2013).

A substudy[51] on pain treatment during, or shortly after, giving birth shows that addicted OST patients are treated with significantly lower amounts of analgesics than non-dependent women (Höflich et al. 2012). On the other hand, they are administered non-steroidal anti-inflammatory drugs (NSAID) more often. This finding contradicts previous studies according to which usually higher doses than those specified in the existing protocols were necessary. The reasons for these differences in practice could not be established in the context of the above study. A possible explanation is fear or insecurity on the part of the doctors delivering treatment. It is also pointed out, however, that under-dosing should be avoided.

Young people continue to be an important target group that requires specific attention and specific support. In a focus group at GÖG held in March 2013 (see also Chapter 7.2), a number of activities in several provinces were presented and discussed, aimed at identifying young people showing at-risk patterns of drug use and need for treatment, on the one hand, and establishing the corresponding support network, on the other. An interesting development in this field is that Carinthia plans to provide addiction-related health care within the general youth support services whenever possible (Drogenkoordination des Landes Kärnten 2012). In the future, social education services will thus include addiction-related treatment and support in line

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Three randomised clinical trials and 44 non-randomised studies (e.g. prospective studies, case descriptions) were taken into account.

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For the pilot study, 18 pregnant women addicted to opioids were examined from 2000 to 2002, and in the European part of the MOTHER study, it was 41 women from 2005 to 2009. In both studies, four women dropped out before the study was completed.

51
The study covered 40 pregnancies of 37 mothers addicted to opioids, with 37 births taken into account by the MOTHER study. The control group consisted of 80 mothers without drug addiction who had given birth shortly before or after the mothers in the test group and whose age and type of delivery were similar.

with the clients' individual needs, and the programme for multidimensional family therapy (MDFT) will be implemented. It has also been reported that the department of child and youth neuropsychiatry at Klagenfurt Hospital has sufficient capacities for providing addiction-related care services, and that the staff of the outpatient departments in Klagenfurt and Villach, as well as Spittal and Völkermarkt, include youth psychiatrists.

In Lower Austria, services for relatives are provided not only by addiction advisory centres, but also by an *association focusing on relatives of drug patients*, in the form of facilitated support groups (Hörhan, personal communication). ANS Ost, a working group for the provinces of Burgenland, Lower Austria and Vienna, has prepared a position paper on the development of quality standards for services for relatives. Its completion and presentation has been scheduled for autumn 2013. It is aimed at reaching consensus, particularly regarding general positions and goals, and to provide guidelines for assisting the implementation of services for relatives.

Based on a literature search on age-related aspects of addiction, Köchl et al (2012) recommend taking age- and gender-related aspects into account in clinical practice, by assessing the relevant demand and offering appropriate treatment, if possible through interdisciplinary cooperation in a multiprofessional team. To avoid incorrect diagnoses or overmedication of older addicts, further training courses should be organised for providers of treatment, and any psychoeducation measures taken should be oriented towards the needs of this group of patients.

Regarding **the further development of existing services**, the day-care services of the *Carina treatment unit* (with the focus on psychosocial stabilisation and day-structure services), which are aimed at easing the transition to labour market integration, have meanwhile shown good results (Stiftung Maria Ebene 2013). The *Lukasfeld treatment unit* has now integrated crisis intervention into its range of services, which has become possible thanks to the new detoxification department, which led to an increase in the number of beds as well as in staff capacities.

In the reporting period *Grüner Kreis* expanded its services for parents and children at the Marienhof hospital to include parents in opioid substitution treatment as well (Agostini 2013) because the latter, like many other addicted parents, often need assistance with regard to parenting skills and thus enhanced therapeutic support.

The further development of the treatment system has also been examined in several **recent studies**, which include a number of recommendations. Köchl and Fischer (2012) state that on the grounds of academic findings and efficiency, outpatient treatment should be the main basis for interventions in the context of drug addiction as a psychiatric disorder. Outpatient settings also permit clients to face the challenges of everyday life and encourage social integration. However, it is also emphasised that persons suffering from multiple disorders need multiprofessional and interdisciplinary treatment structures. With regard to the integration of addicted patients into the general health-care system, the role of established doctors is regarded as essential. However, specialised staff, such as clinical psychologists and social workers, should be available in the offices of these doctors in order to ensure services at a high quality level.

A doctoral thesis[52] on indicators for dropping out of treatment at the Styrian *Walkabout* drug treatment centre has shown that the following factors may increase the probability of leaving the programme prematurely: dual diagnoses, a high tendency to play down the condition and wishful thinking at the start of treatment, intensified drug use for stress control as well as a strong craving for psychotropic substances halfway through, or towards the end of, treatment. The recommendations derived from the results include gender-related treatment methods, outpatient preparatory and after-care as an essential, integral part of drug-free treatment, day-care and night-care services as well as support for relatives during and after inpatient treatment. Comorbidity should be treated in a long-term process in outpatient settings, by multiprofessional teams. In addition, (re)integration services are important. The availability of day-care and night-care services may increase the client's motivation to undergo treatment, and additional groups of addicts may be reached (Schnalzer 2012).

Another doctoral thesis[53] examined the links between social capital[54] and effective reintegration (see also Chapter 8.3), and conclusions regarding the further development of long-term treatment were drawn. For instance, the benefit of social capital that is built in relationships between patients should be taken into account as an essential factor in the treatment process. In addition, relationships with other family members should be integrated into the treatment and used to a greater extent. To achieve this, the patient's social background should be examined thoroughly at the start of treatment so that available resources can be identified. (Just 2012)

Many different activities have been carried out for the purpose of **quality assurance** in addiction treatment: In 2012, an expansion of the second-opinion[55] principle (see GÖG/ÖBIG 2012) to include outpatient treatment as well was tested. Since the beginning of 2013, several outpatient services have been eligible for subsidies in the context of the second-opinion principle (SDW 2013). In the context of the *reorganisation of service provision by SDHN and KAV*, a mobile second-opinion system was introduced so that plans for interventions for clients of KAV support and treatment centres can be drawn up on the spot.

In the reporting period, the *Dialog* association started a participative process (integrating its entire staff) to draw up and discuss a treatment policy paper that defines and communicates its

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52
From June 2010 to August 2012, a total of 118 poly-drug users (86 men and 32 women) aged between 16 and 59 were surveyed during their 12-week withdrawal treatment at the Walkabout centre. At four points in time (2nd, 6th, 10th week and after 6 months) the patients were tested with regard to personality, coping behaviour, coming to terms with the disease, temptation coping, as well as the craving for psychotropic substances.

53
The study is based on a literature search as well as on qualitative interviews with experts and problem-centred interviews with former drug-addicts who have undergone long-term treatment.

54
According to Bourdieu, social capital comprises the resources (or advantages) that are created in a person's social networks.

55
Before starting a treatment programme subsidised by SDW, a second opinion is required to examine and confirm the indication for treatment.

main positions and its basic understanding of addiction, target groups, goals, services etc. (Zedrosser, personal communication). For instance, the paper includes the principle that both Petzold's 5-Pillar Model and Meili's Pyramid of Goals should serve as a basis for decisions on individual advice, and that treatment targets agreed upon with the clients should be reviewed regularly and, if necessary, adapted (Verein Dialog 2013). The main elements of Dialog's work which can be defined are the pursuit of a multiprofessional approach and – in keeping with a basic holistic understanding of addiction – cooperation and establishing links with many different organisations and authorities from the social and health sectors, as well as from the areas of education, training and employment.

In 2012, the Tyrolean *Addiction Advice Association*, which was founded in 2011, defined its fundamental principles and approaches: its outpatient drug support services at the provincial level should be based on respect, acceptance and understanding, and on the concept of addiction as a hazardous attempt to solve one's problems (Verein Suchtberatung Tirol 2013).

Again, during the reporting period, many **events** were held to promote the discussion of relevant themes and an exchange among experts. It is not possible to describe them all in the context of the present report. Opioid substitution treatment has been the focus of many events, e.g. the one organised in November 2012 by the Austrian Society of Pharmacologically Assisted Treatment of Addiction (ÖGABS), the Federation of Austrian Professionals Working in the Field of Drug Abuse (ÖVDF) and the Medical University of Vienna, looking back on 35 years of medically assisted treatment of addicted patients in Austria and discussing expectations for the future. In April 2013, the traditional substitution forum took place at Mondsee, and in March 2013, an interdisciplinary symposium on the disease of addiction was held at Grundlsee. The 3rd study days on complex addiction services organised by *Caritas Akademie* in Graz were held under the heading 'Being high and moving'[56], with movement discussed and understood both as an aspect of treatment, and with regard to causes (phenomenology) or changes (in drug policies). Addiction and spirituality was the theme of an intercultural dialogue organised on the occasion of the 30-year anniversary of *Grüner Kreis.* The annual meeting of the *Anton Proksch Institute* in January 2013 focused on psychiatric disorders in addiction patients.

56
For further details please visit www.streetwork.caritas-steiermark.at/studientage-komplexe-suchtarbeit (11 June 2013; in German).

5.3 Access to treatment

5.3.1 Characteristics of treated clients

The client year 2012 is the seventh year for which data of the DOKLI nationwide documentation system of clients of Austrian drug services have been available[57] (see also Tables A23–A28). As the structure of the variables has changed compared to previous years after the documentation system has been revised, and as recent modifications in Vienna's documentation system (see GÖG/ÖBIG 2012) now virtually exclude biases due to double counts of clients who have turned to several service providers in Vienna, a comparison with data of previous years is possible to a limited extent only.

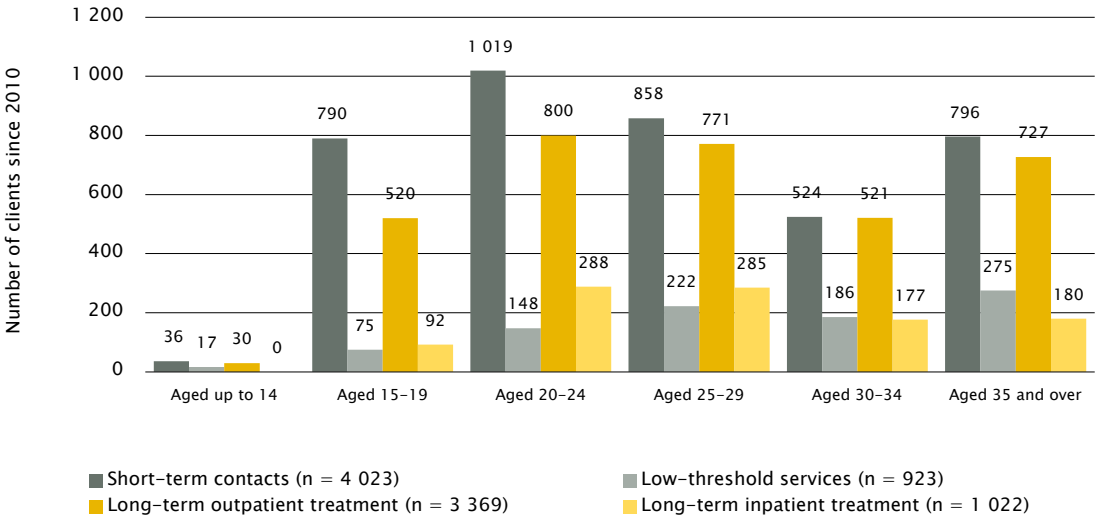
The drug support and treatment centres in Austria that are covered by the DOKLI system communicated data on a total of 3 369 people who had started **long-term outpatient treatment** in 2012. For 1 429 of them this was the first drug treatment they had ever had in their lives. 1 022 clients started long-term **inpatient/residential treatment**, and for 289 of them this was their first long-term drug-related treatment. Apart from these persons undergoing conventional drug-related medical treatment, DOKLI also registered 923 people turning to **low-threshold services,** and 4 023 people requiring drug-related services in the form of **short-term contacts**.

16% of clients receiving long-term outpatient treatment and 9% of clients in inpatient treatment were under 20 years old (low-threshold services: 10%; short-term contacts: 21%). Between 40% (low-threshold services) and 56% (long-term inpatient treatment) of the clients are between 20 and 29 years old (see Figure 5.4 and Table A23).

In all settings studied, the percentage of women clients was between 23% and 29%.

57
When interpreting the results, one has to bear in mind that, while double counts of the clients from one and the same centre can be ruled out, due to the aggregate character of the data, double counts of clients who visited several centres in 2012 cannot be avoided (with the exception of Vienna). The percentage 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 2010 approximately 22% of clients registered in BADO were provided services by more than one centre (two centres:13.5%; more than two centres: 7.6%; IFES 2011b). However, as drug support and treatment services are more easily accessible in Vienna due to its higher geographical density compared to rural areas, the percentage of double counts may be slightly smaller in the rest of Austria.

Figure 5.4:
Number of persons starting drug-related treatment or service uptake in Austria in 2012, by age and type of service



Source: GÖG/ÖBIG under preparation; DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

In the traditional treatment settings (long-term outpatient and inpatient/residential treatment), opioids predominate as primary drugs[58]. Cocaine continues to play an insignificant role in this respect (see Figure 5.5 and Table A27). This underlines the fact that in Austria, in contrast to a number of other EU countries, opioids are the most important substances with regard to drug use requiring treatment (see, e.g. EMCDDA 2012).

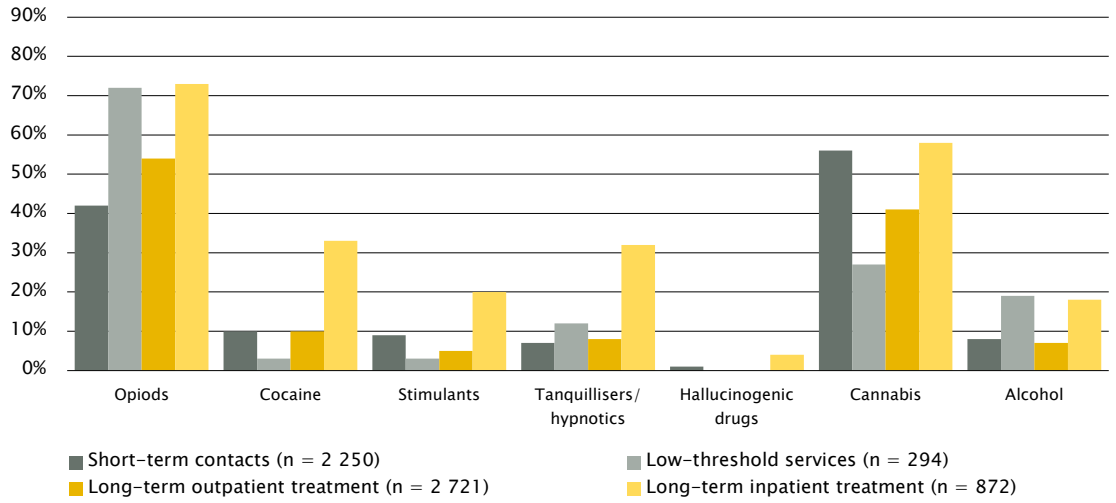
The percentage of users indicating cannabis as their primary drug is between 27% and 58%, depending on the setting. In part, this figure has to be qualified, however, as people who use only cannabis account for a very high percentage of people referred to compulsory treatment (see also GÖG/ÖBIG under preparation).

When using the DOKLI data as a basis for general statements on patterns of use of clients receiving addiction-related services, one has to bear in mind that only a small share of people undergoing OST are registered in the DOKLI system. According to the 2012/13 epidemiology report, a total of approximately 19 000 persons were receiving drug-related services in 2011:

58
The primary drug is the drug which causes the greatest problems from the personal viewpoint of the client. Here, problems – on the basis of ICD 10 – are understood as psychosocial and health-related distress and not solely legal problem situations. As a rule, the primary drug is the drug due to which the client has started the current treatment. If a client cannot decide which drug is the primary drug, several drugs may be indicated. 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. 'Drug use not requiring treatment' has to be ticked in cases of intermittent use of the corresponding drug in the past six months, without harmful use or manifest addiction problems. 'Only legal problems' has to be ticked if no drug use requiring treatment is found but if clients have been referred to treatment for legal reasons (GÖG/ÖBIG 2013b).

this figure is an extrapolation taking into account overlapping data of the substitution registry with those of DOKLI, possible double counts in DOKLI and DOKLI's coverage. A proportion of 89% of these clients suffer from (poly-drug) addiction problems involving opioids (see Figure 5.6; GÖG/ÖBIG under preparation).

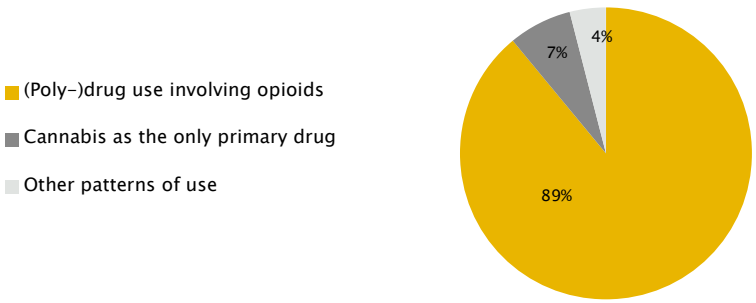
Figure 5.5:
Primary drug(s) used by persons starting drug-related treatment or service uptake in Austria in 2012, by type of service



Note: Multiple answers were permitted.

Source: GÖG/ÖBIG under preparation; DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

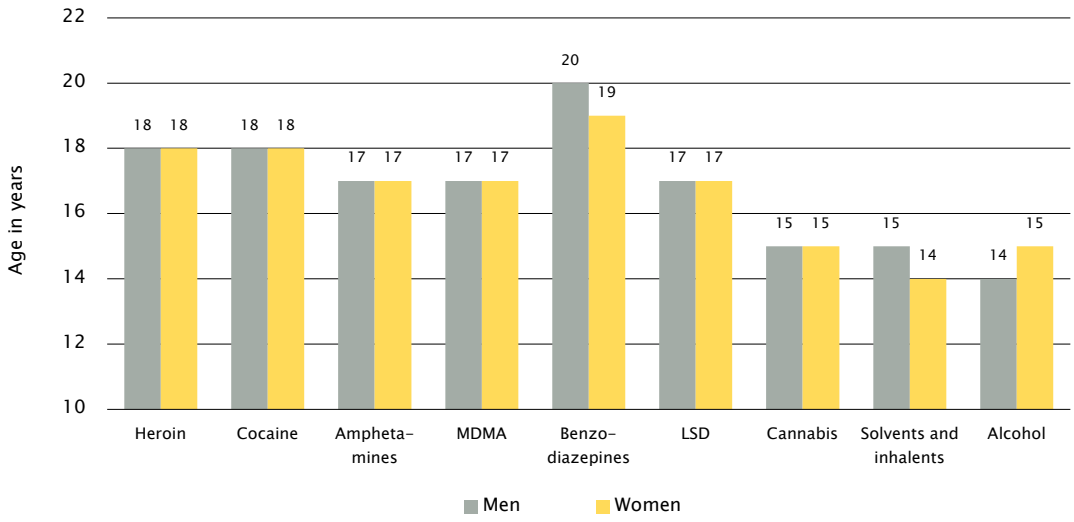
Figure 5.6:
Patterns of use of clients receiving drug-related services in Austria (estimate), in 2012



Sources: GÖG/ÖBIG-DOKLI; eSuchtmittel; graphic representation: GÖG/ÖBIG

Further details regarding age of first use and preferred route 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 17 and 20 (see Figure 5.7). A younger age of first use is only found in the case of cannabis, solvents and inhalants, as well as alcohol.

Figure 5.7:
Age of first use (median) of persons starting long-term outpatient treatment in Austria in 2012, by substance and gender



Source: GÖG/ÖBIG under preparation; DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Approximately one in three clients receiving inpatient or long-term outpatient treatment are in OST at that point in time (opioid substitution treatment started in the course of treatment or service provision is not documented in this context). In low-threshold centres, the corresponding percentage is 76%. In all settings, the percentage of people in opioid substitution treatment tends to rise with the age of clients.

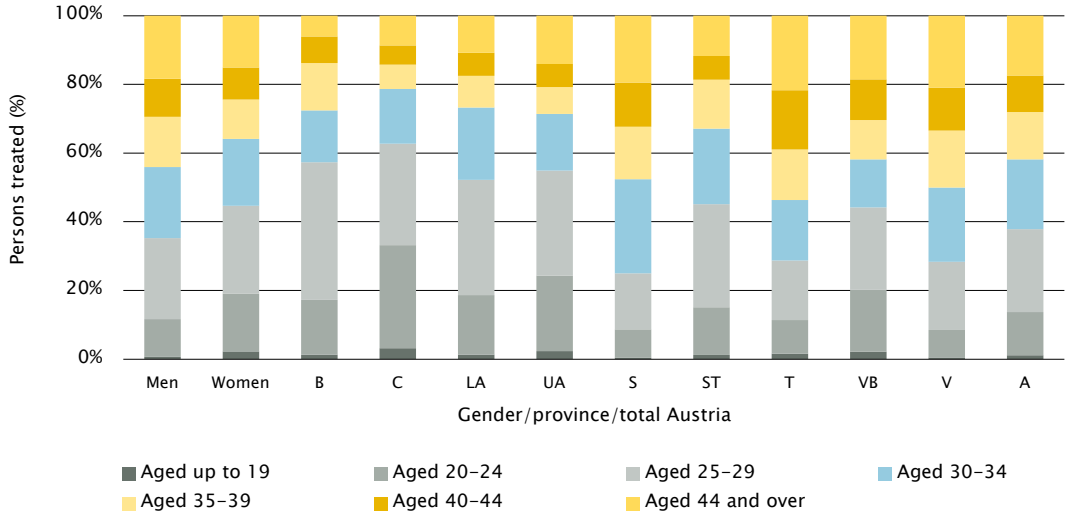
According to DOKLI, 42% of clients in outpatient settings and 67% of DOKLI clients in inpatient treatment indicate experience of injecting drug use. These percentages have remained fairly constant or have slightly declined in the long run, while being considerably smaller among clients undergoing long-term drug-related treatment for the first time in their lives (see GÖG/ÖBIG under preparation). The DOKLI data of 2012 again confirm that snorting plays an important role among heroin or opioid users (see Busch and Eggerth 2010 and GÖG/ÖBIG 2008a).

A proportion of 73% of the total 16 892 people registered as OST patients in 2012 are men, and 27% are women. The gender ratio is almost identical (74% men, 26% women) among the total 1 207 people registered as entering opioid substitution treatment for the first time in 2012.

Figure 5.8 shows the age structure of clients registered as undergoing opioid substitution treatment in 2012, by gender and province. Regarding the nationwide situation, 14% of clients undergoing OST are younger than 25. 24% are in the 25 to 29 age group; 34% are between 30 and 39; and 28% are 40 or older. Female clients tend to be younger than male clients. Differences are also found at the regional level. For instance, in Burgenland, Carinthia, Lower Austria

and Upper Austria, more than half of clients in treatment are under 30, while this group accounts for less than one third in Salzburg, Tyrol and Vienna.

Figure 5.8:
Age structure of clients registered as undergoing opioid substitution treatment in Austria in 2012, by gender and province



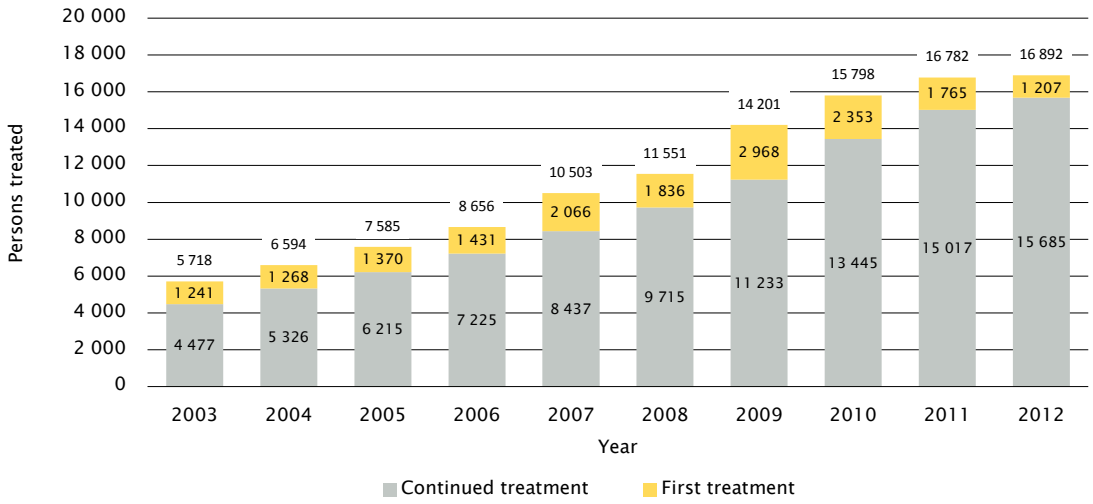
Source: BMG; calculation and graphic representation: GÖG/ÖBIG

5.3.2 Trends of treated population and treatment provision

As DOKLI has been available only since 2006, few statements on long-term trends can be given (see Chapter 5.3.1). However, a time series going back over many years can be provided for opioid substitution treatment monitoring (see also ST TDI and ST24).[59]

59
The national monitoring of opioid substitution treatment is performed by the Ministry of Health and was, until 2009, based on reports from the treating doctors. Since then, reports by the competent district authorities have been used. Before the implementation of *eSuchtmittel*, the reports were not always complete or else were not provided in due time (see ÖBIG 2003, GÖG/ÖBIG 2010c). This problem has been solved since *eSuchtmittel* was introduced in spring 2011. The quality assurance measures taken in this context have significantly improved the validity of the time series data, particularly with regard to the last few years (elimination of ghost cases; see Chapter 4.1). Only a small percentage of treatments that had been concluded before 2011 without reporting this under the former system could not be subsequently entered. This error seems to apply primarily to treatments before 2007, however, as reporting routines already started to improve significantly as of 2007 (see GÖG/ÖBIG 2011b). Still, the number of first treatments, particularly in the 2008 and 2009 figures, may be biased due to subsequent reporting of people already undergoing treatment, who have thus been incorrectly included in the number of clients starting treatment). The figures given as of 2011 can be regarded as reflecting the actual situation.

Figure 5.9:
Development of annual reports of the number of persons currently undergoing OST in Austria, by first treatment and continued treatment, 2003–2012



Note: **Continued treatment** means treatment started before the respective year or repeated treatment of persons already having undergone opioid substitution treatment in the past.
First treatment means treatment of persons who have never been in opioid substitution treatment before.

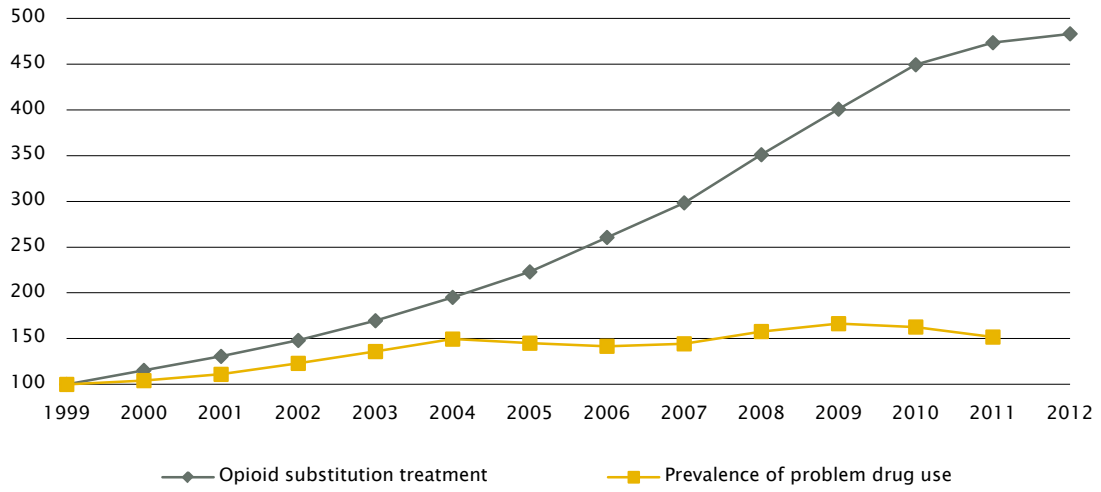
Source: BMG; calculation and graphic representation: GÖG/ÖBIG

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 (Figure 5.9). If the treatment figures are related to the prevalence estimates, it shows that in-treatment rates have massively risen in the course of time. While the estimated number of persons with problem patterns of drug use (opioid use) has gone up by only 50% since 1999, the number of persons currently in OST is almost five times as high as then (see Figure 5.10). This is obviously a very favourable development (GÖG/ÖBIG under preparation).

In all, approximately 50% to 56% of problem opioid users are currently undergoing OST, and 56% to 63% are receiving addiction-related support and treatment services (GÖG/ÖBIG under preparation).

Chapter 5.3.1 provides data on persons in OST broken down by age, gender and region, and Table A22 gives figures on reports of OST treatments by province.

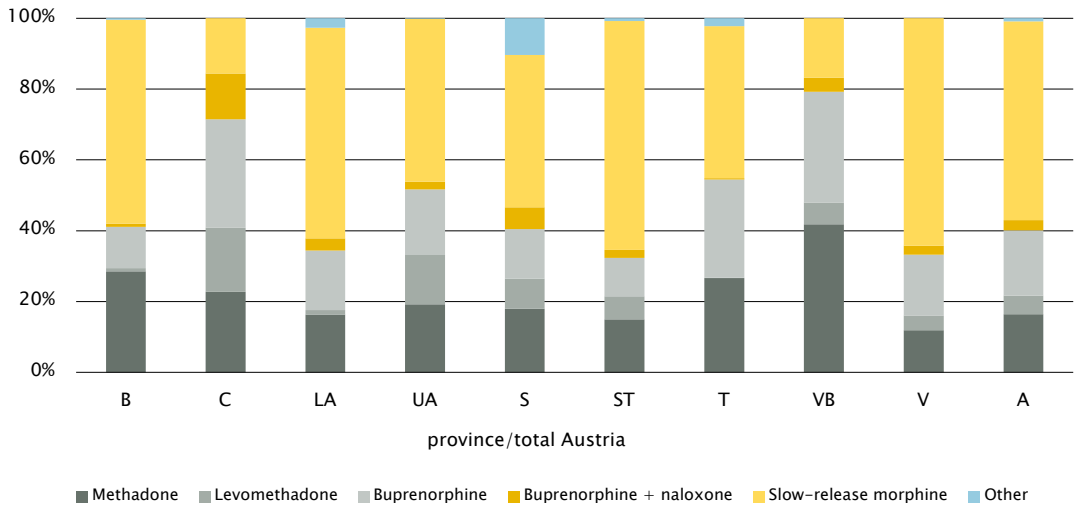
Figure 5.10:
Development of the number of persons in opioid substitution treatment and estimated number of problem drug users (index – 1999 = 100%)



Sources: DOKLI, eSuchtmittel; calculation and graphic representation: GÖG/ÖBIG

In Austria, slow-release morphine is the substitution substance that is most frequently prescribed (56%), followed by buprenorphine (18%) and methadone (16%). However, pronounced differences between the individual provinces are apparent: for instance, in Carinthia and Vorarlberg, less than one out of five persons receiving OST are administered slow-release morphine, compared to more than two thirds in Vienna and Styria (see Figure 5.11). Differences are also found with regard to the age of clients and type of substitution medicine prescribed (see Figure 5.12). The proportion of older clients being prescribed slow-release morphine is slightly above average.

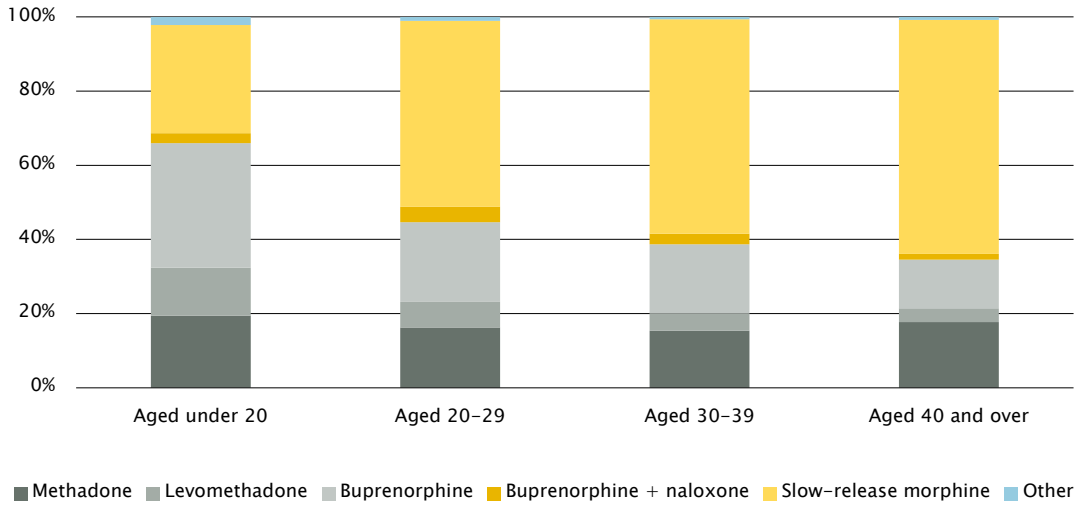
Figure 5.11:
Persons in opioid substitution treatment in Austria, by substitution medicine and province, in 2012



Note: The figures relate to 16 642 of a total of 16 892 people, as no data on the substitution medicine prescribed are available for the remaining 250 people (2%). If the substitution medicine was changed in the course of the year, the substance prescribed most recently was entered.

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Figure 5.12:
Persons in opioid substitution treatment in Austria, by substitution medicine and age



Note: The figures relate to 16 642 of a total of 16 892 people, as no data on the substitution medicine prescribed are available for the remaining 250 people (2%). If the substitution medicine was changed in the course of the year, the substance prescribed most recently was entered.

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

6 Health Correlates and Consequences

6.1 Introduction

Regarding drug-related comorbidity and infectious diseases, particularly HIV and hepatitis are of great relevance for drug users, due to the risk of infection from 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 are thus hardly conclusive (ÖBIG 2006). Data on vaccination rates regarding hepatitis A and B are given in the 2009 health report on Austria (GÖG/ÖBIG 2009c). The data sources mentioned do not permit analyses as to the specific group of injecting drug users, because IDU data are not gathered separately. In the case of HIV infections, only a laboratory reporting system exists, where the number of new infections is entered. It is not possible to relate these data to age or at-risk group. AIDS is a notifiable disease, however. The anonymised reporting system for AIDS cases permits conclusions as to manner of transmission, age, gender and other demographic parameters. Since highly active anti-retroviral therapy (HAART) has become available, this form of statistics has, however, lost its importance, as only a few AIDS cases have since been reported (mostly end-stage cases, persons not responding to treatment, or cases diagnosed at a very late stage; Klein, personal communication). In the present day, the most important information on the HIV epidemic in Austria comes from the Austrian HIV cohort study (AHIVCOS), which at present includes data from seven treatment centres. By the beginning of 2013, a total of 7 584 patients were in the cohort. The cohort is assumed to include around two out of three persons with HIV infections currently living in Austria, and 85% of persons with positive HIV tests who are receiving anti-retroviral treatment (AHIVCOS 2013[60]).

The data on infectious diseases among injecting drug users are inadequate; they are not by any means representative (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 low-threshold *Ambulatorium Suchthilfe* [Addiction Support Outpatient Centre] (previously: *ganslwirt*[61] data). 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

60
The report has also been published as an e-book: http://issuu.com/agesnews/docs/ages_hiv-bericht_2013_ebook 11 June 2013).

61
In mid-2012, the *ganslwirt* low-threshold centre was relocated and then run under the name *jedmayer* (see GÖG/ÖBIG 2012).
Half of the 2012 data on infectious diseases were gathered at *ganslwirt*, and the other half at *jedmayer*, or at the ASK addiction outpatient centre, which has also been integrated into the new *Ambulatorium.*

person who already knows that they are infected with HIV will not usually 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 or not hepatitis C and HIV infections were found, and these 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.

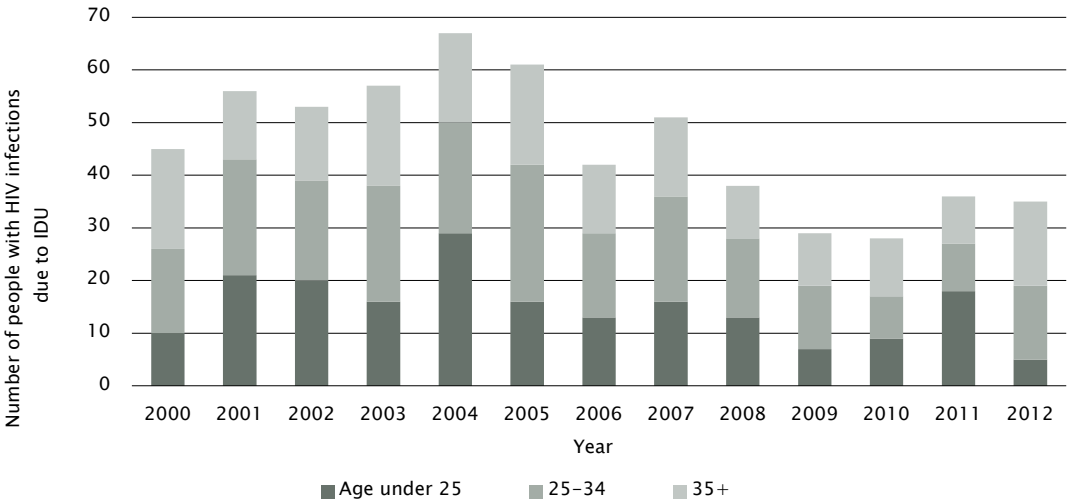
In Austria, the Ministry of Health has collected data on drug-related deaths (DRDs) since 1989. In the case of directly drug-related deaths, a causal connection between death and drug use may safely be assumed, i.e. the persons in question died as a result of acute drug poisoning (overdoses). Data on DRDs are given in ST5 and ST6.

6.2 Drug-related infectious diseases

In the early 1990s the HIV prevalence rate was still as high as around 20% in the group of injecting drug users, but has gone down to low levels since then (2012: 0% to 12%, see Table 6.1), with the largest numbers found among drug-related deaths. Here, slightly elevated figures have repeatedly been registered in recent years (e.g. 2009: 5% to 12%; see GÖG/ÖBIG 2010a). Figure 6.1 shows that the percentage of persons with HIV infections due to IDU who have been included in Austria's HIV cohort study[62] has gone down in recent years. However, in 2011 we see a rise for the first time since 2007, especially in the group aged under 25. As of 2012, the figures have not continued to rise.

62
The Austrian HIV cohort study (AHIVCOS) was started in 2001 at five Austrian HIV treatment centres (General Hospital Vienna, Vienna Otto Wagner Hospital, General Hospital Linz, Provincial Hospital Innsbruck, Provincial Hospital Graz-West). Since 2008, the Provincial Hospitals of Salzburg and Klagenfurt have also taken part in AHIVCOS. A special software (HIV Patient Management System) has been developed for the study. By 1 July 2013, a total of 7 584 patients with HIV infections had been included in the cohort. The study team assumes that the cohort covers approximately 85% of all HIV patients in anti-retroviral treatment (ART) and about half of all patients testing positive for HIV who do not receive ART. Approximately 1 800 to 2 800 people are estimated to have HIV infections that have not been diagnosed. The cohort thus includes around two in three people with HIV infections in Austria. The study analyses both the most likely mode of transmission and the sociodemographic characteristics of clients, as well as numerous medical parameters (AHIVCOS 2012).

Figure 6.1:
AHIVCOS: Number of persons in Austria indicating HIV transmission from injecting drug use, by age and year



Sources: AHIVCOS 2013 and Zangerle, personal communication; graphic representation: GÖG/ÖBIG

In the available sources of data, the hepatitis B prevalence rates range from 2% to 23% in the reporting period. In the majority of cases one can rule out the possibility that any positive test results may be due to 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. It lay between 34% and 70% in 2011, and between 20% and 69% in 2012. Recent figures provided by the two most important sources of data (DOKLI and the Vienna Ambulatorium (the former *ganslwirt* data) indicate a rise or stabilisation at a very high level (see Table 6.1 and Figure 6.2). However, on grounds of data quality and data collection settings, it cannot be verified whether or not this is a general trend. In order to obtain reliable figures on the prevalence of infectious diseases in persons with drug problems, an improvement of the national monitoring routines would be of great importance (e.g. conducting a representative seroprevalence study).

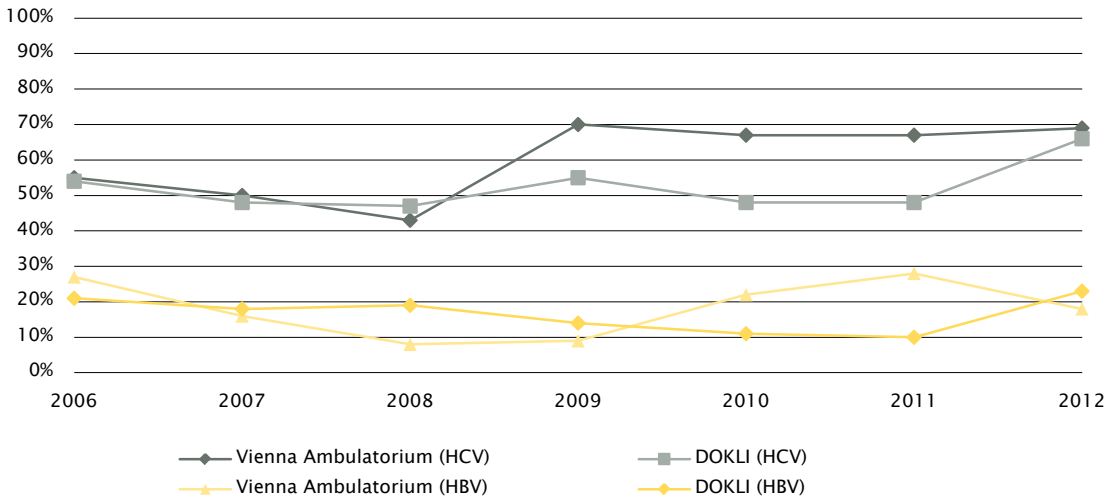
The AHIVCOS study also includes data on hepatitis B and hepatitis C coinfections. While the chronic hepatitis B[63] coinfection rate is 4%, and 16% regarding chronic hepatitis C[64] in the entire current cohort (as at 1 January 2013; see AHIVCOS 2013), the corresponding percentages are 6%

63
Positive HBsAg or HBV DNA test results.

64
HCV-Ab positive and HCV-RNA positive, or HCV-Ab negative but HCV-RNA positive, or HCV-Ab positive and no HCV-RNA test result available.

and 61%, respectively, among clients indicating infection in the context of injecting drug use. A total of 95% of persons infected through injecting drug use whose HCV results are available (n = 890) have either tested positive for HCV-AB or for HCV-RNA, or are undergoing HCV treatment, and have therefore definitely been infected with HCV. Coinfection, particularly with hepatitis C, thus constitutes a major problem among people with HIV infections transmitted through IDU.

Figure 6.2:
HCV and HBV infection rates covered by DOKLI and the Vienna Ambulatorium (former *gangslwirt* data), 2006–2012



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

Source: ST9; graphic representation: GÖG/ÖBIG

Regarding HCV-RNA results, a high proportion of patients testing positive for HCV-Ab display a chronic development of the disease. Again, the percentages reported for HCV-RNA prevalence differ greatly (e.g. Marienambulanz: 41%, Vienna Ambulatorium: 72%).

Regarding HCV genotype testing, no AHIVCOS data are available. Among a total of 518 persons testing positive for HIV (with IDU as the infection route) suffering from HCV co-infections[65], genotype 1 was found in 62%, genotype 3 in 28%, genotype 4 in 6% and genotype 2 in 5% (AHIVCOS 2013; Zangerle, personal communication).

65
These data relate to persons with positive HIV test results and HIV coinfections who have contacted a treatment centre included in the AHIVCOS study at least once since 2005, who have been infected with HIV in the context of injecting drug use and whose HCV genotype is known.

Table 6.1:
Data on hepatitis B, hepatitis C-Ab and HIV infection rates among injecting drug users in Austria, in 2012

Source of data	HBV rate	HCV-Ab rate	HIV rate
Lukasfeld treatment unit	2% (1/59)[1]	41% (24/59)	0% (0/59)
Vienna Ambulatorium	18% (24/132)[2]	69% (104/150)	5% (7/142)
Caritas Marienambulanz	13% (13/100)[3]	66% (66/100)	0% (0/100)
DOKLI	23% (38/166)	66% (116/175)	1% (3/204)
Drug-related deaths (fatal poisoning) in 2012	not available	20% (27/135)[4] 44% (27/61)[4]	5% (7/135)[4] 12% (7/60)[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 had definitely had contact with hepatitis B.
3 This percentage relates to persons in whom both HBVc and HBVs antibodies were found. People who tested positive only for anti-HBVs were not counted because this results from HBV vaccination.
4 Out of a total number of 135 forensic reports on directly drug-related deaths, only 60 or 61, 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.

Source: ST9; calculation and graphic representation: 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 on the survey year 2011 (see Table A30, IFES 2012a). 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 lie at similar levels as in previous years. HIV prevalence has also remained to a high degree stable at 4% (based on self-reporting), which is, however, considerably higher than the percentages given in the majority of data sources listed in Table 6.1 (IFES 2012). An almost linear correlation between rises in hepatitis C infections and the age of clients is apparent: in the group aged under 21, the prevalence rate is as low as 10% but goes up to 37% in the group aged over 40. The setting of the survey (self-reporting by clients) does not permit a distinction between positive testing for HCV antibodies and positive HCV-RNA results. The data on infection prevalence rates obtained from case histories of OST patients surveyed in the context of the EQUATOR study (see Chapter 5.2) also indicate high hepatitis C infection rates (42%). 12% of the respondents said they had tested positive for HBV, and 3% said they had HIV infections (Stöver 2012a).

The reports on the long-term national statistics on AIDS diseases show that injecting drug use ranks last regarding risk situations (14 cases, i.e. 21%), after heterosexual contacts (n = 22) and homosexual contacts (n = 18). Another 12 cases were entered under 'other/unknown infection route' in 2012 (BMG 2013; see Table A8).

Data on other drug-related infections are available only for tuberculosis (TB). Only one of the 118 persons for whom tuberculosis entries exist in the corresponding DOKLI data set (see Chapter 5.3) tested positive for TB. These figures confirm that TB is not a relevant problem among registered clients of drug support and treatment services. The TB vaccination rate given is based on the data of 349 people The data of the reporting year again confirm the small vaccination coverage for TB (2%; GÖG/ÖBIG under preparation).

The DOKLI data set on hepatitis A vaccinations includes 399 people, and regarding hepatitis B vaccinations, 508 people. The **vaccination coverage** of 19% for hepatitis A and 24% for hepatitis B is in fact small. However, among people under 20, slightly higher vaccination rates have been registered than in the other age groups (GÖG/ÖBIG under preparation). Still, these figures reflect previous vaccinations rather than the present status of immunisation.

6.3 Other drug-related health correlates and consequences

According to the statistics from Vienna's *BADO* documentation (surveying year 2011), 66% of people covered indicated current health problems[66]. Besides chronic hepatitis C (26%), dental problems were indicated most frequently (21%), followed by gastrointestinal problems (14%), psychiatric distress (16%), skin and venous problems, and epileptic seizures (8% and 6%, respectively). 12% of female clients said they had gynaecological problems (IFES 2012a). In the past five years, no significant changes have emerged with regard to types of health problem indicated (see Table A30).

According to the statistics on problems addressed in advice sessions at the Vienna *Ambulatorium*, the issue of mental distress was raised in 18% out of a total of 3 245 talks, and physical problems were discussed in 20% of cases (SHW 2013b; see Chapter 8.3). In Vienna, mental or physical health was discussed in slightly less than one third of *streetwork's* advice and support sessions (SHW 2013c).

A study by the Department of Forensic Medicine at the Medical University of Vienna examined the effects of chronic opioid dependence on myocardial fibrosis (Seltenhammer et al. 2013).[67] It has been established that chronic addiction to opioids in fact leads to myocardial fibrosis. Due to the respiratory depressant effects of opioids, the heart is insufficiently supplied with oxygen, which in the long run leads to fibrotic changes in the heart. As a result, even low doses may cause (fatal) overdoses in chronic opioid users.

61% of the Austrian OST patients interviewed for the EQUATOR study (see Chapter 5.2) said they had suffered from depression at some time in the past, and 41% indicated anxiety disorders. 18% of the participants in the study had already experienced non-fatal overdoses (Stöver 2012a).

Apart from psychiatric comorbidity and the health consequences of the infectious diseases

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66
These indications of health problems are exclusively based on self-reports by clients and not on specific diagnostic interviews, medical findings or test results.

67
At the Department of Forensic Medicine at the Medical University of Vienna, 76 drug-related deaths from 1993 and 1994 were retrospectively compared to 23 deceased at the same age who had not used drugs. The years 1993 and 1994 were chosen because in those years additional cocaine use was found to be rather low. In two out of three drug-related deaths, several narcotic drugs were found, and heroin was found in the same number of cases.

discussed above, **somatic diseases** and damage resulting from the chronic effects of toxins or the precarious life conditions of many injecting drug users are also worthy of mention.

Physical comorbidity (concomitant organic diseases) is analysed annually on the basis of test results (macroscopic and microscopic histological analyses of internal organs) obtained in the context of forensic examinations of cases of directly drug-related death. As in previous years, these findings reveal pronounced organic damage among drug users (GÖG/ÖBIG under preparation).

In the majority of indirectly drug-related deaths[68], the cause of death was a disease such as myocarditis, cirrhosis (mostly resulting from hepatitis C) or cancer. Three persons died of AIDS, four had fatal accidents, two committed suicide (not by fatal drug poisoning), and three died of other causes (e.g. murder; GÖG/ÖBIG under preparation).

It is not possible to make any definite statements on the prevalence of psychiatric or physical comorbidity: one reason is that the samples in question are not representative. The data provided should thus be regarded as statements concerning the frequency of incidents. For the same reason, no interpretations in a political, legal, economic or social context can be given either.

6.4 Drug-related deaths and mortality

The term 'directly drug-related death' refers to people whose death is a direct consequence of narcotic drug use, i.e. caused by acute drug poisoning (overdoses; see SMG Section 2). The annual statistics also include fatal overdoses of *new psychoactive substances*, which are, however, counted separately.

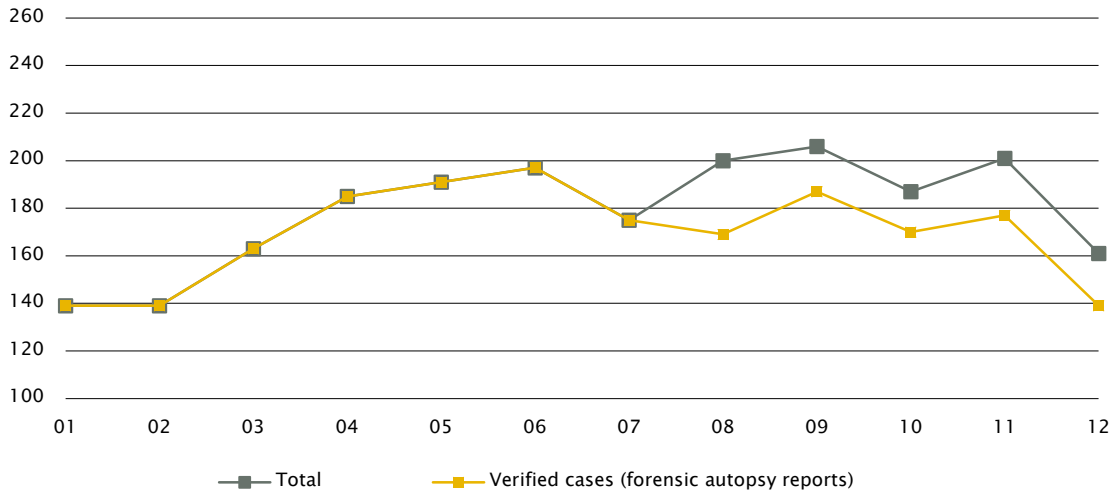
The classification of causes of death is based on the results of (forensic) autopsies, including chemical/toxicological testing. In cases in which no autopsies have been carried out, a list compiled by Statistics Austria on cases recorded as drug deaths in the general cause-of-death statistics, as well as the confirmation-of-death certificates have been used as a reference.

In 2012 a total of 139 fatal overdoses were verified in the context of autopsies. An additional 22 deaths – for which no autopsies were performed – are very likely to result from drug overdoses (narcotic drug poisoning given as the cause of death in the confirmation-of-death certificate

68
In the case of indirectly drug-related deaths the cause of death is not acute fatal poisoning involving a narcotic drug but due to the patients' history of drug use, their death could be related to drug use.
As these cases can only be included in the corresponding statistics if suspicion of an indirect relation to drug use is reported, the available data cannot be assumed to be complete (see GÖG/ÖBIG 2007).

after external post-mortem examination)[69]. A total number of 161 deaths directly related to overdoses is therefore assumed for 2012. It is impossible to deduce short-term trends as the annual figures vary considerably (see Figure 6.3). However, after a noticeable rise between 2003 and 2006, the number of fatal poisoning seems to show a slow decline (see Figure 6.3). Definite statements on trends cannot be given before the figures of the next few years are available. Figures for individual provinces and age groups are given in Tables A3 to A7 in the Annex.

Figure 6.3:
Directly drug-related deaths in Austria, verified by forensic reports and total figures, 2001-2012



Source: GÖG/ÖBIG under preparation; graphic representation: GÖG/ÖBIG

In 15% of drug-related deaths for which conclusive toxicological analyses were available, only illicit drugs (one drug or a combination of several drugs) were found. In 47% of cases, psycho-pharmaceuticals were detected as well, in 12% alcohol was found in addition to illicit drugs, and in 26%, both substances, i.e. alcohol as well as psychopharmaceuticals. As in previous years, fatal poly-drug overdoses involving opioids clearly predominate (see Figure 6.4). Patterns of poly-drug use involving opioids, where the effects of different substances may be potentiating and are thus difficult to control, continue to be widespread and to constitute serious health risks.

69
In these cases, no autopsies were ordered to be performed in order to verify the cause of death, but based on circumstantial evidence and conditions at the scene of death, fatal poisoning without the involvement of a second person was assumed. These cases have not been verified, as drug-related deaths in a medical sense (e.g. no blood tests for drugs were performed), but in accordance with the European standard, they are regarded as DRDs. Thus, statements on long-term trends can be made (until 2008, autopsies were performed in almost all cases of death in which drug-related overdoses were suspected).

With regard to distinguishing between heroin, morphine and slow-release morphine (e.g. the substitution medicine of Substitol®), certain factors have to be taken into account: there are no markers with which slow-release morphine can definitely be identified in the organism, it is therefore listed as morphine. However, in some cases fatal heroin poisoning is also found in this category, for the following reason: heroin is also converted into morphine in the body, but in the case of heroin use, the typical 6-MAM marker can be detected by urinalysis. There are no uniform testing routines for this metabolite of heroin in Austria however, and forensic autopsies differ from those carried out by the health officials (according to information from several forensic institutes, 6-MAM tests are routinely carried out, even though the results are not always explicitly included in the reports). Only cases in which tests for the heroin marker have been performed can thus be listed as heroin poisoning in the statistics. The six deaths in this category thus represent the minimum number of deaths related to heroin poisoning. All other cases have been entered under morphine, and only nine in a total of 100 cases relating to morphine poisoning have been attributed to exclusive morphine use (without the involvement of any other narcotic drugs, alcohol or psychopharmaceuticals).

In 2012 two persons died due to overdoses of *new psychoactive substances* (GÖG/ÖBIG 2012) without any narcotic drug being involved: in one person, a 'structure resembling designer amphetamines' was detected, and in the other case, death was attributed to monointoxication with methoxetamine, a ketamine derivative. In another four cases, *new psychoactive substances* combined with narcotic drugs (opioids or cocaine) were found. The substances detected were 4-MEC, a chemical resembling cathinone, MDPV and mCPP (GÖG/ÖBIG under preparation).

In 2012 a women from Upper Austria died after using a 'bathing salt' according to her own information, which is usually assumed to be connected with *new psychoactive substances*. In a forensic examination, a toxic concentration of bupivacaine, a local anaesthetic, was found, but no narcotic drugs or *new psychoactive substances* could be detected.

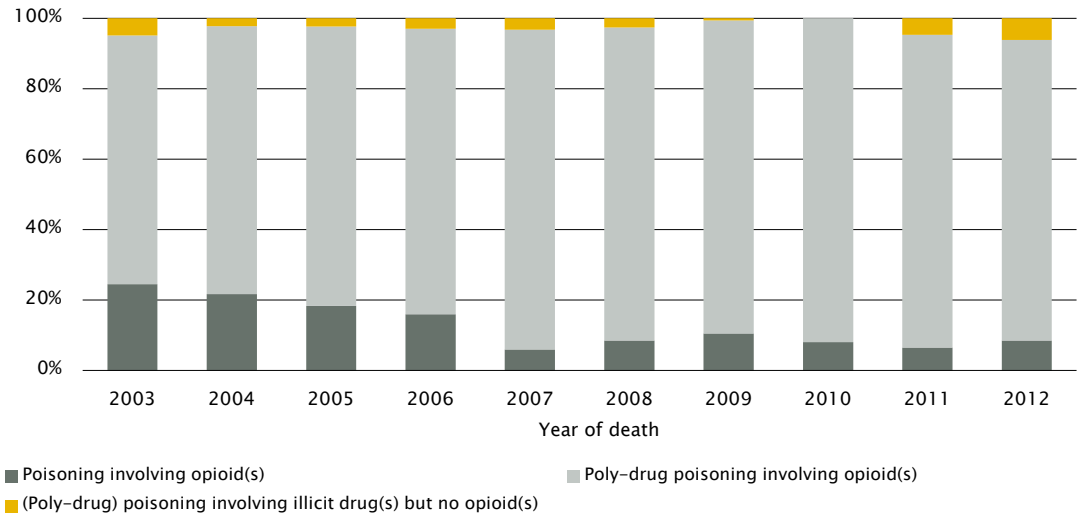
The grouped median[70] of the age at death was 30 years in 2012, i.e. at a level similar to previous years (2009: 29; 2010: 29; 2011: 30). The proportion of persons under 20 (7%)[71] is comparable to the percentages found in the past decade (2009: 10%; 2010: 7%; 2011: 13%; see Figure 6.5 and Table A5 in the Annex). The percentage of women in directly drug-related deaths was 20% of the verified drug-related deaths[72], which corresponds to the long-term average.

70
Grouped median means that 50% of cases lie above this figure and 50% lie below this figure.

71
If the drug-related deaths for which no autopsies were performed are included, the corresponding proportion is 9%.

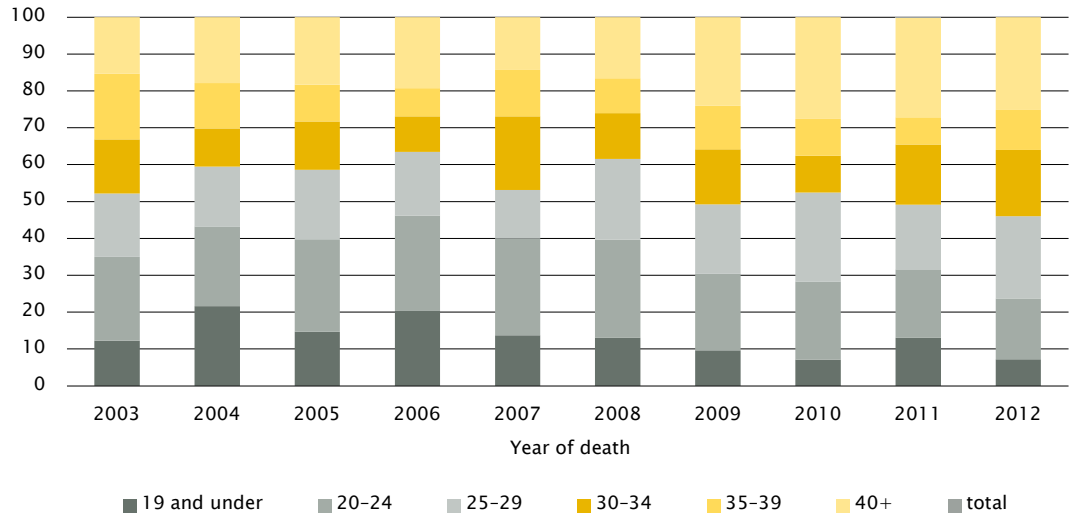
72
If the drug-related deaths for which no autopsies were performed are included, the corresponding proportion is 19%.

Figure 6.4:
Percentage of directly drug-related deaths in Austria, by cause of death, 2003-2012



Source: GÖG/ÖBIG under preparation; graphic representation: GÖG/ÖBIG

Figure 6.5:
Age distribution of directly drug-related deaths in Austria, 2003-2012



Source: GÖG/ÖBIG under preparation; graphic representation: GÖG

7 Responses to Health Correlates and Consequences

7.1 Introduction

In Austria the responses to health correlates and consequences include a wide range of interventions. The relevant measures focus on preventing drug-related infectious diseases, in particular through 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 at low-threshold centres. The available information and data come mostly from the annual reports of individual units and the Drug and Addiction Coordination Offices in the provinces.

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

At the federal level, measures aimed at reducing drug-related deaths and at harm reduction continue to be of great significance and will be integrated into the national addiction strategy (see Chapter 1.3). The relevance of emergency interventions and harm reduction is also emphasised in the Delphi study initiated by the Ministry of Health, in the study's field of interventions regarding support and treatment services. Based on the concept of accepting assistance, general need is indicated for free low-threshold services, outreach social work, information on available ambulance services in the case of alcohol or drug poisoning, as well as the nationwide availability of syringes and syringe exchange services to prevent infections. On the other hand, drug-checking programmes are mentioned as possible first points of contact for advice and promotion of risk competence (Uhl et al. 2013a).

Initiatives specifically focusing on drug-related emergencies and deaths are mainly pursued in the context of low-threshold services, by individual support centres, and in some cases also at the provincial level. Information and advice services play an important role in this context. However, emergency services are of great relevance as well, e.g. crisis intervention and observation (SHW 2013c, SHW 2013g, Caritas Vorarlberg 2013). Specific first-aid courses for drug users and staff of drug assistance services have again been organised in low-threshold centres (Ex und Hopp 2013).

Young people showing at-risk patterns of use have become increasingly important as a target group of support centres and experts. In spring 2013, the REITOX Focal Point organised a focus group with Austrian experts working in this field to study this issue (see Chapter 5.2). In order to

avoid emergencies and overdoses, the continuity of treatment and support is essential among this target group.

Drug checking, for instance the services offered by *checkit!* in Vienna, continues to be important for preventing and reducing emergencies in party settings. Even though 17% of the samples analysed in 2012 did contain the expected ingredients, users had to be warned due to the high doses found, and warnings were also necessary because 28% of the samples contained ingredients that posed considerable health hazards. The results were also reported to the EMCDDA's *Early Warning System* (EWS). Event services typically focus on patterns of use including overdoses (SHW 2013d).

Drug consumption rooms and health rooms continue to be discussed among experts and by the media in Austria[73]. In the report on the Delphi study initiated by the Ministry of Health to prepare a national addiction prevention strategy, drug consumption rooms are mentioned in the field of interventions regarding support and treatment services, provided that a broad political consensus can be found and that there is a legal basis to ensure certainty of the law (Uhl et al. 2013a). In 2012, a diploma thesis on harm reduction and drug consumption rooms in Austria was submitted, which is based on interviews with experts and discusses the pros and cons of consumption rooms from health-related, social, economic, legal as well as moral and ethical points of view (Summer 2012).

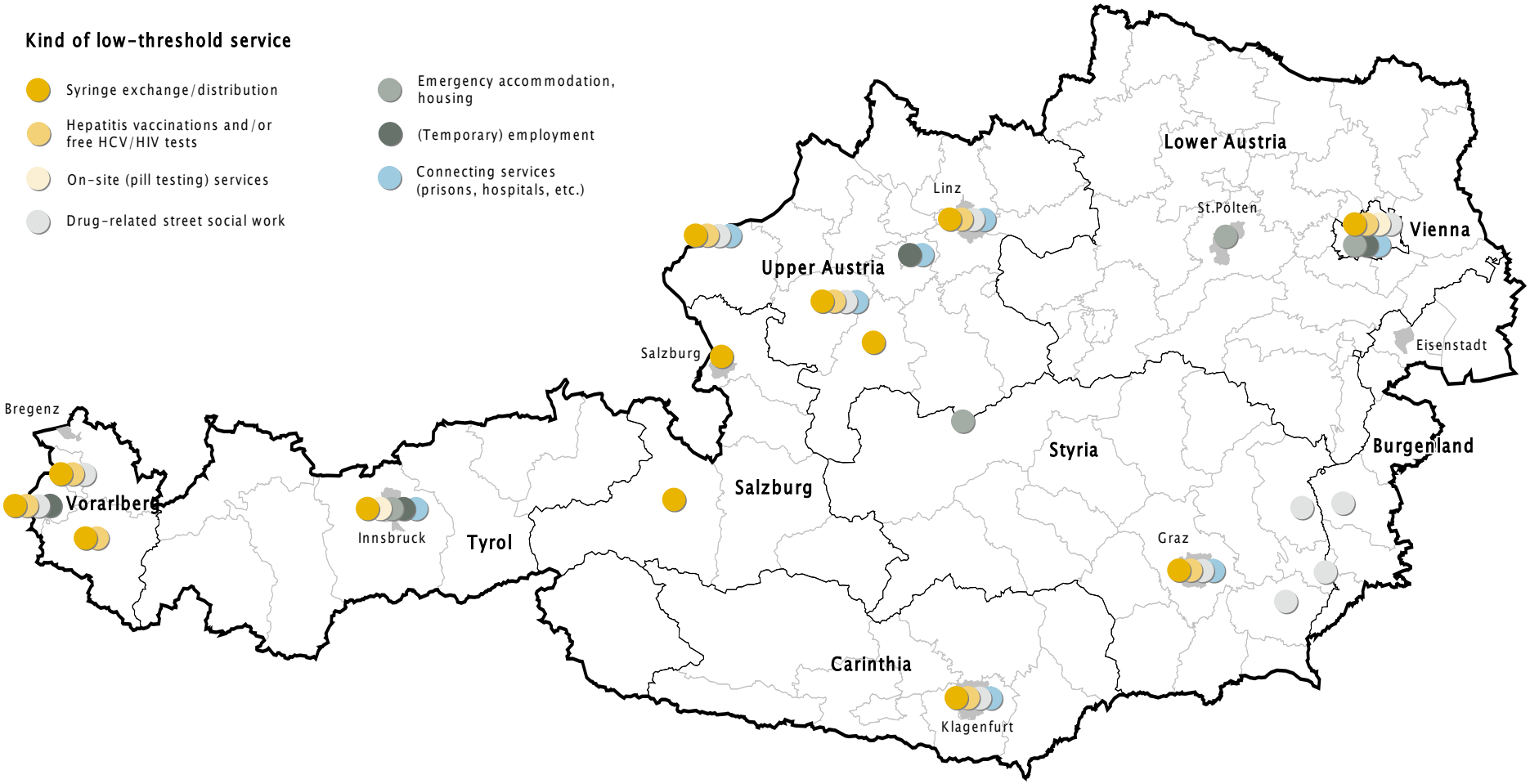
For an overview of the locations of specialised harm reduction services for drug users in Austria, broken down by municipality, see Map 7.1.

7.3 Prevention and treatment of drug-related infectious diseases

The prevention of infections continues to play an important role in low-threshold centres and outreach work: in this context the **exchange and sale of syringes** is of great relevance. In the majority of centres, the return rate for used syringes is very high (97%; SHW 2013a, Caritas Vorarlberg 2013). In addition to the established programmes for the exchange and sale of syringes that are run at the provincial level, in Austria it is also possible to buy syringes and needles at pharmacies and vending machines. Syringe vending machines exist in five provinces (see Table A29, GÖG/ÖBIG 2011a).

73
E.g. http://i-dk.org/ (2 July 2013; in German, with an introduction in English).

Map 7.1:
Specialised low-threshold harm-reduction services for drug users in Austria, in 2013



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

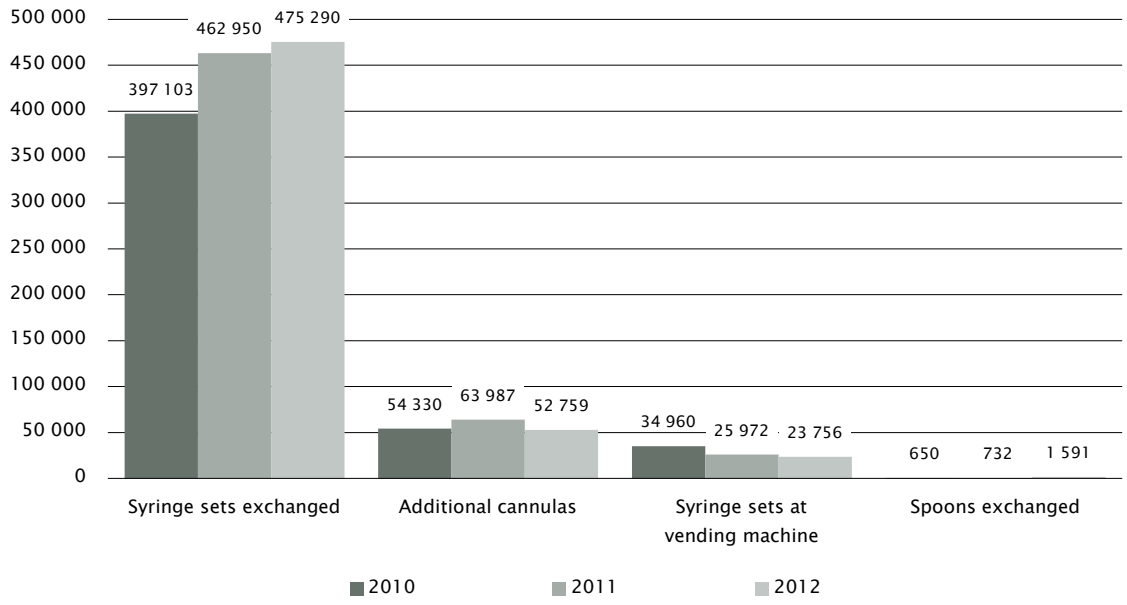
Compared to the previous reporting year, the situation regarding syringe exchange services has seen some change: in Wörgl (Tyrol), a vending machine has been operated since December 2012 (Gstrein, personal communication). Carinthia established two new street social work services that include syringe provision. This development is also reflected in the number of syringes that have been returned (see Table A29). In Vienna, the new social medicine centre *jedmayer* was opened, which has replaced the former *ganslwirt* and *TaBeNo-Süd* centres, so now there are two permanent locations where syringes can be exchanged. The *streetwork* service on Karlsplatz square only dispenses emergency syringe sets. In 2012 the Karlsplatz contact point issued a daily average of 54 syringe sets, and 10 sets a day were issued in the context of street social work (SHW 2013a, SHW 2013c). In Steyr, Upper Austria, a syringe vending machine and five public disposal boxes were installed in 2013, in the context of the *Flow Akut* project (Institut Suchtprävention 2013). In Salzburg, the plan for new low-threshold services including syringe exchange was completed, but its implementation has been suspended for budgetary reasons (GÖG/ÖBIG 2012, Suchtkoordination des Landes Salzburg 2013). As a response to great demand, the I.K.A low-threshold centre in Graz has increased its opening hours to 50 hours per week (Ederer, personal communication).

In the individual provinces, the number of syringes that have been returned or sold has slightly risen. In 2012, a total of 4 297 664 syringes or needles were issued to drug users in Austria (excluding Vorarlberg[74]; see Tables A29, ST10). Figure 7.1 shows that Graz has registered a rise in exchanged syringe sets and spoons in 2012. The number of sets bought at vending machines has slightly decreased, however (see ST10 and Table A29). Syringes sold to drug users by pharmacies are not documented systematically, therefore no figures can be given.

Safer use and **safer sex** are addressed particularly in the context of low-threshold services for drug users. Since November 2012 *Ex und Hopp* (Vorarlberg) has been running a comprehensive programme focusing on safer use, which addresses injecting drug users and other groups with risky patterns of use, as well as the members and staff of the *Starke Süchtige* [Strong addicts] support group. The project includes films and discussion events, advice sessions, safer-use courses, first-aid courses and anonymous HIV/hepatitis testing. The interim report that is available shows that since the start of the project, safer-use rules have increasingly often been discussed during the regular opening hours. The safer-use project weeks programme has meanwhile been attended by other low-threshold services in Vorarlberg (Ex und Hopp 2013). The *Kontaktladen* low-threshold centre in Graz registered a significant increase in safer-use advice sessions in 2012 (2011: 46; 2012:147). Safer use has also become an important theme in *Harlekin*, Kontaktladen's magazine (Caritas Diözese Graz 2012a, 2012b, 2013a). Safer use, safer sex, preventing infections, ways out of injecting use and first aid are issues that are also addressed in pre-treatment sessions and in the context of clients' preparation for discharge (see Preinsperger, personal communication).

74
No 2012 figure are available for Vorarlberg. For this reason, no total figures for Austria (GÖG/ÖBIG 2012) can be given.

Figure 7.1:
Syringes and paraphernalia issued in Graz, 2010–2012



Source: Caritas Diözese Graz-Seckau 2013a; graphic representation: GÖG/ÖBIG

In spring 2013, the Medical University of Vienna organised the final meeting of the *REDUCE* (Reducing Hepatitis C Risk Behaviours among Female Drug Users) project of the European Union. The project results, i.e. a tool kit for measuring HCV risk behaviour and a manual on group interventions to reduce risk behaviours including a video are available on the project website[75].

Hepatitis vaccination programmes are another essential intervention with regard to the prevention and treatment of drug-related infectious diseases. However, such programmes are available only in a small number of drug support and treatment centres. The vaccination services are usually combined with free HIV and viral hepatitis testing (Caritas Diözese Graz-Seckau 2013a, SHW 2013a).

In Vienna, **hepatitis infections** among drug users in Vienna are routinely treated at all gastroenterology outpatient departments of Viennese hospitals (see GÖG/ÖBIG 2012).

75
http://www.thereduceproject.imim.es/manual.html (9 July 2013; in German).

7.4 Responses to other health correlates among drug users

Interventions with regard to **psychiatric comorbidity** continue to be part of the activities of drug-related support and treatment centres (see GÖG/ÖBIG 2011b and 2012). Psychiatric comorbidity has also been on the agenda of the focus group on risky drug use among young people organised by GÖG. Vienna's *Dialog* association reports a rising number of young people suffering from massive psychological distress, rather than problem patterns of drug use. In order to meet the needs of these clients, Dialog's services have been adapted accordingly, and its cooperation with other service providers has been intensified. As the staff includes experts in child and youth psychiatry, and as links to other service providers have been established, the reorientation of services and referral of clients have worked well (Zedrosser, personal communication).

Interventions and activities that focus on the general **state of health** of drug users are integrated into all services delivered by the drug support and treatment centres, with different focuses depending on the setting in question. Mental and physical health are central issues especially in advice sessions in the context of low-threshold services (SHW 2013c, Verein Substanz 2013; see Chapter 6.3). In July 2012, the *jedmayer* and *the* Vienna *Ambulatorium* low-threshold centres were opened. As a consequence, as of December 2012, the weekend and holiday services for persons in opioid substitution treatment, which had been provided at Otto Wagner Hospital, Pavilion W, until then, have been taken over by the Vienna *Ambulatorium.* All persons in OST who are facing a bottleneck in the supply of substitution medicines receive first treatment in the outpatient clinic, and if necessary, they get medicines to close the gap in supply. The former services performed by Ambulatorium will be continued, i.e. provision of medical care for patients who are not undergoing opioid substitution treatment, and treatment of patients on weekends or holidays. Furthermore, Ambulatorium is a contact point for external experts who need input with regard to questions of addiction medicine (SHW 2013g).

In view of the rising demand for **mobile services** for persons with addiction problems, the *Umbrella Organisation of Vienna Social Institutions* (Dachverband Wiener Sozialeinrichtungen 2012) has cooperated with experts in the areas of social care, health care and drug services to draw up an evidence-based guideline for action. This guideline is part of a set of practical guidelines for providers of mobile services, aimed at raising awareness and helping their staff identify addiction problems and respond to addicted clients to whom they are delivering daily care and support services. It is emphasised, however, that the clients' wishes have to be respected, and that withdrawal or detoxification always requires supervision by a doctor or professional support, with the staff of mobile services providing assistance in this regard.

In a diploma thesis drawn up at the University of Vienna, the **roles and approaches of professional caregivers in low-threshold drug support centres** were studied by means of semi-structured interviews. The analyses of the data underline the importance of interdisciplinary cooperation and external networks. Professional caregivers in this setting play a significant role in the provision of basic medical services and advice with regard to prevention (Karanitsch 2012).

In the reporting period, a new agreement for **services for addicted patients in hospital** was concluded with the General Hospital Vienna (AKH), under which the existing drug social work services at AKH were integrated into the *CONTACT* hospital connection service. *CONTACT* is also in charge of ensuring the continuity of services between the psychiatric departments of the Vienna Hospital Association and the Vienna addiction and drug services network (SDW 2013).

In the context of low-threshold drug support, special services for women are offered, which usually take place in specific settings. They include advice on **issues that specifically concern women** (e.g. working in prostitution to finance drug use, experience of violence, or eating disorders) as well as gynaecological treatment.

8 Social Correlates and Social Reintegration

8.1 Introduction

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 and treatment services for drug users and similar institutions, as well as information issued by the Addiction and Drug Coordination Offices in the provinces. Additional information on this aspect is also provided in SQ28 as well as Map 8.1, which shows specialised social integration services provided by drug support centres and treatment centres in Austria, giving the towns and cities where the relevant services are available.

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

Interventions aimed at the social (re-)integration of (former) drug addicts address both clients after drug-free treatment and people who are currently using drugs. In Austria, measures 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 into 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 part in a range of other services that focus on unemployment, homelessness and leisure activities.

8.2 Social exclusion and drug use

The social situation of drug users turning to treatment, advice and support 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 arise mainly among socially disadvantaged people. All it shows is that this group will more readily utilise the drug support and treatment system than people who (still) have their own social and financial resources (see Chapter 5.3).

In 2012, according to Statistics Austria[76] an average of around 189 000 persons were out of work (according to the international definition), which corresponds to an increase of 10 000 persons compared to the previous year, and an employment rate of 4.9%. The groups that were

76
http://www.statistik.at/web_en/statistics/labour_market/unemployed_looking_for_work/index.html (18 July 2013).

particularly affected were the long-term unemployed, people with non-Austrian nationality, people with disabilities and older people; approximately half of the people registered as newly unemployed have not completed school[77]. The Austrian Institute of Economic Research also points out that low education levels pose the greatest risk of unemployment, and while there is demand for skilled workers and highly qualified staff, unskilled workers are unable to find employment[78].

Around half of the persons interviewed for the EQUATOR study (Goulão and Stöver 2012; see Chapter 4.3) said they had completed vocational training. The figures of the DOKLI client year 2012 (see Chapter 5.3) show that the percentage of employed persons continues to be the lowest among clients receiving inpatient treatment (6%). Particularly among clients of long-term outpatient services, the percentage of women who have jobs is significantly smaller compared to men (women: 28%; men: 34%; see Table A24). In the client year 2012, 50% of people taking up low-threshold services said their housing situation was stable. In contrast, among the group of clients receiving long-term services, around 90% continued to indicate a stable housing situation (see GÖG/ÖBIG under preparation and Table A26).

According to a survey[79] conducted in 2006 among Austrian support and treatment centres (BAWO 2009), a total of around 37 000 people in Austria are homeless (multiple counts cannot be ruled out). Approximately 31 000 adults and around 6 000 young people had contacted the corresponding services in order to prevent eviction, receive outpatient care, as well as accommodation or assistance related to housing. More recent figures are only available from the city of Salzburg, where a survey among homeless people was again conducted in 2012 (Forum Wohnungslosenhilfe Salzburg undated)[80]. According to the survey, in 2012 a total of 945 people (October 2011: 847) were registered as homeless by Salzburg's social service providers.

Sociodemographic data from Tyrol are given in the annual report of the Tyrolean Addiction Advice Association (SbTirol 2013). In 2012, almost 80% of a total of 572 clients aged between 14 and 65 indicated a stable housing situation. Around 45% said they had regular work, and slightly

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77
http://www.salzburg.com/nachrichten/oesterreich/wirtschaft/sn/artikel/314407-im-juni-auf-jobsuche-64888 (18 July 2013; in German).

78
http://science.apa.at/site/politik_und_wirtschaft/detail.html?key=SCI_20130628_SCI40111351013448696 (18 July 2013; in German).

79
In 2006 the National Platform of Social Services for Homeless People (BAWO 2009) conducted a quantitative and qualitative survey among organisations providing services for homeless people and similar service providers such as advice and support centres for women, on behalf of the Austrian Federal Ministry of Labour, Social Affairs and Consumer Protection.

80
As at 1 January 2013, approximately 150 000 registered citizens had their primary place of residence in the city of Salzburg. http://www.stadt-salzburg.at/internet/politik_verwaltung/salzburg_in_zahlen/einwohner_321402/einwohnerzahlen_1_1_2013_375125.htm (18 July 2013; in German).

more than 20% were unemployed. Around 25% to 30% of the clients were skilled workers, and the same proportion was accounted for by unskilled workers.

In her diploma thesis (see Chapter 4.3) Nagel (2012) surveyed sociodemographic data of drug addicts in Tyrol. The analysis showed that 84% of the respondents indicated a stable housing situation, and 15% were homeless. Regarding gender-related differences, female drug users turned out to be affected by unstable housing or homelessness to a greater extent than men. When those indicating an unstable housing situation were interviewed in more detail, it was revealed that shelters for the homeless were almost exclusively frequented by men, while women mostly indicated 'other' when asked about their housing. The author assumes that this often means short-term accommodation in exchange for sexual favours. With one exception, all persons surveyed had health insurance.

The replacement of the welfare assistance system by the means-tested minimum income scheme (see GÖG/ÖBIG 2012) has had great influence on former recipients of welfare assistance and might also be relevant for addicted persons. The Federal Ministry of Labour, Social Affairs and Consumer Protection has meanwhile provided a first report on the new system (BMASK 2012b). The provinces have some leeway with regard to defining the details of their means-tested income schemes, and most of them have used it in a positive way. For instance, Lower Austria, Vorarlberg and Vienna defined higher minimum standards for children, Tyrol grants additional payments, Upper Austria and Salzburg adopted generous provisions for admissible additional income, and provisions for actual housing cost coverage exist, for instance, in Vorarlberg and Tyrol. In Burgenland, means-tested minimum income may also be granted as a precautionary measure to prevent imminent emergencies, and has to be offered by the authorities without application if circumstances are known that indicate need for this type of support (BMASK 2012).

At present, approximately 193 000 persons are receiving the means-tested minimum income (2011: approx. 180 000 persons). However, these two figures are comparable only to a limited extent, as several provinces have meanwhile modified their schemes.

8.3 Social reintegration

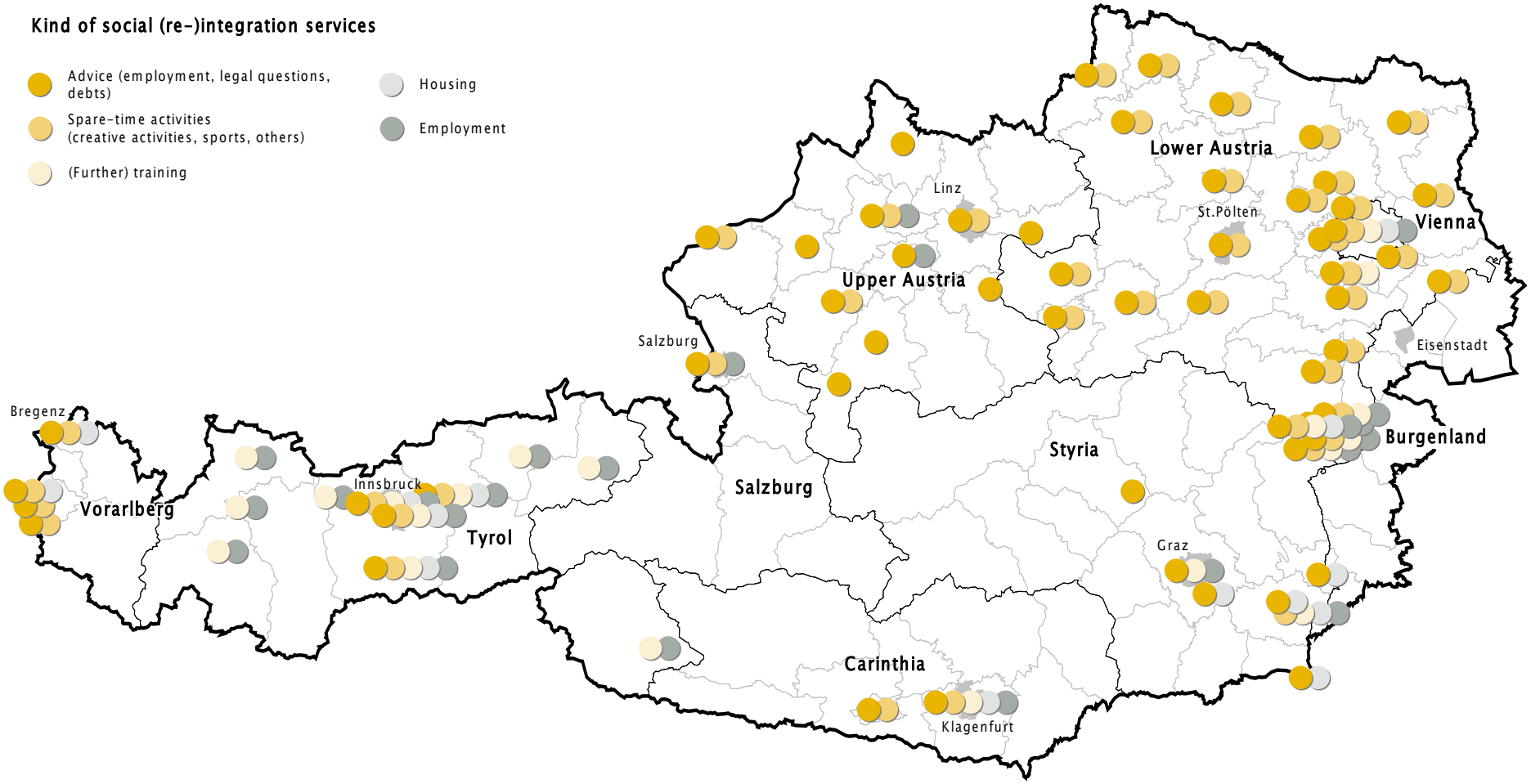
Services aimed at social (re)integration are delivered in the areas of employment and training, housing and leisure activities (see also Map 8.1). Regarding **employment**, the corresponding interventions are oriented towards low-threshold access to occupation on a per-day basis as well as for longer periods. In the field of training, new programmes for experts, but not for clients, have been established. Many of the social (re)integration services described in the reports of recent years (GÖG/ÖBIG 2010a, GÖG/ÖBIG 2011b, GÖG/ÖBIG 2012) have been continued or replaced by follow-up projects (e.g. *Standfest II*). Below, further information on the expansion of existing, or establishment of new, services in this area is provided.

In order to improve the cooperation between all providers of services to addicted clients on the one hand, and to encourage an intensive exchange on different frameworks and legal provisions with regard to the concepts of fitness to work and employability on the other, a project on addiction disease and fitness to work was drawn up on behalf of WiBAG, an enterprise providing business services in Burgenland. The project was aimed at the training staff of Burgenland's Public Employment Service (AMS), to help them respond professionally to clients showing problem patterns of drug use and to communicate the individual institutions' attitudes towards (un)fitness to work, (un)willingness to work and disease/health. The two-day seminar was attended by over 60 AMS staff (Hausleitner personal communication).

Similar further training events were organised in Lower Austria as well. For instance, in summer 2012 the first PUMAS training on professional responses to dependence issues in social integration services took place. It communicates basic knowledge on drugs, dependence-related diseases as well as prevention and treatment options. The participants are also assisted in finding professional ways of responding to (former) addicts, and organising the working routines of their organisation in line with the potential and needs of this target group (Hörhan, personal communication). Currently plans are under way to organise another PUMAS training to take place in autumn 2013, which will particularly address staff of socioeconomic enterprises (social integration organisations), as well as organisations providing services to homeless people in Lower Austria. In 2012 approximately 20 staff from a total of four Lower Austrian social economic enterprises took part in a PUMAS training programme (Fachstelle für Suchtprävention Addiction Prevention Unit NÖ 2013).

The patients at the *Carina treatment unit* in Vorarlberg take the first steps toward labour integration during residential treatment, in individual coaching sessions where their interests are discussed, job applications are drawn up, contacts to relevant stakeholders are established, and where they prepare for working life. In 2012, these services were complemented by establishing a 'job group', which helps the patients prepare for job application, and encourages an active exchange among patients in a difficult situation in life. The labour integration services are also taken up by the patients in the day clinic (Stiftung Maria Ebene 2013).

Map 8.1:
Specialised providers of outpatient and inpatient drug support services focusing on social (re)integration in Austria, in 2013



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

Caritas of the Diocese of Feldkirch runs the *Wald [forest] employment project*. It is one of the main pillars of the new *Caritas Café* contact point and meeting place and closely cooperates with Caritas's addiction unit at Feldkirch. The Wald project addresses persons who cannot be fully integrated into the labour market and who are currently suffering from substance-related addiction problems. As of 2012, the Wald programme has been opened to persons addicted to legal as well as to illicit drugs. A maximum of 12 jobs are available on five days a week (forest work, textile recycling, work in a cooking project at *Caritas Café* and a garden project), providing daily structure and possibilities of employment for three hours a day. In 2012, a total of 57 persons (61% addicted to an illicit primary drug, 39% addicted to a legal primary drug) took part in the project, and 11 persons were even able to find work in the regular labour market[81] (Caritas der Diözese Feldkirch 2013).

In Vienna, people who cannot (yet) be integrated into the regular labour market have access to occupation in two socioeconomic enterprises: *fix und fertig* (run by the Vienna Addiction Services) and *gabarage upcycling design* (run by the association *social design business*). These two enterprises offer both temporary jobs and employment on a per-day basis. The *Vienna Job Exchange* is in charge of matching applicants with jobs in order to ensure that the enterprises' capacities are efficiently used and that members of their target group are hired. As the *Vienna Public Employment Service* has defined the requirement of 'distance from the labour market' as a prerequisite for eligibility, it has become difficult for many people in the target group of addicted persons to find employment through this channel. The *Vienna Public Employment Service* agreed to suspend this requirement for 2013, it will therefore be possible to use the resources of the two social economic enterprises to a greater degree (SDW 2013, see also ÖBIG 2005). In 2012, *fix und fertig* employed 287 persons in 7 392 one-day jobs, which is an average of almost 30 jobs per day. On average, 23% of applicants had to be turned down every day. The average age has risen further, to 38 at present, and particularly clients over 45 have shown great interest in the job opportunities (SHW 2013f).

Since spring 2012, *gabarage* and *fix und fertig* jointly have been running the model project *A.I.Q.* (labour market integration with integrated qualification), which has been cofinanced by the European Social Fund and is aimed at promoting the labour-market integration of addicted persons who are distant to the labour market. The model project forms a link between traditional occupational therapy and socioeconomic enterprises. On the one hand, regular workshops and trainings are organised where participants may find occasional or hourly occupation to acquire handicraft skills that are relevant on the labour market, as well as soft skills (formal qualification), and in addition, 'older', more experienced members of the target group offer a sociocultural exchange on an equal footing (informal qualification). The latter constitutes a new peer approach in this field. The medium-term goal is to at least integrate the participants into to the subsidised labour market. The workshops are jointly held by a project instructor and a peer client with a great deal of life experience. In 2012, the *A.I.Q* project offered 25 daily jobs: it was

81
Employment in the regular labour market refers to jobs which, in contrast to subsidised employment, do not result from active labour market policy interventions.

then possible to directly refer two persons to the regular labour market, while five participants started (further) training (SDW 2013, SHW 2013f).

In her doctoral thesis[82], Just (2012) studied the influence of social capital on the social integration of patients undergoing long-term drug treatment (see also Chapter 5.2.2). According to Just, the reintegration goals in the individual treatment programmes are defined in very general terms and do not go into depth. While they do underline support with regard to job-seeking, training, housing, financial situation and leisure activities, it is not specified how the integration of former drug patients might be achieved in such a way as to permit them to lead drug-free lives in the long run. It is generally assumed that former drug addicts should be oriented towards society as far as working environments as well as housing and leisure activities are concerned, which will then in turn bring about reintegration. However, this can only work if the person in question has actually been integrated some time prior to becoming involved in drugs. From the perspective of many drug addicts, integration into the social mainstream works in a different way because, for them, the process of integration involves learning new patterns of behaviour and leaving old habits behind. For former drug addicts, reintegration means having to meet requirements for which considerable skills are needed, and this leads to the assumption that reintegration is out of reach. For instance, it is difficult to lead a drug-free life if relationships with drug users continue to be maintained. On the other hand, it is impossible, within six months or one year, to exchange one's entire social environment and focus on other areas of life such as work, leisure activities or housing (Just 2012)

The interviews reveal, for instance, that establishing contacts at work is an extraordinary challenge for former drug addicts because they feel ashamed and their self-esteem is low. In other words, relationships with colleagues at work cannot be regarded as a source of social capital for patients in long-term drug treatment. They often avoid talking with colleagues and distrust others who are getting into contact with them. It can thus be concluded that, especially in workplace contexts, people need more time and that socialisation and integration is a long-term process here (Just 2012)

The services in the field of **housing** are of a structure similar 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.

At the *Carina treatment unit* in Vorarlberg, all 61 patients completing treatment were able to find stable housing, with more than three out of four living on their own (Stiftung Maria Ebene 2013).

82
The study is based on a literature search, as well as on 15 qualitative interviews with experts and 25 problem-centred interviews with former drug-addicts (13 women, 12 men) who had undergone long-term treatment. All interviews were conducted from April to December 2010. The experts were interviewed at three long-term treatment centres (Grüner Kreis, Erlenhof and Pavilion 1 of Otto Wagner Hospital), and in centres of the Vienna addiction and drug services network.

The 15 assisted housing spaces that are provided by the *Vienna Addiction Services* were occupied throughout 2012. 10 clients moved out during that period, and 6 of them as planned, i.e. they were referred to council flats owned by the City of Vienna. Usually, clients need the assisted housing service for 24 months (SHW 2013b).

In the further training workshops on health and housing organised by the *Vienna Platform for Health and Homelessness*[83], this theme is regularly addressed. For instance, guided tours of a temporary housing unit are offered, or health promotion in the context of services for homeless people is discussed. In addition, approaches to, and experience with, drug use in support centres, as well as with problems linked to homelessness and drug services, are presented. The Vienna Platform is an open forum for experts in the fields of homeless services and health care, as well as for persons affected by homelessness. The Platform's goal is to raise public awareness of health promotion and health-care issues among homeless people, to point out links between the health-care system and services for the homeless, and to use the manifold competences and experience of the participants to develop a joint strategy. For instance, it is possible to attend a short-term training to become a continuity officer for health and housing, or to attend events that are recognised as job-related further training.

Many of the above service providers also organise **leisure** activities with low-threshold and one-off events, as well as activities extending over longer periods, and some of them require signing in and signing out by participants. The main focus is on sports, art as well as cultural and creative activities and on shared experience. In this context, artistic and cultural activities, and recently also creative work, have played increasingly important roles. The majority of activities are, however, not open to all, but only to clients of the corresponding centre, often in the context of therapy. The existing services have been continued (see, e.g. GÖG/ÖBIG 2010a). A wide range of leisure activities are organised as an integral part of the services offered. For instance, *Walk about* played an important role in the programme offered by the *Z6 youth centre.* It is run as experience-based group work designed and organised by the drug advice centre. Some of the leisure activities take place in the youth centre, but most of them are outdoor events (e.g. skiing, dancing, horseback riding etc.; Z6 2013). Since November 2012, the new *jedmayer* drug advice centre run by the *Vienna Addiction Services* has offered day-structuring leisure activities, as well as health-related workshops (SHW 2013b).

The creativity events held by *Grüner Kreis* have been expanded and have met with great interest, for instance, at the 2012 Wiener Festwochen cultural festival or at an exhibition at the Graz University Centre of Theology (Neuhold 2013a, 2013b).

83
www.gesundheit-wohnungslosigkeit.at (22 July 2013; in German).

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

9.1 Introduction

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. Further sources include academic and other publications, the annual reports of drug support and treatment services and information by the Addiction and Drug Coordination Offices in the provinces. This information is also provided in ST11 and SQ31. The Narcotic Substances Act (SMG) plays an important role as a basis for measures taken by prosecution authorities (see also Chapter 11 in GÖG/ÖBIG 2011b). The SMG distinguishes between narcotic drugs, psychotropic substances and precursor substances. The substances that come under the individual groups are listed in separate regulations, where a distinction is also made between misdemeanours, i.e. illicit handling of drugs (SMG Section 27) and felonies, i.e. preparation for drug trafficking (SMG Section 28) as well as drug trafficking (Section 28a), although the offence described under Section 28, para. 1 cannot in fact be classified as a felony. In order to avoid unnecessary complication, all reports to the police relating to violations of Sections 28 and 28a of the SMG are referred to as felonies, and all reports relating to Section 27 are referred to as misdemeanours.

The 2008 report (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. Figures for 2012 concerning violations of the Act on New Psychoactive Substances have been made available for the first time.

As explained in previous years and emphasised by the Federal Ministry of the Interior (BMI 2013a), the statistics on reports to the police primarily reflect the intensity and focuses of police activities in this field.

In 2012 the number of reports relating to violation of the SMG has seen a decrease compared to the previous year, and is now at the same level as in 2010. Regarding convictions for felonies (i.e. violations of SMG Section 28), the rising trend of the past year has continued, while convictions for misdemeanours (SMG Section 27) have decreased. However, due to a break in the time series[84], it is only to a limited extent possible to compare the new figures to those prior to 2012.

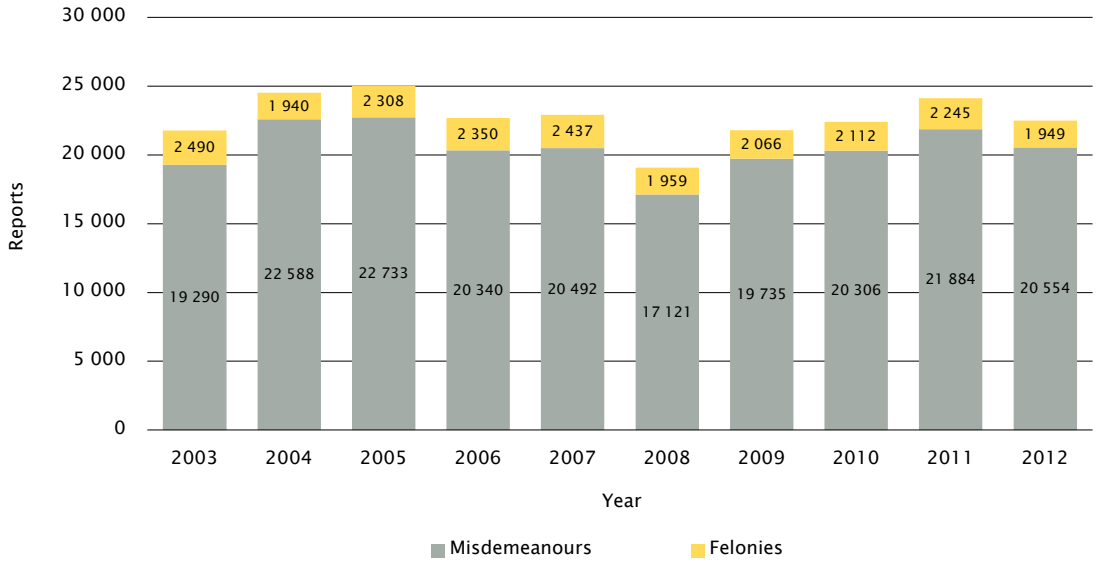
84
As of 2012, a break in the time series for figures relating to the leading offence has to be taken into account: since that year, information on the offence that is decisive for the punishment imposed has been provided by the courts. Previously, Statistics Austria determined the leading offence, using an algorithm to calculate the offence with the highest range of punishment in cases where a defendant was found guilty of several offences.

9.2 Drug-related crime

In the present report, the term **drug-related crime** refers to misdemeanours or felonies committed in connection with the Narcotic Substances Act (SMG). In 2012, the number of reports to the police relating to violation of the Narcotic Substances Act (SMG) has seen a decrease compared to 2011 (from 25 892 to 23 797) and is now at the same level as in 2010 (see also Tables A9 and A10).

A total of 22 503 reports (2011: 24 129) concerned narcotic drugs. The majority of the other reports (1 294) related to psychotropic substances, and eight to precursor substances. Regarding type of report (see Figure 9.1), 2012 saw a decline in reports due to both felonies (-13%; preparation for drug trafficking – SMG Section 28, or drug trafficking – SMG Section 28a) and misdemeanours (-6%; illicit handling of drugs – SMG Section 27).

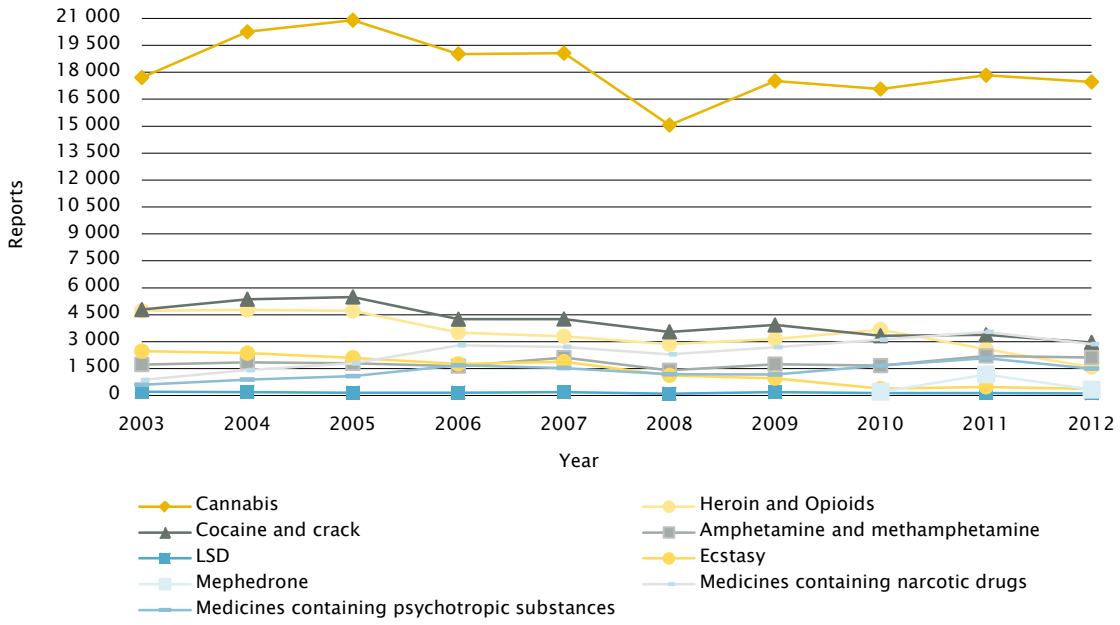
Figure 9.1:
Development of reports relating to violation of the Narcotic Substances Act in Austria (narcotic drugs only), by misdemeanours and felonies, 2003–2012



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

In terms of substances involved (see Table A11 and Figure 9.2), a decline with regard to all substances compared to the previous year is apparent (in the case of mephedrone, even a 72% decline), excluding precursor substances. In the individual provinces, the number of reports by substances involved mostly show a decline as well, or have remained at constant levels; this also applies to medicines containing psychotropic substances and to mephedrone. Only in the case of cannabis and amphetamine, as well as methamphetamine, have small increases in reports to the police been registered in a few provinces (see Table A12). 2012 is the first year for which data on reports relating to substitution medicines have been available: 2 108 of a total of 2 558 reports in this group concerned substitution medicines containing morphine (BMI 2013b).

Figure 9.2:
Development of reports relating to violation of the Narcotic Substances Act in Austria, by type of substance, 2003–2012



Note: As the figures are broken down by type of drug, double counts in individual reports cannot be ruled out.

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

In 2012 a total of 23 797 reports to the police led to 1 569 arrests (2011: 1 697) in connection with drug-related investigations. However, no further details regarding arrests (such as type of offence or substances involved) can be provided.

Figure 9.3 below, which is based on the judicial criminal statistics, shows the development of convictions under SMG Sections 27 and 28 over the past 10 years, with regard to the leading offence. Compared to the period from 2006 to 2009, during which the number of convictions under the SMG continuously decreased, since 2010 (n = 4 363) an increase has become apparent, which has also continued in 2011 (n = 4 444). Due to the break in the time series, the 2012 data are comparable with the former figures only to a limited extent, and as in previous years, in 2012 the number of convictions for misdemeanours (SMG Section 27) have been considerably higher than convictions for felonies (SMG Section 28): 2 810 v. 1 403 cases. The proportion of convictions for violation of the SMG, out of the total number of convictions in Austria, was 12.0% in 2012 (see also Table A13).

Figure 9.3:
Convictions in Austria under SMG Sections 27, 28 and 28a, 2003–2012*

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 drugs.
SMG Section 28 = preparation for trafficking in narcotic drugs.
SMG Section 28a = trafficking in narcotic drugs.
Note: The figures refer to the leading offence, i.e. the offence that is most severe with regard to the range of punishment, therefore not all convictions under the SMG are covered.
* As of 2012, data on the legal basis of conviction has no longer been compiled by Statistics Austria but by the courts.

Source: Statistics Austria (judicial criminal statistics); graphic representation: GÖG/ÖBIG

2012 is the first year for which data on all offences[85] of which a defendant has been found guilty are available. In 2012, 4 261 defendants were found guilty of a total of 7 457 drug-related offences and thus convicted by Austrian courts. The number of convictions in which psychotropic substances were decisive in terms of the punishment imposed (SMG Sections 30, 31 and 31a) was highest in 2011 (117 convictions) and fell to 47 in 2012. However, a total of 195 offences connected with psychotropic substances were registered (BMJ 2013).

Table 9.1 gives the number of final convictions under the Narcotic Substances Act (SMG), and specifies how many SMG offences were involved in each case. Some of the figures are more than 100% above those in Table A14, which shows the number of final convictions under the SMG by basis of conviction, gender and age group.

Table 9.1 gives the number of final convictions that are based on SMG offences. The 2012 figures, which are the first that include all SMG-related offences of which a defendant has been found guilty, show that offences relating to SMG Sections 27 and 28 have been much more

85
As of the reporting year 2012, **all** offences of which defendants have been found guilty in a reporting year can be included in the statistics.

frequent than is reflected in the offences that have been decisive in terms of the punishment imposed. This is of great significance particularly with regard to offences that are not severely punished, because until now, in the case of convictions for several punishable offences, only the offence with the greatest range of punishment was included in the statistics. The figures that are now available show that the actual number offences of which defendants were found guilty is up to 100% higher than the figures that have been provided so far (Table A14).

Table 9.1:
Number of final convictions under the Narcotic Substances Act (SMG), including number of SMG offences of which defendants were found guilty, by basis of conviction, gender and age group, in 2012*

Basis of conviction		Aged 14–19	Aged 20–24	Aged 25–29	Aged 30–34	Aged 34+	Total
SMG total	Men	809	2 148	1 424	999	1 366	6 746
	Women	78	230	168	91	144	711
SMG Section 28 or 28a	Men	114	460	355	337	505	1 771
	Women	12	61	44	29	53	199
SMG Section 27	Men	695	1 657	1 038	628	793	4 811
	Women	65	161	113	58	81	478

SMG Section 27 = illicit handling of narcotic drugs.
SMG Section 28 = preparation for trafficking in narcotic drugs.
SMG Section 28a = trafficking in narcotic drugs.
* As of the reporting year 2012, **all** offences leading to final convictions in a reporting year can be included in the statistics. The table shows how often defendants were found guilty of offences relating to the SMG.

Source: Statistics Austria (judicial criminal statistics); graphic representation: GÖG/ÖBIG

In 2012, slightly over 70% of all persons convicted for SMG offences were punished by imprisonment, with prison sentences suspended on probation, as in the past, accounting for slightly more than 40%. The percentage of young people punished by imprisonment was 2.4%, and for 1.9% the prison sentence was suspended with probation (see Table A15).

For details regarding statistics on convictions in Austria, please consult Chapter 11 of the 2008 report (GÖG/ÖBIG 2008c). For lack of data, the main offences described cannot be broken down into subgroups. Chapter 9.6 of the present report includes a comparison of the trends regarding reports to the police, convictions and application of statutory alternatives to punishment.

Schumann (2012) provides data on **other drug-related crime,** especially offences committed in order to support drug habits. In his article on criminal statistics and imprisonment data, the author describes the groups of offences that are most often found in the context of repeated convictions: typical forms of offences to support drug habits. In the observation period (2010), a proportion of 16% of persons convicted or having served prison sentences due to violation of the SMG were re-convicted for offences against property, and 10% for offences against life and limb. In the case of first convictions concerning illicit handling of drugs (violation of SMG Section 27), the former group accounted for 18% and the latter for 11% (Schumann 2012). For more information see also Jagsch (2012) in Chapter 9.4.

9.3 Prevention of drug-related crime

Initiatives taken in the context of prevention at the provincial level and by centres providing services for drug users are primarily aimed at raising the general feeling of security and ease in the public space.

According to SHW 2013, drug users have not been found to spend time in public places for any length of time anywhere in Vienna (i.e. there is no permanent open drug scene). When looking for substances, social contacts or sleeping possibilities, drug users change from one (public) place to another and tend to be always on the move. Parallel to this, drug users have been integrated into the *jedmayer* day centre. In order to establish new contacts in the context of street social work and to maintain existing contacts, *streetwork* and *jedmayer* staff cooperate to run workshops aimed at offering daily structure and leisure programmes, and they organise outdoor activities (SHW 2013c; see also Chapter 8.3).

Furthermore, the parks and streets around the *jedmayer* centre are areas of community-oriented outreach social work. The goal here is to enhance the acceptance of the new centre, to get into contact with addicted persons in the neighbourhood, and to integrate them into Vienna's health and social care system, as well as finding quick, practical solutions in the case of problems and conflicts around *jedmayer*. No permanent open drug scenes or open drug trafficking has been found in this context. A few complaints were made about drug-using paraphernalia in the open space, and were dealt with immediately. Good contacts have been established among the residents and business owners in the neighbourhood (SHW 2013b).

During the winter, Vienna's services for homeless people were temporarily opened to non-eligible clients[86] as well, and as of November, *help-U* and *sam* staff thus made nightly rounds to offer homeless people places in emergency shelters, to ensure their survival in temperatures that were dangerous to health and in fact life-threatening (SHW 2013h).

After an evaluation in 2011 (see GÖG/ÖBIG 2012) and in agreement with the district administration, *sam 9* expanded its activities to additional areas in the 9th district of Vienna, primarily around the underground stations of Rossauer Lände, Friedensbrücke and Spittelau as well as Votiv Park and Arne Carlsson Park. *sam 9* had been informed that a rising number of people with alcohol problems and/or without housing were frequenting the above areas and that use of illicit substances and the resulting waste (especially packaging of medicines and syringes) was increasing (SHW 2013e).

86
For instance, nationals of the new EU member states are not eligible for the regular support services for homeless people and can only go to emergency shelters run by charity organisations, which are, however, often full (SHW 2013e).

During the preparatory phase for the Vienna Charter[87], *help U* organised a discussion event that took place at Ressel Park in September 2012, which focused on coexistence in public spaces. The event was attended by all dialogue groups, with particular interest shown on the part of addicted people. The discussion and presentation of different living situations and environments helped promote mutual understanding of the attending users of the public space and provided important input to the Vienna Charter (SHW 2013h).

The European Centre for Social Welfare Policy and Research, and the St. Pölten and Campus Wien Universities of Applied Sciences cooperate to run the AGORA project on building a health-promoting public sphere for young people and adults[88]. It is a practical project oriented towards specific settings, and aims at the cooperation of those professional groups that influence the public space with regard to certain forms of behaviour that pose health risks: police officers, (mobile) social workers, journalists and caterers. It has been planned to survey typical patterns of interaction, to enhance the cooperation between the stakeholders with regard to health-promoting aspects and to contribute to consolidating these forms of cooperation. The selected forms of behaviour posing health risks include use of psychoactive substances (alcohol, illicit drugs and tobacco) and its consequences, such as violence in the public sphere. The project, which is supported by FGÖ [Health Austria Fund], WiG [Vienna Health Promotion] and the Province of Lower Austria, aims at improving the communication and cooperation between the police and social workers in order to find de-escalating responses to drug use in public. Guidelines for caterers, shop owners and journalists who come across users of legal or illicit drugs will be drawn up, and a common curriculum for police officers and social workers on the problem of intoxication in public will be established. The main goal is to reduce the use of both illicit and legal substances.

In the discussion regarding hair analyses (see Chapter 1.3), the Ministry of the Interior pointed to experience gathered in a pilot project that has been run by the police in Vienna since 2010. The project is based on the Driving Licences Act: persons whose driving licence has been withdrawn are monitored by public health officers during a defined drug-free period, as a prerequisite for reissuing driving licences (Stadler, personal communication). The necessary checks are performed by urinalyses or hair tests. The main point of criticism concerning hair tests is that they are subject to systematic errors, due to genetic differences in growth rates, structure, colour as well as exposure (Schmid 2013).

87
The Vienna Charter was developed in direct communication with the Viennese and is aimed at laying down principles for good neighbourly relations in Vienna. The themes covered include, e.g. behaviour in road traffic and cleanliness of public spaces http://www.wien.gv.at/english/living-working/vienna-charter.html (15 July 2013).

88
http://www.wig.or.at/AGORA.343.0.html (15 June 2013; in German).
http://inclusion.fhstp.ac.at/index.php/projektestartseite/245-agora (15 July 2013; in German).
http://www.euro.centre.org/agora/index.php (15 July 2013; in German).

9.4 Interventions in the criminal justice system

In Austria, statutory alternatives to punishment are possible in accordance with the principle of treatment instead of punishment[89]. Regarding the implementation of the legal framework, information on the application of statutory alternatives to punishment is available (for details see ÖBIG 2004). In addition to the figures on convictions (see Chapter 9.3), Figure 9.4 and Table A16 provide data on temporary discontinuation of penal action by the public prosecutors (SMG Section 35) and dismissal of proceedings (SMG Section 37), as well as suspension of sentence (SMG Section 39).

Jagsch (2012) studied the data of two comparable subpopulations[90], as well as subgroups of the populations, with regard to legal and sociodemographic differences, and also differences relating to the fact that one group were undergoing health-related measures in the context of treatment instead of punishment[91], while the other (imprisoned population) were not (see also GÖG/ÖBIG 2012). When the persons in the two samples (imprisoned v. health-related measure) were related to legal categories, it showed that people in the non-imprisoned group were overrepresented in the categories of drug possession or drug trafficking, as well as possession plus trafficking, while the persons in the imprisoned sample were primarily found in the categories of property offences and/or violent offences. 84% of the non-imprisoned group and 94% of the imprisoned group indicated that they had already been in prison for a drug offence at some time in the past (Jagsch 2012).

The non-imprisoned subpopulation was further divided into three subgroups (THC group, opioid group and cocaine group): no person in the THC group said they had committed another offence in order to support their drug habits, while 44% of the cocaine group and more than half of the opioid group indicated having committed such an offence. When asked how often they had been convicted in the past, a significant result was revealed: 85% of the THC group have never before been convicted, and 15% only once; while approximately 25% of the cocaine group and around 40% of the opioid group had been convicted more than once for drug-related offences. It also showed that in the case of persons without previous convictions, the current health-related measures had been granted by the police, the public prosecutors or the court before the convic-

89
The principle of treatment instead of punishment relates to criminal policy, health policy and social policy measures that are taken in order to reduce drug abuse. Besides settlement by diversion, the measures include a special form of suspension of sentence, which may be granted to persons convicted because of violation of the SMG or related offences committed to support drug habits (Rast 2013).

90
The data sources were an epidemiological file of all persons imprisoned in Austria as at 1 April 2011 because of violation of the SMG (2 044 persons) and a file with questionnaire data of 140 adult clients of several Viennese providers of health-related measures, who had been interviewed in person from March 2010 to March 2011.

91
Health-related measures are applied as an alternative to court proceedings, to punishment or to serving a sentence. They may be applied at any stage of proceedings.

tion stage, i.e. these persons had not been subject to full-length court proceedings (Jagsch 2012).

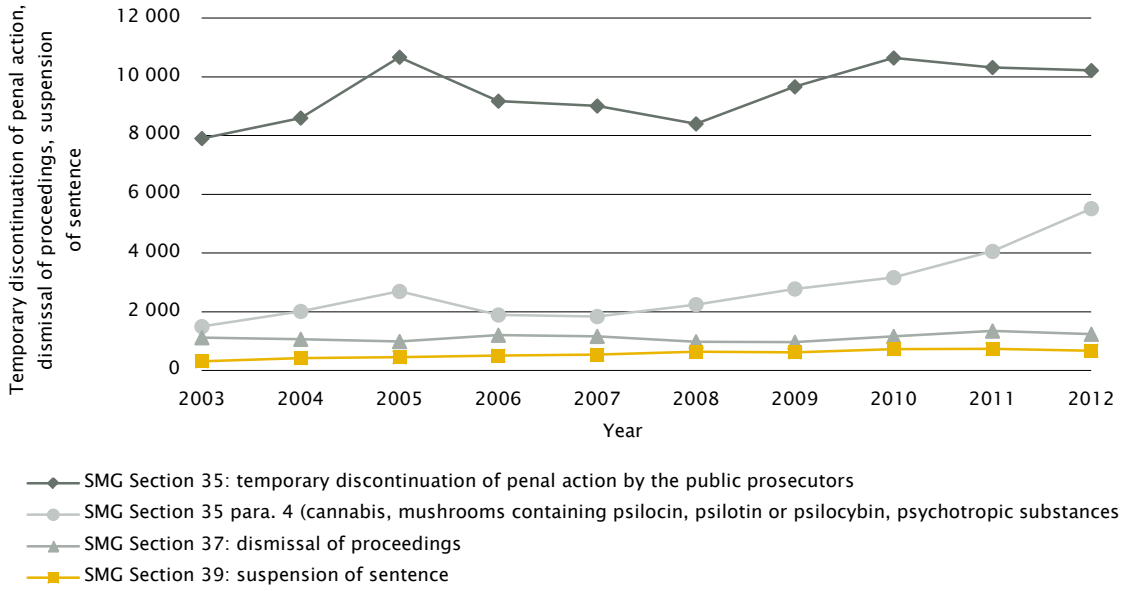
If the non-imprisoned group is divided into outpatients (75%) and inpatients (25%), it is apparent that additional offences to support drug habits are more often found among persons undergoing inpatient treatment (55%) than outpatients (39%). 16% of the inpatient group indicated more than 25 prior convictions for offences related to the SMG, and 32% of inpatients (but 83% of outpatients) indicated one conviction or less (Jagsch 2012).

Figure 9.4 shows a slight decrease regarding temporary discontinuation of penal action by the public prosecutors in 2011, though paralleled by a considerable increase with regard to cannabis, mushrooms containing psilocin, psilotin or psilocybin, as well as psychotropic substances. This development has continued in 2012. Table A14 provides additional information concerning final convictions under the SMG in 2012, broken down by basis of conviction, gender and age group.

Regarding suspension of sentence according to the principle of treatment instead of punishment (SMG Section 39), Figure 9.4 and Table A16 reveal that the number of cases continually rose over the years until 2011, and a slight decline is only apparent in 2012. This increase is one of the reasons why the cost of medical treatment and other therapies for drug users was rising continuously until 2011. It has shown a downward trend for the first time in 2012 – presumably due to the new regulations limiting cost-coverage by the Ministry of Justice, which, in accordance with SMG Section 41, has to bear the costs of health-related measures (see Table 9.2 and GÖG/ÖBIG 2012).

As already discussed in GÖG/ÖBIG 2012, in 2011 the maximum period of inpatient treatment in the context of treatment instead of punishment was limited for the first time, and access to treatment instead of punishment has been generally restricted for repeat offenders. Experts continue to emphasise that this will run counter to the desired effect, as a period of inpatient treatment that is reduced to six months will not be sufficient for many clients. Especially severely addicted patients with very low levels of education and training and without social relationships will not be able to organise their lives under these conditions, let alone cope with their addiction problems at a psychological level. However, according to Muhr (2013), there are provinces that provide funding for longer periods of treatment in the context of treatment instead of punishment.

Figure 9.4:
Development of statutory alternatives to punishment applied in Austria, from 2003 to 2012



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

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Table 9.2:
Expenditure by the Austrian Federal Ministry of Justice for inpatient treatment in the context of treatment instead of punishment, from 2003 to 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Expenditure in EUR mill.	2.77	3.20	4.61	4.85	5.86	6.48	7.03	8.54	8.77	8.46

Source: BMJ 2013; graphic representation:© GÖG/ÖBIG

A central component of treatment instead of punishment is to apply diversion as a way of settling criminal proceedings. Under certain circumstances, the public prosecutors are obliged to discontinue penal action temporarily if the defendant agrees to undergo a health-related measure. After a defined probationary period, penal action is discontinued permanently. In approximately 40% of cases based on reports relating to the SMG, diversion is applied (Rast 2013).

Compared to the previous year, the number of diversion offers (2012: 12 538) under SMG Section 35 (temporary discontinuation of penal action) and Section 37 (temporary dismissal of proceedings by the court) has decreased by 3.5%. The majority of diversion offers (almost 84%) was initiated by the public prosecutors, with diversion under SMG Section 35 for adolescents and young adults playing the most important role (37.5% and 34.5% , respectively, of all settlements

by diversion). A total of 80% of the diversion proceedings were settled successfully and penal action was discontinued permanently. Regarding SMG Sections 35 and 37, the corresponding proportion is 74% (women: 79%, men 73%; adolescents: 77%, young adults: 71%; BMJ 2013).

In her diploma thesis, Leeb (2011) compared the level of motivation for undergoing treatment among addicted persons in the treatment instead of punishment programme to the motivation of clients in treatment without court directives[92]. No significant differences between the two groups were apparent. This result is of clinical relevance, as it shows that one cannot assume a lower level of motivation for treatment among addicted clients who are treated due to court directives, compared to clients who start treatment voluntarily.

Based on Leeb (2011), the diploma thesis by Zwettler (2012) studied the question whether, after a catamnesis period[93] of six months, significant differences are apparent between the level of motivation of addicted clients following court directives (i.e. clients in the treatment instead of punishment programme), and that of addicted clients undergoing outpatient addiction treatment for some other reason. In her panel study[94], the author surveyed persons who had already been studied by Leeb (2011). Again, after six months, no differences in the level of motivation for treatment were found between the two groups. The results regarding the clients' emotional situation show that, at first, the clients not following court directives suffered significantly greater emotional stress than those in treatment due to court directives. After six months, however, no differences in stress levels were apparent.

In her diploma thesis Burtscher (2012) conducted a quasi-experimental cross-sectional study[95] to examine the main characteristics and the level of motivation for treatment among clients of the Viennese *Schweizer Haus Hadersdorf* treatment centre, who are undergoing inpatient treatment following court directives (see also Chapter 5.2.1). Almost half of men and three in four women said that at least one of their relatives was addicted as well; and in one out of three cases, it was a parent. One women in the sample indicated that she did not have a criminal record, the rest of women and all men had prior convictions. The majority of convictions related

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92
In a quasi-experimental cross-sectional study, 61 clients of the P.A.S.S. association were selected in the surveying period from July 2010 to March 2011. 32 persons were in the test group following court directives, and 29 persons were in the control group without court directives.

93
Catamnesis is a report drawn up after treatment, e.g. after a patient has been discharged from hospital, in order to examine and document the success of the treatment.

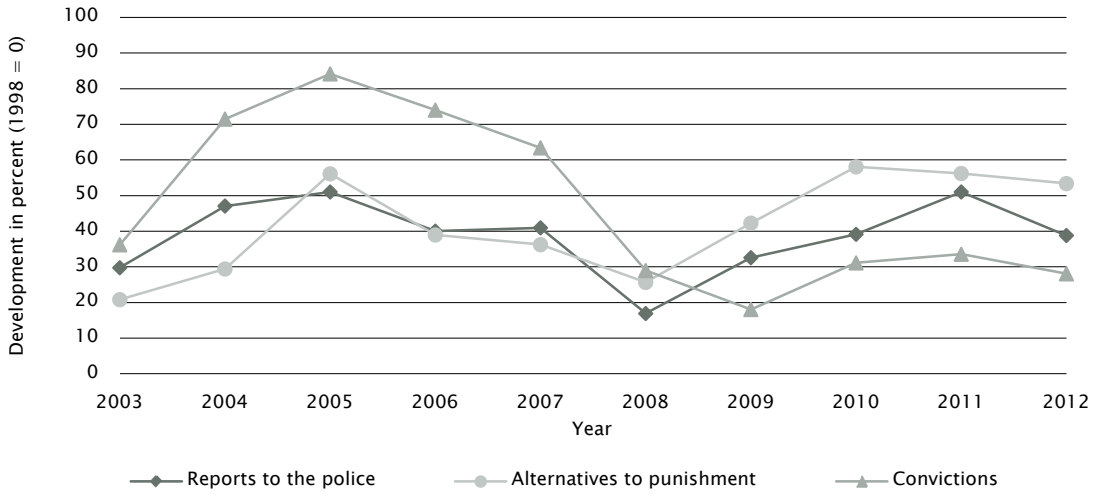
94
The dependent sample consisted of clients surveyed in the diploma thesis by Leeb (2011) who were still in treatment after six months. They were clients of the P.A.S.S addiction advice service in Vienna; the final sample size was 43 persons: 23 of them were undergoing drug treatment due to court directives, and 20 were in treatment for other reasons.

95
During a 10-month survey period, a sample consisting of 34 men (81%) and 8 women (19%) undergoing treatment due to court directives were interviewed at the Schweizer Haus Hadersdorf pre-treatment care centre.

to offences connected with drug addiction (95% of respondents). Half of the persons interviewed had already been convicted for property offences at least once. Violent offences ranked third: 48% of the sample had previous convictions in this category. Further results of the studies concern the clients' motivation to change: at the beginning of treatment, the clients following court directives mostly were in the stages of contemplation and action, i.e. regarding stages of change, no significant differences can be discerned between these clients and the group of clients without court directives.

A comparison of trends regarding reported offences, convictions and the application of alternatives to punishment reveals interesting results. Figure 9.7 shows the trend based on an index taken as 100% in 1998, i.e. in the year when the SMG entered into force. In the period of analysis between 2003 and 2012, the percentages of convictions went up most significantly. As of 2007, reports to the police and convictions have gone down to similar degrees, but we see a smaller decline regarding alternatives to punishment. Since 2008 the percentages both of reports to the police and of cases where alternatives to punishment are applied have risen to similar degrees. However, as far as convictions are concerned, this trend was not apparent prior to 2009. In 2011 a further increase in both reports and convictions was registered, and as of 2012 a downwards trend is apparent. Regarding the figures for conviction, the break in the time series described in Chapter 9.2 has to be taken into account. The slight decline in alternatives to punishment apparent since 2010 has continued.

Figure 9.5:
Comparison of index-linked developments of reported drug offences, convictions and application of statutory alternatives to punishment in Austria, from 2003 to 2012*



Note: The calculations are based on the year 1998, i.e. the year in which the Narcotic Drugs Act was replaced by the Narcotic Substances Act.
The figures for convictions refer to the leading offence, i.e. the most serious offence with regard to the range of punishment.
* As of 2012, Data on the legal basis for convictions has no longer been compiled by Statistics Austria but by the courts.

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

9.5 Drug use and problem drug use in prisons

The available information on drug use in prison has been discussed in greater detail in Chapter 11 *(Drug-related Health Policies and Strategies in Prison)* of the 2011 report (GÖG/ÖBIG 2011b). Furthermore, the selected issues chapter of the 2001 report *(Drug Users in Prison)* also provides information in this regard (ÖBIG 2001). More recent information has not been available.

9.6 Responses to drug-related health issues in prison

In Austria, interventions regarding drug-related health issues in prison primarily relate to substitution treatment, drug-free zones in prisons and, to a smaller extent, harm reduction measures. However, no specific measures oriented towards infectious diseases exist (see Chapter 6.2).

Since 2012, prisoners undergoing health-related measures in Tyrol have had the opportunity to take part in weekly information sessions. Furthermore, clients who have been granted imprisonment under eased conditions may receive outpatient psychosocial services at the Innsbruck advisory centre once a week during the last six months of imprisonment. In 2012 these services were taken up by several imprisoned clients; their exact number is not, however, available (SbTirol 2013).

The Prisons Directorate is currently running a project to develop standards for service provision to addicted persons in regular prisons or custody centres for mentally ill offenders. These standards for advice, support and treatment services have to be in line with the current legal situation and the state of the art in research. The general approach of regarding addiction or dependence as a disease means that those suffering from addiction, both in prison and outside, are entitled to receive adequate advice, support and treatment. Therefore, guidelines and specific standards for implementation are to be drawn up for different groups of prisoners (in pre-trial custody, in regular prisons, young people, women, mothers) and different stages of imprisonment (committal to prison/admission, imprisonment period, preparation for release, release). The project team consists of experts in the prison system as well as experts from the Vienna Addiction and Drug Coordination and the Anton Proksch Institute. Project completion is scheduled for the beginning of 2014 (Fuchs, personal communication).

Information on OST in Austrian prisons is provided in Chapter 11 of the 2011 report on the drug situation (GÖG/ÖBIG 2011b). For information on health-related measures during imprisonment see Chapter 9.4. More detailed information on drug-related health interventions during imprisonment is provided in the Selected Issues Chapter on *Drug-related Health Policies and Services in Prison* (Chapter 11) of the 2011 report on the drug situation (GÖG/ÖBIG 2011b).

9.7 Reintegration of drug users after release from prison

The majority of reintegration measures for drug users is also open to former prisoners.

Chapter 11 of the 2011 report on the drug situation (GÖG/ÖBIG 2011b) provides information on further activities aimed at reintegration after release from prison.

10 Drug Markets

10.1 Introduction

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 *checkit!*[96], as well as BMI/.BK (see ST13, ST14 ST15 and ST16) and BASG/AGES (Austrian Federal Office for Safety in Health Care/AGES Medicines and Medical Devices Agency)[97].

10.2 Availability and supply

The latest data on availability and supply of illicit substances in Austria come from studies conducted in 2009 and 2010, and have been described in the 2011 report on the drug situation (GÖG/ÖBIG 2011b).

10.3 Seizures

Austria does not play a major role in the production of illicit drugs (BMI 2012). Drug trafficking routes have been described in detail in the report of the previous year (GÖG/ÖBIG 2012). No new information has become available since then.

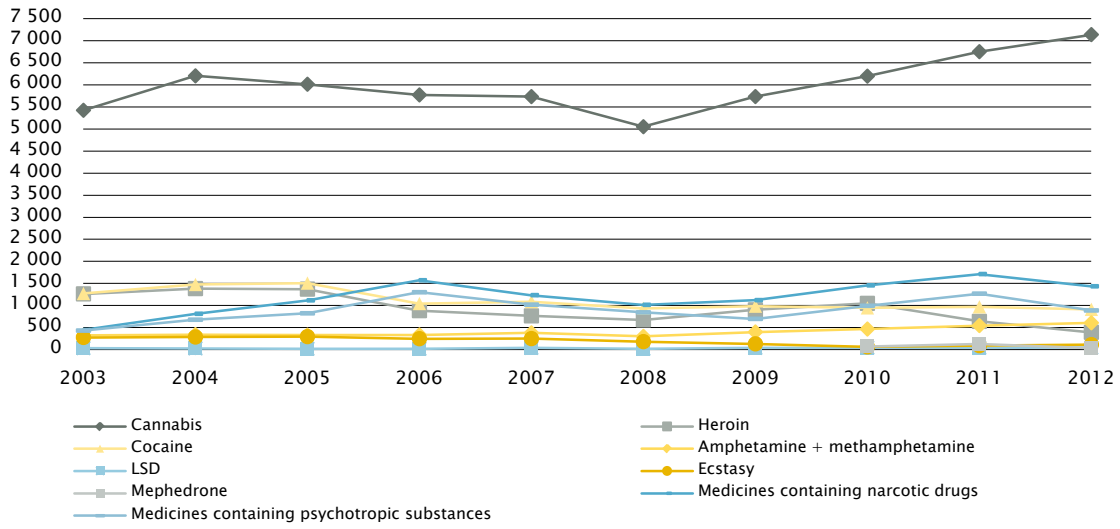
Compared to 2011, quantities seized have decreased, in part quite dramatically, in the case of heroin, cocaine, mephedrone, medicines containing narcotic drugs and medicines containing psychotropic substances. Increases have been recorded in the case of cannabis, amphetamine, LSD and ecstasy (see Figure 10.1 and Table A17).

The quantities 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 are often not intended for Austria (transit), distort the general picture.

96
checkit! is a cooperation project run jointly by the *Vienna Addiction Services* and the Clinical Institute of Medical and Chemical Laboratory Diagnoses of the Medical University of Vienna. It offers lab analyses of psychoactive substances at music events (parties, raves, festivals etc.).

97
Until 1 January 2012, when the Act on New Psychoactive Substances entered into force, the *Austrian Agency for Health and Food Safety* (AGES), on behalf of the Ministry of Health, regularly analysed products sold in head shops. Since then, AGES has, whenever necessary, analysed substances seized by the police and customs authorities.

Figure 10.1:
Number of seizures of narcotic drugs and medicines with psychotropic ingredients in Austria, 2003–2012



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

In the media controversy over opioid substitution treatment (see Chapters 1.3 and 5.2.1), the main point of criticism regarding use of prescribed OST medicines containing morphine was that these medicines might be diverted and sold on the black market. In order to outline the quantities of substitution medicines traded on the black market, the figures on OST medicines seized (2012: 8 636.5 tablets/capsules; 2011: 10 039.5; BMI 2013b), which the BMI provided in response to an enquiry, can be compared to the quantities of tablets and capsules containing slow-release morphine that have been sold legally (2012: 10 214 600 tablets/capsules; 2011: 9 871 000; Schopper, personal communication). In other words, a proportion of 0.8% (2012) or 0.10% (2011), respectively, of the substitution medicine prescribed were traded and seized on the black market. When interpreting this information, one has to consider the following aspects:

» The number of seizures as well as of reports to the police strongly depend on the intensity of police activities (see Chapter 9.1).
» The number of tablets and capsules seized refers to all substitution medicines and not only to slow-release morphine.
» The quantities found per seizure (averaging 6.8 tablets/capsules) have been fairly small.
» The number of opiate addicts in OST, as well as the number of patients who have been prescribed slow-release morphine, has risen in the same period.

10.4 Price/purity

In the context of the *checkit!* project (see Chapter 2.4), a total of 933 samples bought as psychoactive substances were analysed at 13 music events of the party and clubbing scenes in the

provinces of Vienna and Lower Austria in 2012. A proportion of 24% of the samples analysed contained the expected ingredients in the expected dose. Another 17% did contain the expected ingredients but users had to be warned because the doses were very high. 31% of the samples contained unexpected ingredients, and in the case of 28% of the samples, warnings due to of highly hazardous ingredients were necessary (SHW 2013d).

Approximately 59% of the total of 145 samples sold as ecstasy did not contain pharmacologically active substances other than the expected ingredient of MDMA[98] (or MDE/MDA), which has been the highest percentage since 2008 (see Table A19). The average MDMA content (median) was 112.5 mg, which is more than twice as high as a few years ago. The number of pills containing high doses of MDMA has increased considerably: in approximately one in four tablets tested, between 100 and 200 mg of the expected ingredient was detected (v. 3% in 2011). If men take MDMA doses over 1.5 mg per kg body mass, and women, doses of more than 1.3 mg per kg body mass, the negative effects of MDMA predominate, and neurotoxic effects are more likely to occur. An alarming development in 2012 has been that para-methoxyamphetamine and para-methoxymethampetamine (PMA and PMMA) were found in 14 pills bought as ecstasy (more than 10% of pills analysed). In past years PMA and PMMA, a substance related to PMA, have repeatedly led to the death of users in Europe and also in Austria. In the majority of pills containing PMA/PMMA, up to eight additional psychoactive substances were detected, which further increases the risk of severe health problems. Therefore warnings were issued via the Austrian and European early warning system, as well as the media.

Whereas in the previous year *new psychoactive substances*[99] were found in 40% of the tablets tested, the corresponding percentage went down to approximately 14% in 2012, which seems to be an effect of the adoption of the New Psychotropic Substances Act. Most notably, piperazine has almost completely vanished as an ingredient of ecstasy pills: in 2009 substances from this group were found in around half of the pills analysed, but in 2012 they were detected in only 3% of the pills (see Tables A19 and ST15).

Regarding the total of 222 samples of MDMA in powder or crystalline form, or as capsules that had been handed over for testing, the results were similar to those of the previous year: 83% of the samples only contained the expected ingredient (see Table A20). The average MDMA content (median) was 760 mg per gram. As in the previous year, in approximately 10% of the powder, crystalline or capsule samples bought as MDMA that were analysed, substances from the group of *new psychoactive substances* were detected.

Only 7% of the 273 samples bought as speed and analysed by *checkit!* contained only amphetamine as their sole pharmacologically active component. Another 56%, apart from amphetamine, also contained caffeine (see Table A21). In 19 samples, 4-methylamphetamine (4-MA) was

98
3,4 methylenedioxy-N-methylamphetamine.

99
As defined by the New Psychoactive Substances Act, which entered into force on 1 January 2012.

identified in addition to other substances. 4-MA is closely related to amphetamine and was in the focus of pharmaceutical research in the past as a possible appetite suppressant, though no useful results have been revealed. Recently, this substance has appeared as a recreational drug in several European countries. Cases of poisoning and also death from unknown causes have already been recorded in connection with 4-MA in a number of European countries. The number of samples in which *new psychoactive substances* were found has seen a small decline compared to 2011, from 6.4% to 4.0%. Only 2% of the samples bought as speed were found to contain methamphetamine. One in four speed samples was regarded as posing considerable health risks.

Only around 13% of a total of 104 samples bought as cocaine and analysed by *checkit!* actually contained cocaine and no other pharmacologically active substance. In approximately 66% of the cocaine samples, levamisole was detected, a phenomenon also observed in other European countries. The most dangerous side-effect that levamisole may have is a change in the blood composition and a weakened immune system, which in turn may cause potentially lethal infections. Phenacetin was found as an adulterant in 47% of the cocaine samples tested. Phenacetin used to be administered as a pain killer and to reduce fever, but due to its carcinogenic risks and associated renal problems caused by combinations of phenacetin and other analgesics, this substance was withdrawn from the market.

2012 has seen a decline in *new psychoactive substances*. While in 2011 a proportion of 18% of samples handed in contained new psychoactive substances as (expected or unexpected) ingredients, this applied to only 13% in 2012. New psychoactive substances, in particular, have declined in importance as additives to typical recreational drugs. The percentage of samples bought as new psychoactive substances and handed over for testing has gone down slightly (from 5% to 4%).

During the reporting period, the Austrian Agency for Health and Food Safety (AGES) analysed 41 samples that had been seized by the police or customs authorities due to suspected violation of the New Psychoactive Substances Act. The tests revealed diverse (synthetic) cannabinoids as ingredients of incense blends, e.g. STS-135 and AKB-48. Only the latter substances are not covered by the New Psychotropic Substances Act; the Ministry of Health is preparing their inclusion in the Act. Numerous substances that are meanwhile prohibited under the New Psychotropic Substances Act (mostly from the cathinone group) were detected in powders and pills; only 5FUR-144 (= XLR-11) has not been covered by the Act, but the Ministry of Health is preparing its inclusion.

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

Table 10.1:
Purity and price (EUR per gram/pill/unit) of various drugs sold at retail level in Austria in 2012

		Herbal cannabis*	Cannabis resin*	Brown heroin*	White heroin*	Cocaine*	Ampheta-mine*	Ecstasy**	LSD***
Purity	Minimum	0.03%	0.9%	0.1%	–	0.3%	0.4%	13 mg	–
	Maximum	39.2%	57.7%	30.9%	–	99%	99.5%	232 mg	–
	Median	9.8%	9.4%	5.1%	–	31.8%	11%	112.5 mg	–
Price	Minimum	7	5	30	–	40	10	4	4
	Maximum	10	8	60	–	125	120	25	20
	Typical	8	8	50	–	80	20	10	10

* Price per gram.
** Price per pill.
*** Price per unit.

Note: The data on prices provided by the Ministry of the Interior (herbal cannabis, cannabis resin, heroin) are based on information obtained by undercover police agents. The data on prices provided by *checkit!* (cocaine, amphetamine, ecstasy, LSD) are based on information by users.

Source: BMI/.BK; SHW 2013d; graphic representation: GÖG/ÖBIG

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Personal communications (alphabetic order)

Name and page	Institution or function
Drobesch-Binter, Barbara	Provincial Addiction Prevention Unit, Carinthia
Ederer, Klaus Peter	Addiction Coordinator, Styria
Fuchs, Stefan	Federal Ministry of Justice / Prisons Directorate
Gollner, Gerhard	kontakt + co Suchtprävention Jugendrotkreuz
Gstrein, Christof	Addiction Coordinator, Tyrol
Hausleitner, Burgi	Addiction Prevention Unit, Burgenland
Hörhan, Ursula	Addiction Coordinator, Lower Austria
Franz, Katalin	MDA basecamp
Klein, Jean-Paul	Federal Ministry of Health
Preinsperger, Wolfgang	Anton Proksch Institute
Prenn, Andreas	SUPRO Addiction Prevention Unit
Schopper, Johanna	Federal Ministry of Health, Federal Drug Coordinator
Schwarzenbrunner, Thomas	Addiction and Drug Coordinator, Upper Austria
Stadler, Gerhard	Federal Ministry of the Interior
Zangerle, Robert	Innsbruck University Hospital, Department of Dermatology and Venereology
Zedrosser, Christof	Dialog Association

Databases

There are hardly any relevant databases that are accessible to the public in Austria. Therefore, only Suchthilfekompass [Addiction Support Compass] (**http://suchthilfekompass.goeg.at/**; website in German) and Statistics Austria (**http://www.statistik.at/**) can be listed here.

This year, the search for **Austrian academic publication** has been intensified[100]. Below, all accessible academic studies that have been published by Austrian (co-)authors in 2012, and until 2013, have been listed. The list does not claim to be exhaustive. Those studies that have been cited in the main part have also been included in the Bibliography.

Alho, H., Auriacombe, M., Fischer, G., Maremmani, I., Scherbaum, N., and Torrens, M. (2013). Can outcomes monitoring of opioid maintenance treatment be improved in Europe? A statement by some European experts with interest in opioid maintenance treatment and its safety. Heroin Addiction & Related Clinical Problems 15 (1), 63-64.

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In order to identify the corresponding studies, a search for names of selected Austrian academics was carried out in the relevant literature databases. From the results, those publications that correspond to the criteria of the present report have been selected. As not all studies have been available as full texts, only a part of them has actually been used for the report, and on the other hand, a few studies that do not fully meet the criteria for this report may also have been included.

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In addition to publications in academic journals, relevant **doctoral, diploma and master's theses** submitted at Austrian universities have been compiled[101]. The following list does not claim to be exhaustive. Those theses that have been cited in the main part have also been included in the Bibliography.

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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)

Anababa – Ailem ve Ben / Mama & Papa – Meine Familie und ich –
promotion of parenting skills among parents of Turkish origin
(SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg)

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, Upper Austria)

Clever and Cool (annual project on preventing addiction and violence at school)
(Institut Suchtprävention, Upper Austria)

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The services listed are currently included in the EDDRA database. They have been listed as described in the database entries, which may go back several years ago.

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 Wien, 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)

FamilienBande – Was geht ab?! (family-oriented project)
(Akzente Suchtprävention – Fachstelle für Suchtvorbeugung 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 project: 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)

Service for young drug users and their families
(Dialog Association, 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 for 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. Most of the Austrian websites are only available in German, however

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

Burgenland Addiction Coordination
http://www.psd-bgld.at/leistungen/suchtkoordination/

Carinthia Drug Coordination
http://www.gesundheit-kaernten.at/sucht/drogenkoordination-land-kaernten.html

Lower Austria Addiction Coordination
http://www.suchtvorbeugung.at/suchtkoordination/

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

Styria Addiction Coordination
http://www.verwaltung.steiermark.at/cms/ziel/74837628/DE/

Tyrol Addiction Coordination
http://www.tirol.gv.at/gesellschaft-soziales/soziales/suchtkoordination/

Upper Austria Addiction and Drug Coordination
http://www.land-oberoesterreich.gv.at/cps/rde/xchg/ooe/hs.xsl/32040_DEU_HTML.htm

Vienna Addiction and Drug Coordination
http://www.drogenhilfe.at

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

Provincial Addiction Coordination Units

Burgenland: Fachstelle für Suchtprävention Burgenland
http://www.psd-bgld.at/leistungen/fachstelle-fuer-suchtpraevention/

Carinthia: Landesstelle für Suchtprävention Kärnten
http://www.suchtvorbeugung.ktn.gv.at/

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

Upper Austria: Institut Suchtprävention
http://www.praevention.at

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

Vorarlberg: SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg
http://www.supro.at

Austria 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 (addiction prevention documentation and research at Anton Proksch Institute)
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 in 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 – Jugend- und Suchtberatung (advice for young people and information on addiction)
http://www.jugendundkultur.at/de/auftrieb/home/

b.a.s. – Steirische Gesellschaft für Suchtfragen (Styrian addiction advice association)
http://www.bas.at

Blue Monday Gesundheitsmanagement (health management association)
http://www.bluemonday.at

Bundesarbeitsgemeinschaft Streetwork – Mobile Jugendarbeit Österreich (federal association of mobile street social work for young people in Austria)
http://www.bast.at

Carina – treatment unit
http://www.mariaebene.at/carina/

Caritas 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! – Verein Wiener Sozialprojekte (pill testing service, Vienna Social Projects Association)
http://checkyourdrugs.com

CONTACT – Spitalsverbindungsdienst (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 (Medical University of Vienna addiction clinic)
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

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

Jedmayer low-threshold centre
http://www.suchthilfe.at/beratung-betreuung-wohnen/jedmayer/

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 (addiction advice for young people)
http://www.agathon.cc

Jusy – Jugendservice Ybbstal, Waidhofen/Ybbs (young people's services)
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_servicestellen.html&dim=1680,1020

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

Lukasfeld (treatment unit)
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

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

Plattform Drogentherapien – Informationen zur Opiatabhängigkeit (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 (psychosocial centres)
http://www.psz.co.at/

Rumtrieb – Mobile Jugendarbeit (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 (foundation, 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/

Suchthilfe Wien gGmbH (Vienna Addiction Services)
http://www.suchthilfe.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 (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 (drug advice services)
http://www.gesundheit-kaernten.at/sucht/betreuung-beratungsstellen/drogenberatung-viva.html

Vorarlberger Drogenhilfe (drug support services)
www.suchthaufen.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 2013

Study (year of publication)	Area covered year of data collection (period)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience	
				Age	%
Bevölkerungsbefragung Österreich/ general population survey, Austria (Uhl et al. 2005a)	Austria 2004 (lifetime)	General population aged 14 and over (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 2006/7 (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
Bevölkerungsbefragung Österreich/ general population survey, Austria (Uhl et al. 2009b)	Austria 2008 (lifetime)	General population aged 14 and over (n = 4 196)	Cannabis	14+	12
			Ecstasy	14+	2
			Amphetamines	14+	2
			Cocaine	14+	2
			Opioids	14+	1
			Biogenic drugs	14+	2
			LSD	14+	2
			Solvents and inhalants	14+	2
Wiener Suchtmittelstudie/ drug survey, Vienna (IFES Institute for Empirical Social Studies 2009)	Vienna 2009 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	16
			Ecstasy	15+	3
			Amphetamines	15+	3
			Cocaine	15+	4
			Opioids	15+	3
			Biogenic drugs	15+	4
			Other drugs (e.g. LSD)	15+	3
Bevölkerungsbefragung OÖ/ general population survey, Upper Austria Seyer et al. 2010)	Austria 2009 (lifetime)	General population aged 15 and over (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
Wiener Suchtmittelstudie/ drug survey, Vienna (IFES Institute for Empirical Social Studies 2011a)	Vienna 2011 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	21
			Ecstasy	15+	3
			Amphetamines	15+	3
			Cocaine	15+	5
			Opioids	15+	2
			Biogenic drugs	15+	6
			Other drugs (e.g. LSD)	15+	2
Wiener Suchtmittelstudie/ drug survey, Vienna (IFES 2009)	Vienna 2013 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	24
			Ecstasy	15+	4
			Amphetamines	15+	4
			Cocaine	15+	5
			Opioids	15+	2
			Biogenic drugs	15+	7
			Other drugs (e.g. LSD)	15+	4

Summary and graphic representation: GÖG/ÖBIG

Table A2:
Overview of selected youth surveys on drug experience among young people in Austria from 2001 to 2011

Study (year of publication)	Area covered year of data collection (period covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience by age	
				Age group	%
Schulstudie Burgenland/ school survey, Burgenland (Schönfeldinger 2002)	Burgenland 2001 (lifetime)	Students from year 7 to year 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 survey (Dür and Mravlag 2002)	Austria 2001 (lifetime)	Students aged 15 (n = 1 292)	Cannabis	15	14
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 et al. 2005)	Styria 2005 (lifetime)	Apprentices aged approx. 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 survey (Dür and Griebler 2007)	Austria 2005/6 (lifetime)	Students aged 15 (n = 1 239)	Cannabis	15	14
Bevölkerungsbefragung OÖ/ general population survey, Upper Austria (Seyer et al. 2007)	Upper Austria 2006 (lifetime)	Young people 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

Continued next page

Table A2 continued

Study (year of publication)	Area covered year of data collection (period covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience by age	
				Age group	%
Schulstudie Burgenland/ school survey, Burgenland (Falbesoner and Lehner 2008)	Burgenland 2007 (lifetime)	Students from year 7 to year 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 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)	Young people 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 Suchtverhalten von Jugendlichen in NÖ/ youth survey, Lower Austria (Bittner et al. 2010)	Lower Austria 2009 (lifetime)	Young people aged 13 and 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
HBSC survey (Ramelow et al. 2011, Currie et al. 2012).	Austria 2010 (lifetime)	Students aged 15 and 17 (n = 1 820 and 1 490)	Cannabis	15	14
				17	27
Flash Eurobarometer Youth Attitudes on Drugs (European Commission 2011a and b)	Austria 2011 (lifetime)	Young people aged 15 to 24 (n = 501)	Cannabis	15–24	18.1

Summary and graphic representation: GÖG/ÖBIG

Table A3:
Number of directly drug-related deaths in Austria, by cause of death, 2003–2012

Cause of death	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Opioid poisoning	40	38	31	27	9	13	18	13	11	11
Poly-drug poisoning involving opioid(s)	115	133	134	137	138	136	153	148	151	111
(Poly-drug) poisoning involving narcotic drug(s) or NPS[1] without opioid(s)	8	4	4	5	5	4	1	0	8	8
Fatal poisoning of unknown type	0	10	22	28	23	16	15	9	7	9
Verified directly drug-related deaths, total	163	185	191	197	175	169	187	170	177	139
Drug-related deaths without verification by autopsy[2]	–	–	–	–	–	32	19	17	24	22

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

NPS = *new psychoactive substances.*
2: See GÖG/ÖBIG 2011b.

Table A4:
Number of verified directly drug-related deaths in Austria by province, 2003–12

Province	2003	2004	2005	2006	2007	2008[1]	2009[2]	2010[3]	2011[4]	2012[5]	2003–12
Burgenland	2	5	3	3	5	1	1	3	3	2	28
Carinthia	6	4	6	7	4	6	5	6	3	6	53
Lower Austria	13	31	29	38	27	34	26	30	28	20	276
Upper Austria	13	15	13	14	12	20	21	10	12	18	148
Salzburg	5	7	8	6	3	11	13	17	6	9	85
Styria	14	12	17	12	16	21	10	11	15	7	135
Tyrol	13	15	17	16	11	18	15	18	23	14	160
Vorarlberg	5	8	6	6	7	2	14	10	8	7	73
Vienna	92	88	92	95	90	55	82	65	79	56	794
Unknown	0	0	0	0	0	1	0	0	0	0	1
Total	163	185	191	197	175	169	187	170	177	139	1 753

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

1: Plus 32 drug-related deaths without verification by autopsy.
2: Plus 19 drug-related deaths without verification by autopsy.
3: Plus 17 drug-related deaths without verification by autopsy.
4: Plus 24 drug-related deaths without verification by autopsy.
5: Plus 22 drug-related deaths without verification by autopsy.

Table A5:
Number of verified directly drug-related deaths in Austria by age group, total and by gender, 2003–2012

Age group	2003		2004		2005		2006		2007		2008[1]		2009[2]		2010[3]		2011[4]		2012[5]	
	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%
19 and under	20	12.3	40	21.6	28	14.7	40	20.3	24	13.7	22	13.0	18	9.6	12	7.1	23	13.0	10	7.2
20–24	37	22.7	40	21.6	48	25.1	51	25.9	46	26.3	45	26.6	39	20.9	36	21.2	33	18.6	23	16.5
25–29	28	17.2	30	16.2	36	18.8	34	17.3	23	13.1	37	21.9	35	18.7	41	24.1	31	17.5	31	22.3
30–34	24	14.7	19	10.2	25	13.1	19	9.7	35	20.0	21	12.4	28	15.0	17	10.0	29	16.4	25	18.0
35–39	29	17.8	23	12.4	19	9.9	15	7.6	22	12.6	16	9.5	22	11.8	17	10.0	13	7.3	15	10.8
40 and over	25	15.3	33	17.8	35	18.3	38	19.3	25	14.3	28	16.6	45	24.1	47	27.6	48	27.1	35	25.2
Total	163	100	185	100	191	100	197	100	175	100	169	100	187	100	170	100	177	100	139	100
Men	133	81.6	147	79.5	148	77.4	155	78.7	136	77.7	134	79.3	150	80.2	140	82.4	135	76.3	111	79.9
Women	30	18.4	38	20.5	43	22.5	42	21.3	39	22.2	35	20.7	37	19.8	30	17.6	42	23.7	28	20.1

1: Plus 32 drug-related deaths without verification by autopsy.
2: Plus 19 drug-related deaths without verification by autopsy.
3: Plus 17 drug-related deaths without verification by autopsy.
4: Plus 24 drug-related deaths without verification by autopsy.
5: Plus 22 drug-related deaths without verification by autopsy.

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Table A6:
Distribution of verified directly drug-related deaths in Austria by cause of death and age, in 2012

Cause of death			Age group									
			< 15	15–19	20–24	25–29	30–34	35–39	40–44	45–49	> 49	Total
Fatal poisonings	Opioids	One opioid	0	1	4	2	2	1	1	0	0	11
		Several opioids	0	0	0	0	0	0	0	0	0	0
		+ alcohol	0	0	1	2	4	2	1	3	0	13
		+ psycho-pharmaceuticals	0	2	8	12	6	8	3	3	3	45
		+ alcohol & psycho-pharmaceuticals	0	3	0	2	7	3	2	6	7	30
	Opioids and other narcotic drugs	Narcotic drugs only	0	0	1	2	0	0	0	1	0	4
		ND + alcohol	0	0	0	1	0	0	0	0	0	1
		ND + psychopharma-ceuticals	1	2	5	2	2	1	0	1	0	14
		ND + alcohol & psychopharmaceuticals	0	0	0	2	1	0	0	1	0	4
	Narcotic drugs without opioids	Narcotic drugs only	0	0	2	1	1	0	0	0	0	4
		ND + alcohol	0	0	1	1	0	0	0	0	0	2
		ND + psychopharma-ceuticals	0	0	0	0	1	0	1	0	0	2
		ND + alcohol & psychopharmaceuticals	0	0	0	0	0	0	0	0	0	0
	Fatal poisoning/ unknown type		0	1	1	4	1	0	1	1	0	9
	Verified **directly** drug-related deaths, total		1	9	23	31	25	15	9	16	10	139
	of these: men		0	6	17	29	18	9	9	16	7	111

ND = narcotic dugs or *new psychoactive substance(s).*

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Table A7:
Distribution of verified directly drug-related deaths in Austria by cause of death and province, in 2012

Cause of death			Province									
			B	C[1]	LA[2]	UA[3]	S[4]	ST	T	VB	V[5]	A[7]
Fatal poisonings	Opioids	One opioid	0	0	1	3	1	1	1	1	3	11
		Several opioids	0	0	0	0	0	0	0	0	0	0
		+ alcohol	1	0	1	0	1	1	2	0	7	13
		+ psychopharmaceuticals	1	3	8	6	1	2	6	3	15	45
		+ alcohol & psycho-pharmaceuticals	0	0	5	3	2	0	4	1	15	30
	Opioids and other narcotic drugs	Narcotic drugs only	0	1	0	0	1	0	0	0	2	4
		ND + alcohol	0	0	1	0	0	0	0	0	0	1
		ND + psychopharmaceuti-cals	0	0	1	4	1	2	0	2	4	14
		ND + alcohol & psycho-pharmaceuticals	0	0	0	0	0	0	0	0	4	4
	ND without opioids	Narcotic drugs only	0	0	2	1	0	0	0	0	1	4
		ND + alcohol	0	1	0	0	0	0	1	0	0	2
		ND + psycho-pharmaceuticals	0	1	0	0	0	0	0	0	1	2
		ND + alcohol & psycho-pharmaceuticals	0	0	0	0	0	0	0	0	0	0
	Fatal poisoning/unknown type		0	0	1	1	2	1	0	0	4	9
	Verified **directly** drug-related deaths, total		2	6	20	18	9	7	14	7	56	139
Verified directly drug-related deaths **per 100 000 inhabitants** aged 15 to 64			1.0	1.6	1.9	1.9	2.5	0.9	2.9	2.8	4.7	2.4
Directly drug-related deaths **per 100 000 inhabitants** aged 15 to 64			1.0	1.9	2.1	2.0	2.7	0.9	2.9	2.8	6.0	2.8

ND = narcotic dugs or *new psychoactive substance(s).*

1: Plus 1 drug-related death without verification by autopsy.
2: Plus 3 drug-related deaths without verification by autopsy.
3: Plus 1 drug-related death without verification by autopsy.
4: Plus 1 drug-related death without verification by autopsy.
5: Plus 16 drug-related deaths without verification by autopsy.
7: Plus 22 drug-related deaths without verification by autopsy.

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Table A8:
Development of AIDS cases in Austria by risk situation, 2003–2012

Risk situation	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Homo-/bisexual contact	21	23	28	33	39	28	28	25	20	18
Injecting drug use	20	18	22	21	26	27	16	11	11	14
Heterosexual contact	49	51	45	47	42	38	45	37	21	22
Other cause/unknown	15	14	22	17	22	17	13	21	12	12
Total	105	106	117	118	129	110	102	94	64	66

Source: BMG; calculation and graphic representation: GÖG/ÖBIG

Table A9:
Distribution of reported violation of the Narcotic Substances Act in Austria by first offenders and repeat offenders as well as development of total reports, from 2003 to 2012

Reports	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total number of reports	22 245	25 215	25 892	24 008	24 166	20 043	22 729	23 853	25 892	23 797
First offenders	12 117	14 346	15 569	15 808	16 053	13 634	14 893	19 409	21 828	19 683
Repeat offenders	9 288	9 990	9 520	7 636	7 569	5 990	7 258	3 681	3 247	3 107

Difference between sum of individual figures and total figure = unknown.
Note: All reports, not only narcotic substances but also psychotropic substances.

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

Table A10:
Distribution of reports relating to violation of the Narcotic Substances Act in Austria (narcotic substances only) by type of substance, 2003–2012

Province	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Burgenland	984	967	923	1 033	1 008	871	953	716	801	687
Carinthia	1 659	1 464	1 529	1 190	1 408	1 153	1 372	1522	1422	1 165
Lower Austria	3 017	3 531	3 632	3 050	3 464	2 583	3 165	2978	2917	2 683
Upper Austria	2 782	3 521	3 769	3 209	3 786	3 245	3 908	3660	3590	3 547
Salzburg	868	1 077	1 092	1 001	1 116	1 015	1 096	1099	1431	1 145
Styria	1 570	1 705	1 516	1 435	1 929	1 372	1 669	1607	1878	1 879
Tyrol	2 102	2 695	2 775	2 607	2 454	1 982	2 555	2692	3095	2 570
Vorarlberg	1 146	1 044	1 008	1 240	1 153	976	1 027	1143	1092	1 392
Vienna	7 652	8 524	8 797	7 925	6 611	5 883	6 056	7001	7903	7 435
Total number of reports	21 780	24 528	25 041	22 690	22 929	19 080	21 801	22 418	24 129	22 503

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

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

Table A11:
Distribution of reports relating to violation of the Narcotic Substances Act in Austria, by drug type, 2003–2012

Drug type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Cannabis	17 706	20 252	20 900	19 021	19 063	15 063	17 513	17 066	17 836	17 461
Heroin and opioids	4 717	4 770	4 720	3 516	3 294	2 865	3 157	3677	2 575	1 582
Cocaine and crack	4 785	5 365	5 491	4 252	4 263	3 551	3 930	3332	3 383	2 963
Amphetamine + methamphetamine	1 727	1 843	1 795	1 639	2 112	1 405	1 749	1 669	2 206	2 120
LSD	214	196	160	164	196	101	193	137	138	129
Ecstasy	2 473	2 362	2 106	1 763	1 889	1 127	966	388	485	375
Mephedrone								209	1 179	331
Medicines containing narcotic drugs	872	1 420	1 795	2 800	2 714	2 294	2 693	3 113	3 552	2 864
Other narcotic drugs*	320	304	427	355	323	263	363	185	160	143
Psychotropic substances	11	11	4	14	20	13	16	37	58	35
Psychotropic medicines	603	892	1 081	1 687	1 535	1 185	1 174	1 666	2 086	1 502
Precursor substances	5	0	4	8	2	12	1	3	4	8

– = No data available.
Note: As the figures are broken down by type of drug, more than one substance per report may have been taken into account.
The sum total may therefore differ from the total number of reports.
* Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included.

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

Table A12:
Distribution of reports relating to violation of the Narcotic Substances Act in Austria, by drug type and province, in 2012

Drug type	B	C	LA	UA	S	ST	T	VB	V	Total
Cannabis	635	1 034	2 262	2 916	1 015	1 706	2 422	1 312	4 159	17 461
Heroin and opioids	47	101	189	221	43	28	54	97	802	1 582
Cocaine and crack	84	182	213	250	125	93	316	156	1 544	2 963
Amphetamine and methamphetamine	159	35	302	773	131	196	138	111	275	2 120
LSD	9	4	21	33	3	10	24	11	14	129
Ecstasy	36	11	56	71	29	36	70	25	41	375
Mephedrone	17	10	80	16	3	152	12	2	39	331
Medicines containing narcotic drugs	21	59	215	690	71	139	97	40	1 532	2 864
Other narcotic drugs*	5	6	30	13	10	26	34	5	14	143
Psychotropic substances	0	0	4	7	0	1	8	2	13	35
Medicines containing psychotropic substances	17	42	108	259	26	76	94	27	853	1 502
Precursor substances	0	0	0	2	0	0	0	0	6	8

Note: As the figures are broken down by type of drug, more than one substance per report may have been taken into account.
The sum total may therefore differ from the total number of reports.
* Including mushrooms containing psilocin, psilotin or psilocybin.

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

Table A13:
Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria, 2003–2012

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)
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
2011	4 444	1 185	3 137	36 461	12.2
2012*	4 261	1 403	2 810	35 541	12.0

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:
Section 27 = illicit handling of narcotic drugs.
SMG Section 28 = preparation for trafficking in narcotic drugs.
SMG Section 28a = trafficking in narcotic drugs.

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

* As of 2012, a break in the time series has to be taken into account. As of the present reporting year, the courts have provided information specifying the offence that is decisive for the punishment imposed. Previously, in cases where convictions related to several punishable offences, Statistics Austria had used an algorithm to calculate the leading offence, i.e. offence with the greatest range of punishment. Because of this break in the time series, it is only to a limited extent possible to compare the new figures to those prior to 2012.

Source: Statistics Austria (judicial criminal statistics); graphic representation: GÖG/ÖBIG

Table A14:
Final convictions under the Narcotic Substances Act (SMG) in Austria, by basis of conviction, gender and age group, in 2012*

Basis of conviction		Aged 14–19	Aged 20–24	Aged 25–29	Aged 30–34	Aged 34+	Total
SMG total	Men	485	1 245	838	556	728	3 852
	Women	50	134	99	46	80	409
SMG Section 28 or 28a	Men	84	336	256	228	349	1 253
	Women	10	46	36	19	39	150
SMG Section 27	Men	401	904	577	320	353	2 555
	Women	40	87	61	27	40	255

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

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

* As of 2012, a break in the time series has to be taken into account. As of the present reporting year, the courts have provided information specifying the offence that is decisive for the punishment imposed. Previously, in cases where convictions related to several punishable offences, Statistics Austria had used an algorithm to calculate the leading offence, i.e. offence with the greatest range of punishment. Because of this break in the time series, it is only to a limited extent possible to compare the new figures to those prior to 2012.

Source: Statistics Austria (judicial criminal statistics); graphic representation: GÖG/ÖBIG

Table A15:
Final convictions under the Narcotic Substances Act (SMG): young people and adults, basis of conviction and type of punishment, in 2012

Basis of conviction		Fine	Prison sentence			Other punishment[1]	Total
			Probation	No probation	Partial probation		
SMG total	Young people	82	79	19	5	24	209
	Adults	875	1 260	1 159	593	165	4 052
SMG Section 28 or 28a (felonies)	Young people	5	10	7	0	0	22
	Adults	45	388	530	344	74	1 381
SMG Section 27 (misde-meanours)	Young people	79	69	12	5	22	187
	Adults	822	849	612	249	91	2 623

Young people = persons aged under 18 at the time of the offence.
SMG Section 27 = illicit handling of narcotic drugs.
SMG Section 28 = preparation for trafficking in narcotic drugs.
SMG Section 28a = trafficking in narcotic drugs.

[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, in the case of young people only, conviction with punishment reserved (Juvenile Court Act Section 13) and conviction without punishment (Juvenile Court Act Section 12).

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

* As of 2012, a break in the time series has to be taken into account. As of the present reporting year, the courts have provided information specifying the offence that is decisive for the punishment imposed. Previously, in cases where convictions related to several punishable offences, Statistics Austria had used an algorithm to calculate the leading offence, i.e. offence with the greatest range of punishment. Because of this break in the time series, it is only to a limited extent possible to compare the new figures to those prior to 2012.

Source: Statistics Austria (judicial criminal statistics); graphic representation: GÖG/ÖBIG

Table A16:
Development of statutory alternatives to punishment applied in Austria, 2003–2012

Temporary discontinuation of penal action/dismissal of proceedings	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	9 023	9 666	11 660	10 379	10 175	9 384	10 627	11 807	11 667	11 455
SMG Section 35: temporary discontinuation of penal action by the public prosecutors*	7 902	8 599	10 668	9 173	9 008	8 399	9 661	10 643	10 319	10 215
Of these: SMG Section 35, para.4 (cannabis, mushrooms containing psilocin, psilotin or psilocybin, and psychotropic substances)*	1 499	2 016	2 697	1 895	1 841	2 249	2 780	3 166	4 059	5 515
SMG Section 37 (dismissal of proceedings)*	1 121	1 067	992	1 206	1 167	985	966	1 164	1 348	1 240
SMG Section 39 (suspension of sentence)	318	427	452	507	540	638	624	733	741	673

* These data have been 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 discontinuation of penal action by the public prosecutors.
SMG Section 35, para.4 = temporary waiving of reports in the case of small quantities of cannabis for personal use.
SMG Section 37 = temporary dismissal of proceedings by the court.

Sources: BMG, BMJ; calculations and graphic representation: GÖG/ÖBIG

Table A17:
Number of seizures of narcotic drugs/substances in Austria, 2003–2012

Drug type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Cannabis	5 422	6 202	6 012	5 770	5 732	5 050	5 733	6 195	6 750	7 137
Heroin	1 263	1 383	1 371	883	765	673	901	1 048	640	393
Cocaine	1 271	1 475	1 507	1 044	1 087	936	984	946	970	912
Amphetamine + methamphetamine	321	342	328	334	380	299	400	466	545	607
LSD	33	29	20	20	39	20	39	43	41	47
Ecstasy	276	286	295	248	250	181	131	63	90	113
Mephedrone								73	125	36
Medicines containing narcotic drugs	445	812	1 117	1 571	1 234	1 015	1 121	1 456	1 712	1 435
Other narcotic drugs*	84	87	97	84	92	58	79	72	67	65
Psychotropic substances	6	5	2	2	10	1	2	13	23	22
Medicines containing psychotropic substances	432	678	823	1 300	1 019	843	697	993	1 268	888
Precursor substances	2	0	2	7	1	12	0	1	0	8

* Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included.

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

Table A18:
Seizures of narcotic drugs/substances in Austria by quantity, 2003–2012

Narcotic drug/substance	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Cannabis (kg)	925.9	1 680.9	819.9	1 880.4	1 276.0	873.6	1 139.3	1 292.3	915.6	1 158.6
Heroin (kg)	42.8	235.0	282.2	34.3	117.0	104.0	189.6	96	64.9	222.1
Cocaine (kg)	58.3	75.5	244.9	61.8	78.1	78.38	53.2	241	139	64.6
Amphetamine + methamphetamine (kg)	54.3	27.6	9.6	38.9	19.4	13.00	65	23.4	15.8	35.3
LSD (trips)	298	2 227.5	2 108.5	10 831.5	1 058	225.50	1 581	533.5	1 588	276
Ecstasy (no. of pills)	422 103	122 663	114 104	30 855	66 167	45 335	5 847.5	7 275	45 780	8 998
Mephedrone (kg)	–	–	–	–	–	–	–	2.9	14.2	2.4
Medicines containing narcotic drugs (no. of pills)	10 827	9 031	9 057	12 253	10 376	7 180	8 233.5	11 630.5	12 504	11 039.5
Other narcotic drugs (kg)*	1.8	21.4	5.0	2.4	3.6	2.9	5.3	5.5	0.5	1.1
Psychotropic substances (kg)	0.15	0.05	0.00	0.03	0.20	0.00	0.01	2.6	4.3	2.9
Medicines containing psychotropic substances (no. of pills)	15 650	21 119	27 105	44 416	26 289	24 675	36 624.5	28 178	157 910	18 042
Precursor substances (kg)	25.00	0.00	0.10	9.85	0.17	22.16	0	1	0	2.8

* Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included.

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

Table A19:
Ingredients of samples bought as ecstasy and analysed by *checkit!* at parties and clubbing, 2003–2012

Ingredients	Samples bought as ecstasy (percentages)									
	2003 n=143	2004 n=93	2005 n=53	2006 n=134	2007 n=117	2008 n=146	2009 n=105	2010 n=76	2011 n=135	2012 n=145
MDMA	83.2	72.0	67.9	74.6	60.7	61.6	15.2	21.1	29.6	56.6
MDMA + MDE	7.7	9.7	0.0	1.5	0.0	0.0	0.0	0.0	0.0	2.1
MDMA + MDA	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.0	0.0	0.0
MDE and/or MDA	0.0	7.5	0.0	0.0	0.0	1.4	1.0	0.0	0.0	0.0
MDMA + caffeine	0.7	1.1	5.7	5.2	0.9	0.7	1.0	0.0	5.9	2.1
MDMA + amphetamine	0.7	0.0	1.9	1.5	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + various combinations*	3.5	1.1	13.2	0.0	6.0	7.5	1.9	5.3	18.5	6.2
PMA/PMMA	0.7	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	9.7
Amphetamine	1.4	0.0	1.9	4.5	0.0	0.7	1.0	1.3	0.0	0.0
Methamphetamine	0.0	0.0	0.0	0.7	0.0	0.0	1.0	0.0	0.0	0.0
Caffeine	0.0	1.1	0.0	0.7	1.7	0.0	0.0	6.6	0.7	0.0
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	1.5	16.2	17.8	52.4	47.4	19.3	–[3]
Various combinations*	2.1	7.5	9.4	9.0	14.5	10.3	25.7	11.8	3.0	9.7
New psychoactive substances[1] / NPS[2] + various combinations***	–	–	–	–	–	–	0.0	6.6	23.0	13.8

* 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.

*** *NPS*/NPS + various combinations: Only new psychotropic substances or new psychoactive substances and one or several other ingredients.

[1] *New psychoactive substances* coming under the NPSG, which entered into force on 1 January 2012.

[2] *New psychoactive substances.*

[3] As of 1 January 2012, piperazines have come under the NPSG and have thus been included in the table under *new psychoactive substances.*

Source: Suchthilfe Wien gGmbH; graphic representation: GÖG/ÖBIG

Table A20:
Ingredients of samples bought as ecstasy or MDMA in powder or crystalline form or as capsules and analysed by *checkit!* at parties and clubbing, 2005–2012

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)	2011 (n=163)	2012 (n=222)
MDMA	100.0	100.0	81.5	87.1	69.6	51.6	82.2	80.2
MDMA + MDE	0.0	0.0	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	0.0	2.7
MDE and/or MDA	0.0	0.0	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	0.6	0.0
MDMA + amphetamine	0.0	0.0	0.0	3.2	0.0	0.0	0.0	0.0
MDMA + various combinations*	0.0	0.0	11.1	0.0	4.3	7.7	5.5	1.4
PMA/PMMA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Amphetamine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9
Methamphetamine	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0
Caffeine	0.0	0.0	0.0	0.0	0.0	1.1	1.2	0.0
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	3.2	21.7	0.0	1.2	–[3]
Various combinations*	0.0	0.0	7.4	6.5	4.3	3.3	1.2	5.0
New psychoactive substances[1]/ NPS[2]+ various combinations***	–	–	–	–	8.7	35.2	8.0	9.9

* 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.

*** *NPS*/NPS + various combinations: Only new psychotropic substances or new psychoactive substances and one or several other ingredients.

[1] *New psychoactive substances coming under the NPSG, which entered into force on 1 January 2012.*

[2] *New psychoactive substances.*

[3] As of 1 January 2012, piperazines have come under the NPSG and have thus been included in the *table under* new psychoactive substances.

Source: Suchthilfe Wien gGmbH; graphic representation: GÖG/ÖBIG

Table A21:
Ingredients of samples bought as speed and analysed by *checkit!* at parties and clubbing, 2003–2012

Ingredients	Samples bought as speed (percentages)									
	2003 (n=57)	2004 (n=41)	2005 (n=33)	2006 (n=75)	2007 (n=129)	2008 (n=99)	2009 (n=113)	2010 (n=124)	2011 (n=203)	2012 (n=273)
Amphetamine	35.1	22.0	33.3	24.0	22.5	15.2	9.7	14.5	5.4	7.0
Amphetamine + caffeine	15.8	19.5	6.1	29.3	10.1	27.3	50.4	61.3	55.7	55.7
Amphetamine and meth-amphetamine	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	0.0
Amphetamine + various combinations	29.8	39.0	24.2	24.0	31.8	34.3	15.0	10.5	18.2	24.9
Methamphetamine	1.8	2.4	3.0	0.0	10.1	1.0	0.9	1.6	0.5	2.2
Caffeine	0.0	4.9	9.1	1.3	1.6	3.0	8.8	1.6	7.9	0.0
MDMA	0.0	0.0	6.1	4.0	0.0	1.0	0.0	0.0	0.0	0.0
Various combinations*	17.5	12.2	18.2	17	23.3	14.1	14.2	7.3	5.4	5.5
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	0.0	0.8	2.0	0.9	0.8	1.0	–[3]
New psychoactive substances[1]/ NPS[2]+ various combinations***	–	–	–	–	–	–	0.0	2.4	5.4	4.0

* 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.

*** *NPS*/NPS + various combinations: Only new psychotropic substances or new psychoactive substances and one or several other ingredients.

[1] *New psychoactive substances coming under the NPSG, which entered into force on 1 January 2012.*

[2] *New psychoactive substances.*

[3] As of 1 January 2012, piperazines have come under the NPSG and have thus been included in the *table under* new psychoactive substances.

Source: Suchthilfe Wien gGmbH; graphic representation: 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 2012

Treatment	B	C	LA	UA	S	ST	T	VB	V	A
Continued treatment	206	487	2156	1536	449	1155	1036	569	8091	15 685
First treatment	26	136	197	196	24	94	84	67	383	1 207
Total	232	623	2 353	1 732	473	1 249	1 120	636	8 474	16 892

Note: **Continued treatment** means treatment started before the reporting year or repeated treatment of persons already having undergone opioid substitution treatment in the past.
First treatment means treatment of persons who have never been in opioid substitution treatment before.

Source: BMG; calculations and graphic representation: GÖG/ÖBIG

Table A23:
Persons starting drug treatment or requiring addiction services in 2012, by age and gender, percentages

Age (years)	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
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	0	2	1	2	2	2	1	1	1	0	0	0
15 to 19	19	22	20	7	12	8	15	18	15	8	13	9
20 to 24	25	25	25	14	20	16	23	25	24	28	30	28
25 to 29	22	20	21	23	27	24	23	23	23	28	26	28
30 to 34	13	11	13	21	17	20	16	13	15	17	17	17
35 to 39	7	7	7	12	9	11	9	9	9	8	8	8
40 to 44	5	5	5	11	7	10	6	5	6	5	3	5
45 to 49	4	4	4	5	4	5	4	4	4	3	3	3
50 to 54	2	2	2	3	1	2	2	2	2	2	1	2
55 to 59	1	1	1	2	0	1	1	0	1	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0	0
65 to 69	0	0	0	0	0	0	0	0	0	0	0	0
70 to 74	0	0	0	0	0	0	0	0	0	0	0	0
75 to 79	0	0	0	0	0	0	0	0	0	0	0	0
80 and over	0	0	0	0	0	0	0	0	0	0	0	0
Valid indications	3 101	922	4 023	656	267	923	2 549	820	3 369	785	237	1 022
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.

Sources: GÖG/ÖBIG under preparation, DOKLI analysis of client year 2012;
graphic representation: GÖG/ÖBIG

Table A24:
Persons starting drug treatment or taking up support services in 2012, by employment and gender, percentages

Livelihood/employment	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Full-time employment (over 35 h/week)	-	-	-	12	9	11	31	23	29	5	2	4
Part-time employment (13 to 34 hours/week)	-	-	-	1	1	1	2	3	2	1	1	1
Minor employment (up to 13 h/week)	-	-	-	1	1	1	1	2	1	1	0	1
No employment	-	-	-	87	90	88	66	72	68	93	96	94
Valid indications	-	-	-	362	141	503	2 331	729	3 060	676	208	884
Unknown	-	-	-	269	112	381	165	63	228	21	2	23
Missing	-	-	-	25	14	39	53	28	81	88	27	115

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 data on livelihood are not collected for short-term contacts.

Sources: GÖG/ÖBIG under preparation, DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Table A25:
Persons starting drug treatment or taking up support services in 2012, by place of residence and gender, percentages

Place of residence	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Burgenland	-	-	-	-	-	-	2	1	2	2	1	2
Carinthia	-	-	-	-	-	-	12	15	12	1	4	2
Lower Austria	-	-	-	-	-	-	12	11	11	17	14	16
Upper Austria	-	-	-	-	-	-	6	7	6	12	11	12
Salzburg	-	-	-	-	-	-	4	4	4	3	3	3
Styria	-	-	-	-	-	-	10	10	10	9	6	8
Tyrol	-	-	-	-	-	-	4	3	4	15	27	18
Vorarlberg	-	-	-	-	-	-	12	9	11	9	7	8
Vienna	-	-	-	-	-	-	37	40	38	31	27	30
Abroad	-	-	-	-	-	-	1	1	1	1	0	0
Valid indications	-	-	-	-	-	-	2 430	771	3 201	759	225	984
Unknown	-	-	-	-	-	-	34	13	47	0	0	0
Missing	-	-	-	-	-	-	85	36	121	26	12	38

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.

Data on place of residence are not collected in the context of short-term contacts and low-threshold services.

Source: GÖG/ÖBIG under preparation, DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Table A26:
Persons starting drug treatment or taking up support services in 2012, by current housing situation and gender, percentages

Current housing situation	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Stable e.g. flat of their own	–	–	–	49	54	50	86	82	85	80	77	80
Unstable (e.g. homelessness)	–	–	–	41	36	39	9	12	10	12	17	13
Institution (e.g. hospital, treatment centre) plus additional stable housing (e.g. flat)	–	–	–	0	1	0	2	2	2	5	2	5
Institution (e.g. hospital, treatment centre), no additional stable housing	–	–	–	8	9	8	1	1	1	1	0	1
Assisted housing, plus additional stable housing (e.g. flat)	–	–	–	0	0	0	0	1	1	0	2	1
Assisted housing, no additional stable housing	–	–	–	1	1	1	2	3	2	2	1	2
Prison	–	–	–	1	0	1	0	0	0	0	0	0
Valid indications	–	–	–	421	162	583	2 403	774	3 177	704	209	913
Unknown	–	–	–	212	92	304	125	39	164	4	3	7
Missing	–	–	–	23	13	36	21	7	28	77	25	102

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.

Data on housing situation are not collected in the context of short-term contacts.

Sources: GÖG/ÖBIG under preparation, DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Table A27:
Persons starting drug treatment or taking up support services in 2012, by primary drug and gender, percentages

Primary drug (multiple indications admissible)	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Opioids total	**39**	**52**	**42**	**73**	**71**	**72**	**51**	**63**	**54**	**72**	**77**	**73**
Heroin	27	28	27	41	36	39	40	45	41	56	58	57
Methadone	5	7	5	6	12	7	4	6	4	20	24	21
Buprenorphine	1	2	1	6	0	4	2	3	2	0	0	0
Slow-release morphine	6	11	7	16	24	18	7	10	8	18	19	19
Other opioid	14	18	14	5	7	6	9	11	9	34	35	34
Cocaine group	**11**	**7**	**10**	**3**	**1**	**3**	**12**	**7**	**10**	**34**	**31**	**33**
Cocaine	11	7	10	3	1	3	12	7	10	34	31	33
Crack	0	0	0	0	0	0	0	0	0	1	0	1
Other cocaine	0	1	0	0	0	0	0	0	0	0	0	0
Stimulants total	**8**	**14**	**9**	**3**	**2**	**3**	**6**	**5**	**5**	**21**	**16**	**20**
Amphetamines (e. g. speed)	5	8	6	2	2	2	4	4	4	17	11	16
MDMA (ecstasy) and derivatives	2	4	3	0	1	1	2	2	2	14	13	14
Other stimulant	2	3	2	1	0	1	1	1	1	1	1	1
Tranquillisers/hypnotics total	**7**	**9**	**7**	**11**	**13**	**12**	**7**	**11**	**8**	**29**	**43**	**32**
Benzodiazepines	7	9	7	11	11	11	7	11	8	29	43	32
Barbiturates	0	0	0	0	1	0	0	0	0	4	7	5
Other hypnotics/tranquillisers	0	0	0	0	4	1	0	0	0	0	1	0
Hallucinogenic drugs total	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**1**	**4**
LSD	1	0	1	0	0	0	0	0	0	4	1	4
Other hallucinogenic drug	0	0	0	0	0	0	0	0	0	0	0	0
Cannabis	58	49	56	27	29	27	45	29	41	62	47	58
Solvents and inhalants	0	0	0	0	1	0	0	0	0	1	1	1
Alcohol	8	8	8	18	24	19	7	6	7	16	24	18
Other drugs	5	5	5	0	0	0	2	1	2	3	3	3
Primary drug (indications)	2 746	700	3 446	287	128	415	2 911	905	3 816	2 147	617	2 764
Primary drug indicated (persons)	1 810	440	2 250	210	84	294	2 053	668	2 721	677	195	872
Only legal problems (persons)	128	78	206	31	13	44	83	19	102	18	5	23
No primary drug indicated (persons)	1 098	381	1 479	409	169	578	330	109	439	46	13	59
Missing	65	23	88	6	1	7	83	24	107	44	24	68

Note: Note: All lines except Valid indications, Number of persons with 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 under preparation, DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Table A28:
Persons starting drug treatment or taking up support services in 2012, by injecting drug use and gender, percentages

Injecting drug use	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
No	70	62	68	30	30	30	61	49	58	36	22	33
Yes	30	38	32	70	70	70	39	51	42	64	78	67
Valid indications	2 815	778	3 593	437	176	613	2 335	753	3 088	674	209	883
Unknown	242	133	375	193	78	271	197	62	259	17	5	22
Missing	44	11	55	26	13	39	17	5	22	94	23	117

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.

Sources: GÖG/ÖBIG under preparation, DOKLI analysis of client year 2012; graphic representation: GÖG/ÖBIG

Table A29:
Exchange and sale of syringes by number of provision points and province, in 2012

Province	Number of syringe provision points	Number of vending machines	Number of syringes provided (exchanged or sold)
Burgenland	0	0	0
Carinthia	5[1]	0	26 988
Lower Austria	0	0	0
Upper Austria	4[2]	2	342 232
Salzburg	1	2	9 926
Styria	2[2,3]	3	558 234
Tyrol	2	4	435 827
Vorarlberg	6[4]	7	n/a
Vienna	2[2]	0	2 924 457
Total	**22**	**18**	**4 297 664** [5]

1: Includes three streetwork services.
2: Includes one streetwork service.
3: Service restricted to Graz.
4: Includes two streetwork services.
5: Data incomplete, no comparison to 2011 possible.

Source: ST10/Syringe availability 2013; calculation and graphic representation: GÖG/ÖBIG

Table A30:
Current health problems of clients of Vienna's drug support and treatment centres (BADO), percentages, 2004–2011

Current health problems	2004	2005	2006	2007	2008	2009	2010	2011
Chronic hepatitis C	30	35	31	29	29	26	25	26
Dental problems	19	23	21	19	19	19	19	21
Gastrointestinal problems	11	16	14	12	12	13	13	14
Psychiatric diseases	9	10	12	13	11	14	15	16
Dermatological and venous problems	7	10	8	7	7	8	8	8
AIDS, HIV infection	4	4	4	4	4	4	4	4
Spasms, epileptic seizures	5	6	6	5	5	6	7	6
Chronic hepatitis B	4	4	3	2	3	2	2	2
Chronic ill health	1	1	1	1	2	3	3	3
Gynaecological problems	2	4	4	4	3	3	4	4
STD (sexually transmitted diseases)	*	1	1	*	*	*	*	*
Other health problems	9	8	8	9	11	13	13	13
No current health problems	41	35	38	39	39	37	36	34

* = share of less than 1%.

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

Source: IFES 2012; graphic representation: 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 via parent meetings and mailing, and through the school councils (in which heads of school, teachers, parents and students are represented).

The programme *Eigenständig werden* [Becoming independent] is implemented in primary schools (children aged 6 to 10) over at least ten lessons per year. It pursues the principles of a holistic view of individuals, orientation towards personal resources, interactive learning and the 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 2012/13

Province	Number of completed trainings SY 2012/13	Number of training sessions for teachers[1] SY 2012/13	Number of certified teachers SY 2012/13	Percentage of primary school teachers reached	Number of primary schools reached SY 2012/13	Percentage of primary schools reached	Number of parents' meetings SY 2012/13	Number of workshops SY 2012/13	Number of primary school teachers reached by SY 2012/13	Percentage of primary school teachers reached by SY 2012/13	Number of primary schools reached by SY 2012/13	Percentage of primary schools reached by SY 2012/13
B	1	28	15	1.5	1	0.5	0	2	155	15.6	74	37.8
C	2	60	32	1.4	9	3.8	2	1	301	13.0	110	46.6
LA	5	168	66	0.9	5	0.7	0	2	640	9.0	144	20.3
UA	10	280	202	3.6	41	7.1	22	2	1578	25.2	423	73.7
S	4	112	119	5.2	20	10.8	1	4	467	20.4	116	62.4
ST	1	34	18	0.5	7	1.46	0	4	381	9.9	152	31.66
T	3	72	51	1.6	25	6.6	1	1	419	13.2	214	56.6
VB	3	78	49	3.5	5	3.0	0	2	743	53.1	96	57.5
V	3	72	52	0.95	10	2.5	n.a.	1	1334	24.3	230	84.0

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 Unit; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; graphic representation: GÖG/ÖBIG

The 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 covered in 10 lessons. The principles of the programme take into account the age and growing competence of the students as well as interactions 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, and includes a four-year training course for teachers with 10 individual events and a total of 20 to 44 training sessions per course.

Table A32:
Programme *plus*, school year 2012/13

Province	Number of further training courses for teachers since 2008	Number of teachers with completed training SY 2012/13	Percentage of teachers reached	Number of schools reached SY 2012/13	Number of classes reached SY 2012/13	Percentage of schools reached SY 2012/13	Number of teachers reached by SY 2012/13	Percentage of school teachers reached by SY 2012/13	Number of schools reached by SY 2012/13	Percentage of schools reached by SY 2012/13	Number of classes reached by SY 2012/13
B	9	44	2.8	16	n.a.	30.2	44	2.8	16	30.2	n.a.
C	6	103	3.3	32	66	39.5	103	3.3	32	39.5	76
LA	5	79	0.8	15	68	4.8	79	0.8	15	4.8	79
UA	15	305	3.3	83	175	30.0	305	3.3	83	30.0	175
S	4	59	1.6	22	41	22.2	61[103]	1.6	22	22.2	43
ST	7	156	3.8	35	97	20.2[104]	167	4.1	39	22.5[105]	105
T	6	88	2.1	37	66	29.6	128	2.7	48	38.4	116
VB	6	103	3.9	39	n.a.	60.0	103	3.9	39	60.0	n.a.
V	6	131	1.4	84	24	11.2	131	1.4	84	39.4	77

SY = school year; 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 Unit; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; graphic representation: GÖG/ÖBIG

103
Several teacher terminated/left the programme prematurely.

104
Percentage relates only to lower and new secondary schools.

105
Percentage relates only to lower and new secondary schools.

Under the name *movin'*, the addiction prevention units organise standardised motivational interviewing courses, a technique used in both prevention settings and addiction support and treatment centres. Motivational interviewing permits a supportive atmosphere and rapport, which enhances the motivation to change behaviour. On average, the courses 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' courses, in 2012

Province	Direct/final target group (age group)	Indirect target group (advisors, multipliers)	Number of courses/course series in 2011	Number of training sessions for multipliers in 2012	Number of certified participants in 2012	Documentation yes/no	Process evaluation yes/no
C	Young people aged 12 to 21, in youth centres and social centres or in contact with street workers	Staff of open youth services (youth centres, street work), staff of non-governmental youth welfare services	3	48	49	Yes	Yes
LA	Young people, clients of addiction advice and treatment services	Staff of open youth services and of addiction and drug advice centres	2	40	26	Yes	Yes
UA	Young people aged 12 to 21	Staff of open youth services, basic youth social work course for provincial youth officers, trainers in labour market policy programmes	3	64	48	Yes	Yes
S	Young people in youth centres and support services (workplace/apprenticeship, assisted shared housing), school students, clients of drug support centres, street work, etc.	Staff of youth centres and shared housing for young people, guidance counsellors, apprentice instructors, street workers, police officers specialising in prevention, anti-smoking counsellors, etc.	6	96 (50 minutes each)	76	Yes	Yes
ST	Young people aged 12 to 21, young adults	Staff of open youth services, school social workers/advisors, social education workers, staff instructing or working with young people	5	100	75	Yes	Yes
T	Young people aged 15 to 21	Advisors for young people	1	4	15	Yes	Yes
VB	Young people aged 12 to 21, clients of (addiction) support centres	Staff of (addiction) support centres and open youth services, leisure education staff	2	32	37	Yes	Yes
V	Young people aged 12 to 25	Staff and peers of open youth services, key persons in schools, apprenticeship training and enterprises	7	139	100	Yes	Yes

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 Unit; Addiction Prevention Institute Vienna; Addiction Prevention Unit Carinthia; graphic representation: GÖG/ÖBIG

Table A34:
Austrian population statistics by age group (groups of 5 and 15 years, respectively) and gender; annual average of 2011

Age group	Men	Women	Total
0 to 4	201 780	191 753	393 533
5 to 9	207 620	197 698	405 318
10 to 14	220 655	209 902	430 557
15 to 19	252 643	239 450	492 093
20 to 24	266 848	259 953	526 801
25 to 29	278 925	276 957	555 882
30 to 34	270 511	267 618	538 129
35 to 39	285 673	289 785	575 458
40 to 44	344 444	341 124	685 568
45 to 49	359 923	352 922	712 845
50 to 54	311 664	311 865	623 529
55 to 59	251 271	262 058	513 329
60 to 64	232 572	248 845	481 417
65 to 69	192 570	217 517	410 087
70 to 74	182 685	216 278	398 963
75 to 79	111 260	152 018	263 278
80 to 84	82 574	135 780	218 354
85 and over	51 875	143 884	195 759
Total	**4 105 493**	**4 315 407**	**8 420 900**
0 to 14	630 055	599 353	1 229 408
15 to 29	798 416	776 360	1 574 776
30 to 44	900 628	898 527	1 799 155
45 to 59	922 858	926 845	1 849 703
60 to 74	607 827	682 640	1 290 467
75 and over	245 709	431 682	677 391
Total	**4 105 493**	**4 315 407**	**8 420 900**
15 to 64	2 854 474	2 850 577	5 705 051

Source: Statistics Austria (2013); calculation and graphic representation: GÖG/ÖBIG

Map A1:
Overview of provinces, provincial capitals and districts

Source and graphic representation: GÖG/ÖBIG

Annex B

List of Abbreviations

A	Austria
abs.	absolute
AC	Addiction Coordinator
AGES	Austrian Agency for Health and Food Safety
AHIVCOS	Austrian HIV Cohort Study
AIDS	Acquired Immune Deficiency Syndrome
AKB48	N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide
AKH	General Hospital Vienna
AMS	Public Employment Service
API	Anton Proksch Institute
AR	Addiction Representative
BADO	(basic documentation of clients of drug services in Vienna
BASG	Austrian Federal Office for Safety in Health Care
BGBl	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
BMLV	Federal Ministry of Defence
BMUKK	Federal Ministry of Education, 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
C	Carinthia
COFOG	Classification of Functions of Government
CRC	Capture-recapture (method)
CTC	Communities That Care
DC	Drug Coordinator
DOKLI	nationwide documentation system of clients of Austrian drug services
DOKU	documentation system
DR	Drug Representative/Drug Commissioner
DRD	drug-related death
e.g.	for instance
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
EWS	Early Warning System
FGÖ	Fonds Gesundes Österreich [Health Austria Fund]
GÖG	Gesundheit Österreich GmbH Österreich [Health Austria]

HAART	highly active anti-retroviral therapy
HBSC	Health Behaviour in School-aged Children (WHO survey)
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
EWS	Early Warning System
FGÖ	Fonds Gesundes Österreich [Health Austria Fund]
GÖG	Gesundheit Österreich GmbH Österreich [Health Austria]
HAART	highly active anti-retroviral therapy
HBSC	Health Behaviour in School-aged Children (WHO survey)
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
i.e.	that is
ICD-10	International Classification of Diseases and Related Health Problems
IFES	Institute for Empirical Social Studies
ISP	Addiction Prevention Institute
KAV	Vienna Hospital Association
LA	Lower Austria(n)
LISA	list of doctors qualified to offer opioid substitution treatment
LSD	d-lysergic acid diethylamide
mCPP	meta-chlorophenylpiperazine
MDA	3,4-methylenedioxyamphetamine
MDE	3,4-methylenedioxy-N-ethylamphetamine
MDMA	3,4-methylenedioxy-methylamphetamine
mill.	million
n. a.	not available
NPS	new psychoactive substances
NPSG	Act on New Psychoactive Substances
NPSV	Regulation on New Psychoactive Substances
ÖÄK	Austrian Medical Association
ÖBIG	Österreichisches Bundesinstitut für Gesundheitswesen [Austrian Health Institute]
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
ÖVDF	Federation of Austrian Professionals Working in the Field of Drug Abuse
para.	paragraph
PID	City of Vienna Press and Information Service
PMA	paramethoxyamphetamine
PMMA	para-methoxymethamphetamine

REITOX	European Information Network on Drugs and Drug Addiction (Réseau Européen d'Information sur les Drogues et les Toxicomanies)
SDHN	Vienna addiction and drug services network
SDW	Vienna Addiction and Drug Coordination
SHH	Schweizer Haus Hadersdorf (treatment centre)
SHW	Vienna Addiction Services
SMG	Narcotic Substances Act
SQ	Structured Questionnaire
ST	Standard Table
ST	Styria
StGB	Criminal Code
STS-135	N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indole-3-carboxamide
T	Tyrol
Tb	tuberculosis
TDI	Treatment Demand Indicator
THC	tetrahydrocannabinol
UA	Upper Austria(n)
V	Vienna
v.	versus
VB	Vorarlberg
WHO	World Health Organization
WiG	Vienna Health Promotion
4-MA	4-methylamphetamine = 1-(4-methylphenyl)propan-2-amine

Annex C

Standard Tables & Structured Questionnaires

List of Standard Tables and Structured Questionnaires for Austria

The following list gives an overview of all standard tables and structured questionnaires communicated to the EMCDDA in the context of the national report on the drug situation. If no year of update is given, the table or questionnaire has been updated in the reporting year. The information gathered is used to update the statistical bulletin, the European report on the drug situation as well as other products of the EMCDDA[106].

Standard Table 01:	Standardised results and methodology of adult national population survey on drug use
Standard Table 02:	Methodology and results of school surveys on drug use
Standard Table 05:	Direct drug-related deaths/Drug-induced deaths
Standard Table 06:	Evolution of direct drug-related deaths/Drug induced 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 (Voluntary); Part 4: Notified cases of Hepatitis C and B in injecting drug users
Standard Table 10:	Syringe availability
Standard Table 11:	Reports of 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/Potency at street level of some illicit substances
Standard Table 15:	Composition of illicit drug tablets
Standard Table 16:	Price at street level of some illicit substances
Standard Table 17:	Leading edge indicators for new developments in drug consumption (Voluntary)
Standard Table 18:	Overall mortality and causes of deaths among drug users
Standard Table 24:	Access to treatment
Standard Table 30:	Methods and results of youth surveys (Voluntary)
Standard Table TDI:	Characteristics of individuals starting treatment for drugs by type of treatment centre
Standard Table:	Public expenditure (Voluntary)
Structured Questionnaire 22/25:	Universal prevention
Structured Questionnaire 23/29:	Prevention and reduction of health-related harm associated with drug use (latest update: 2011)
Structured Questionnaire 26:	Selective prevention
Structured Questionnaire 27:	Part 1: Treatment programmes; Part 2: Quality assurance treatment (latest update: 2011)

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See http://www.emcdda.europa.eu/ under *Statistics and country data*, *Publications* etc.

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 (latest update: 2011)

Map 1

Figure 2

Figure 1.1: Overview of the organisational structure of drug policy in Austria 6
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